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GUIDANCE

The use of talking therapy outdoors

Guiding principles:

Outdoor talking therapy is an evidence-based approach. It is typically used to combine the conventional outcomes of indoor therapy with the known benefits of connecting with the natural world.

Meeting with clients in open, outdoor spaces can permit an authentic, human-to-human encounter, whilst at the same time allowing for physical distancing in line with current Covid-19 government recommendations.

Therapy outdoors is supported across diverse client groups and therapy modalities. However, therapy outdoors will not suit all clients, practitioners and services. This guidance document is intended to support individualised assessment and formulation when considering therapy outdoors (e.g. suitability of approach based on client and presenting problem, choice of outdoor activity, practicalities and issues concerning safety, consent and confidentiality).

This document is not intended to supersede local guidance. It is recommended that the practitioner consults relevant policy documents and guidance in their service or professional body. This document should be used in conjunction with appropriate critical thinking and clinical reasoning.

Introduction

In response to the Covid-19 pandemic, practitioners and services have been required to review their continuity plans. Alternatives to conventional face-to-face therapy have largely centred around offering therapy remotely (e.g. telephone or video calling)¹. Although helpful, some practitioners and clients have expressed difficulties with these approaches, such as access to equipment, digital literacy, and restricted non-verbal communication². This guidance document considers the outdoors as another context for offering talking therapy, which may be of particular interest in situations where digital approaches are unavailable or do not meet the needs of the client or practitioner.

Those who are familiar with working outdoors find that when outdoor spaces are used appropriately, they provide a safe and effective space for therapy³. These practitioners and their clients have reported a range of benefits unique to outdoor talking therapy³, such as:

- promoting access and equity of care for clients who find an indoor therapy room encounter too uncomfortable (e.g. its perceived pressure and formality, feeling trapped or pathologised, experiencing difficulties with cognitive and attentional capacity);
- enabling clients to experience greater shared ownership of the therapy space and relationship;
- greater freedom of expression through a sense of escape from day-to-day routines and environments that the client has associated with their difficulties;
- physical movement and/or dynamic surroundings supporting psychological flexibility in those who feel psychologically 'stuck';
- restorative effects of time spent in natural settings (e.g. reduced blood pressure and stress levels);
- interconnectedness with the natural world providing a sense of belonging and wellbeing;
- a deeper connection to the natural world supporting positive and reciprocal environmental behaviours;
- nature's consistent and indifferent stance towards a person's perceived flaws and vulnerabilities providing stability and different perspectives on problems; and
- holistic benefits to the clients' and practitioners' physical as well as psychological health.

In light of the Covid-19 pandemic, outdoor talking therapy may offer additional benefits to those listed above. Current government guidance aims to reduce the spread of the virus through social distancing, which includes reducing unnecessary footfall in contained public places, utilising outdoor spaces and maintaining safer distancing when people do come into contact⁴. Meeting a client in an open, outdoor space may offer an authentic, human-to-human encounter, whilst at the same time allowing for the recommended physical distancing.

This guidance document outlines considerations for ensuring outdoor talking therapy remains a safe, contained and ethical form of practice. The guidance is informed by an in-depth and systematic review of the literature, which was published open-access in the journal [Clinical Psychology Review](#) (Cooley et al., 2020). The review synthesised the experiences of 322 practitioners (clinical psychologists, counselling psychologists, counsellors, psychotherapists, family therapists, clinical social workers and CBT therapists) and 163 service users, all of whom had engaged in outdoor talking therapy*. Articles encompassed a range of client groups (e.g. diverse presenting problems, age groups, ethnicities, health and physical abilities and cognitive ranges), therapy types (e.g. individual, group, couple and family work), and therapy models (e.g. CBT, third wave, psychodynamic, play therapy and systemic). Since this review was published, the present guidance document has been co-produced with a further sample of practitioners and service users, including those from service user reference groups, the ACP-UK and the BPS DCP Faculty of Holistic Psychology.

*To explore the primary research findings in outdoor talking therapy, readers are directed to the review by Cooley et al. (2020). A selection of primary research is also provided at the end of this document.

Considerations for outdoor talking therapy

If therapy outdoors is unfamiliar to the client or practitioner, it may be useful to first reflect on a more familiar context (e.g. indoor therapy) and identify aspects of therapy most valued or considered essential. These aspects may include not wanting to be seen or overheard by others, having therapy in the same space each time, having clearly defined roles between the client and practitioner and the client being free to leave or end a session before the allotted time. It is then important to consider which, if any, of these elements are possible to maintain in the available outdoor setting(s). The following sections are designed to support this decision making process.

OUTDOOR LOCATION AND ACTIVITY

During therapy, the outdoor encounter can vary from low to high intensity with regard to the physical demand, duration of time spent outdoors and the degree of interaction between person and nature.

LOW INTENSITY

Low intensity encounters include sitting outdoors and light walking, of a duration similar to that of indoor therapy. This may take place in areas of natural beauty such as rivers, lakes, mountains and coastal locations. Where access to these areas is limited, such as in urban locations, other viable options include sitting outside the back of a therapy room, local parks, gardens and footpaths.

MODERATE INTENSITY

During moderate intensity encounters, there is a more 'hands-on' interaction with the outdoors. Examples include horticulture, fruit picking, problem-solving and outdoor play activities, outdoor pursuits (e.g. hiking, climbing, paddle sports) and building shelters to sit and talk beneath.

HIGH INTENSITY

The high intensity end of the continuum is less commonly described within literature specific to talking therapies. This approach typically comprises wilderness expeditions or 'adventure therapy', where groups are led by an outdoor instructor and live outdoors for a number of days or weeks, whilst engaging in various outdoor adventure activities (e.g. trekking, canoeing and building shelters and open fires for cooking). In this context, the practitioner will accompany the group either for the whole trip or elements of it and offer intermittent group and/or individual therapy.

ASSESSMENT AND FORMULATION

PRACTITIONER SUITABILITY

Practitioners who regularly engage in therapy outdoors typically report a natural affinity with the outdoors, such as a feeling of security, connection and belief in its restorative potential. They also report benefiting from flexibility in their chosen therapy modality, or an ability to integrate multiple modalities, as they creatively adapt the approaches they use indoors. At a minimum, a practitioner needs to be aware of changing relational dynamics, comfortable enough in the chosen space so that it assists them in their delivery of therapy, and suitably trained if using certain moderate or high intensity outdoor activities.

WORKPLACE SUITABILITY

The practitioner's employing organisation or place of work may also need to be supportive of therapy outdoors. The available evidence suggests that organisations that value a more holistic rather than bio-medical approach to mental wellbeing are often more supportive of outdoor talking therapy. Support from within the workplace may include managerial permission, having adequate insurance, and supervisory support from colleagues and multidisciplinary teams.

CLIENT SUITABILITY

Previous research has found outdoor therapy to be effective across a range of client groups and presenting difficulties. This research has not attempted to provide absolute parameters or categorisation of client suitability. Suitability should therefore be determined on an individual basis using person centred considerations during assessment and formulation. Considerations should include whether the presenting psychological difficulties (e.g. trust, shame, anxiety) could be exacerbated by working outdoors.

Some clients may report an affinity with outdoor spaces through a sense of containment, familiarity, excitement, connection, positive childhood memories, and/or previous therapeutic experiences. Other clients may not share such an affinity or be fearful of certain outdoor environments⁵. At a minimum the client needs to feel comfortable enough in the chosen space so that the space does not impede their ability to engage with therapy over and above that of alternative indoor spaces. At times, the client's reaction to therapy outdoors may be difficult to predict and assessment for suitability is therefore an on-going process, as described in the 'informed consent' section below.

RISKS IN THE OUTDOOR CONTEXT

Approaches to mitigating risk include selecting an outdoor space in close proximity to communities, familiarity and assistance (e.g. utilising outdoor spaces within the grounds of the therapy service); using lone working safety measures (e.g. informing colleagues of timings and location and carrying a mobile phone and/or lone worker device); and having more than one practitioner present (e.g. co-facilitating a group with a support worker). Outdoor talking therapy that involves a lone practitioner in a remote location is typically only used with clients considered of low risk to themselves and others.

If there are concerns regarding a client's physical safety during physical activity and/or exposure to inclement weather (e.g. pre-existing injuries and health conditions), physical health screening tools or confirmation from the client's GP may be necessary. It is also important to consider whether the outdoor setting is accessible for those with mobility difficulties and whether toilet and refreshment facilities are required.

Practitioners should use their clinical judgement as to whether the type or stage of therapy is suitable for a particular outdoor context. For example, some outdoor environments may lend themselves to stabilisation work and developing emotional regulation skills, yet be less appropriate for processing a trauma that is less predictable and highly emotive.

It is also advisable to carry out a risk assessment of the outdoor environment. This risk assessment should include the documentation of any hazards (i.e. anything that has the potential to cause harm), their associated level of risk (i.e. the likelihood of the potential harm being realised) and how the practitioner plans to remove or reduce these risks. Hazards may include challenging terrain, changing weather, lighting conditions and emotional triggers. Whilst it is impossible for an activity to be completely devoid of any risk, practitioners are expected to take reasonable steps in minimising them. Some employers will have their own risk assessment form, or 'positive risk assessment form' and a dedicated health and safety officer to support with this process (see the useful resources section at the end of this document for examples of risk assessment).

THERAPY GOALS

Before embarking on outdoor talking therapy, it is useful to consider whether this is solely a pragmatic choice arising from limited alternatives due to Covid-19 restrictions, or whether the outdoor environment can support the client's formulation and therapy goals. For example, previous research and theories, such as the bio-psycho-social model⁶ and the biophilia hypothesis⁷, formulate how a harmonious and reciprocal relationship with the natural world

can be an important protective factor for psychological wellbeing, or if absent, a source of psychological distress.

To explore whether the outdoors could play a more active role in the client's recovery goals, the practitioner's routine assessment questions could be supplemented with questions such as, *'How would you describe your current relationship with nature/the outdoors?'*, *'What has this relationship been like at other times in your life (e.g. childhood)?'*, *'When and where do you feel safest in nature?'*, *'When and where do you feel unsafe in nature?'*, *'How do you feel about the idea of meeting outdoors for some of our therapy?'* (see the useful resources section for a 'connection to nature' assessment protocol published by the Royal College of Psychiatrists).

INFORMED CONSENT

In electing to take therapy outdoors there emerge certain risks. For example, a common concern is the ability to protect a client's confidentiality due to the potential for coming into contact with other people. Other concerns include the unpredictability of the weather, physical health, or how the dynamic nature of a therapy encounter may be contained in the outdoors.

Such issues can be addressed at the stage of informed consent, through transparency and collaboration. Gaining informed consent needs to be a thorough process, involving three important steps. First, the practitioner and client should discuss the potential for any perceived risks, what can and cannot be controlled and what the alternatives are to therapy outdoors (e.g. indoor and digital options).

Second, the client and practitioner can then work together in contracting agreed steps in seeking to manage or mitigate these risks. For example, these decisions may include, *'the location for therapy that would feel most comfortable'*, *'environments or situations that need to be avoided'*, *'how to respond if/when coming into contact with someone that is known to the client or practitioner'*, *'what would the client like the practitioner to do in this moment?'*, *'how to manage inclement or changing weather conditions'*, *'what to do if the environment becomes unsuitable as a session progresses'*. In this way, the client and practitioner can negotiate strategic responses before an event occurs.

Finally, if initial contracting is agreed and therapy outdoors commences, 'process contracting' becomes essential. Process contracting involves regularly referring back to the initial contract and adapting the agreement as new issues arise within the dynamic outdoor environment. Some refer to this as a 'mini assessment' used at the beginning of, or prior to, each therapy session. If at any point the outdoor therapy begins to feel unsafe for the client or practitioner, without any obvious resolutions within the contract, therapy should cease or be relocated to another environment (e.g. indoor or digital).

This collaborative approach assumes a client's capacity and that election to proceed with therapy outdoors is one based on autonomy and an explicit shared contracting process, rather than the client being a passive recipient of therapy.

INTRODUCING PREDICTABILITY

The outdoor context inevitably implies a more unpredictable and less controllable space than that of the indoor therapy room. However, the sense of containment and controllability can be enhanced by introducing some elements of predictability within the therapeutic frame. Examples include:

- sticking to pre-planned time frames;
- using the same location, route or place to sit;
- selecting environmental features to walk past that can denote the beginning and end of a session;
- maintaining an agenda;
- a practitioner familiarising themselves with a route or location beforehand, to assess risk, ensure there are necessary facilities, and identify features in the landscape that could be incorporated into a session;
- using a private outdoor space;
- using an outdoor space that provides shelter; and
- combining therapy outdoors with other contexts (e.g. indoors and digital).

INCORPORATING THE OUTDOORS INTO THERAPY

PASSIVE VS ACTIVE INCORPORATION

The degree to which the outdoors is incorporated into therapy itself can vary from passive to active. When incorporated passively, the content of the talking therapy is little different to that of conventional indoor therapy, with the outdoors simply providing a backdrop. For example, this may be the case if the outdoors is being used solely for physical distancing purposes during the Covid-19 pandemic. Alternatively, if the outdoor environment features within the client's formulation or is deemed conducive to the therapy goals, there are several ways it can be more actively incorporated into the talking therapy.

EXAMPLES OF ACTIVE INCORPORATION

Stabilisation, mindfulness and other sensory exercises that use the outdoors to support clients in feeling safe, contained and grounded in the present moment (e.g. walking whilst paying attention to the five senses).

Using an outdoor activity to build relationships, social support and/or social competencies within groups (e.g. sharing vulnerabilities, learning from one another, role-modelling and systemic observations).

Experiential learning through role play, drama and distancing techniques that allow clients to experience roles and situations that may be difficult to cope with or recreate in everyday life (e.g. outdoor fictional adventures and building homes/dens/therapeutic spaces in nature).

Using experiences and achievements in the outdoors to challenge old narratives and build new ones (e.g. throwing natural objects into a stream to symbolise the throwing away of old narratives and hiking up a mountain to symbolise strength).

Observing real-life metaphors as a way of fostering acceptance and self-awareness (e.g. metaphors that relate human difficulties to uncontrollable dynamics within the natural world). Metaphors can also be used to internalise the power of nature, building strength and value-driven behaviour (e.g. metaphors that relate human strengths and values to what can be observed in the natural world).

Using a client's interaction with the outdoors as a window into the conscious and subconscious internal world of the client (e.g. observations of how the client may be feeling or behaving in a given situation, changes in posture or gait, or in their choice of location or place to sit).

FURTHER CONSIDERATIONS

Practitioners should be aware of relevant local guidance, insurance policies, first aid training requirements and any permissions required from employers and/or supervisors.

Being away from the therapy room may limit access to available resources (e.g. therapy notes, computer systems). Practitioners should consider what resources they require during therapy and ensure that data protection regulations and GDPR are followed.

The respective roles and boundaries within the therapeutic relationship are often reinforced in conventional indoor settings (formal reception and waiting areas, setup of the therapy room, choice of clothing, etc.). Outdoor environments could be perceived to pose a significant shift away from these implicit boundaries. Practitioners should therefore highlight with the client that their working relationship will remain focused on agreed therapeutic purposes, with adequate time to explore the feelings and emotions that may arise as a result of changes in the therapy environment.

Unless dual qualified, most practitioners working with moderate or high intensity encounters (e.g. outdoor pursuits and adventure expeditions) should be accompanied by qualified outdoor instructors who are responsible for the activity.

Therapy outdoors also raises the potential for creativity in clinical supervision, such as supplementing conventional supervision with support from other professionals (horticulturalists, occupational therapists, outdoor guides, personal trainers, physiotherapists, sport and exercise psychologists, etc.). It may also be beneficial to hold individual or group supervision meetings outdoors.

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REFERENCES

- ¹ British Psychological Society (April, 2020). *Effective therapy via video: Top tips*. Report of a working party of the Division of Clinical Psychology. Leicester: Author.
- ² Skyler, J. (April, 2020). 'Zoom fatigue' is taxing the brain. Here's why that happens. *National Geographic*. Available from www.nationalgeographic.co.uk/science-and-technology/2020/04/zoom-fatigue-is-taxing-the-brain-heres-why-that-happens
- ³ Cooley, S.J., Jones, C.R., Kurtz, A. & Robertson, N. (2020). 'Into the wild': A meta-synthesis of talking therapy in natural outdoor spaces. *Clinical Psychology Review*, 101841.
- ⁴ Gov.uk (2020). Coronavirus (COVID-19): *What you need to do: Guidelines on social distancing*. Available from: www.gov.uk/coronavirus
- ⁵ Milligan, C. & Bingley, A. (2007). Restorative places or scary spaces? The impact of woodland on the mental well-being of young adults. *Health and Place*, 13(4), 799–811.
- ⁶ Engel, G.L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry* 5, 535–544.
- ⁷ EWilson, E.O. (1984). *Biophilia: The human bond with other species*. Cambridge, MA: Harvard University Press.

USEFUL RESOURCES

- Cooley, S.J., Jones, C.R., Kurtz, A. & Robertson, N. (2020). 'Into the wild': A meta-synthesis of talking therapy in natural outdoor spaces. *Clinical Psychology Review*, 101841. Available from www.sciencedirect.com/science/article/pii/S0272735820300295
- Earthwatch Institute (n.d.). *Risk assessment guide for outdoor activities*. Retrieved June 2020 from www.earthwatch.org.uk/images/downloads/education/Risk-Assessment-guide-for-outdoor-activities.pdf
- Jordan, M. (2014). *Nature and therapy: Understanding counselling and psychotherapy in outdoor spaces*. London: Routledge.
- McGeeney, A. (2016). *With nature in mind: The ecotherapy manual for mental health professionals*. London: Jessica Kingsley.
- National Institute for health and Care Excellence (2019). *Physical activity: Everything NICE says in an interactive flowchart*. Available from <https://pathways.nice.org.uk/pathways/physical-activity>
- Natural England (2016). *A review of nature-based interventions for mental health care*. Available from <http://publications.naturalengland.org.uk/publication/4513819616346112>
- Natural England (2020). *Nature connectedness among adults and children in England* [including the 6-item Nature Connection Index scale]. Available from <http://publications.naturalengland.org.uk/publication/6005041314136064>
- Parliamentary Office of Science and Technology (2016). *Green Space and Health*. Available from <https://post.parliament.uk/research-briefings/post-pn-0538/>
- Royal College of Psychiatrists (n.d.). A model of engaging with nature in different contexts. Retrieved June 2020 from www.rcpsych.ac.uk/docs/default-source/improving-care/sustainability/sustainability-engaging-with-nature-different-contexts.jpg?sfvrsn=8dbfa8af_4
- Royal College of Psychiatrists (n.d.). Assessing a person's connections to nature. Retrieved June 2020 from www.rcpsych.ac.uk/docs/default-source/improving-care/sustainability/sustainability-taking-a-nature-based-history.pdf?sfvrsn=9e44cbd1_4
- Walking for Health (n.d.). Risk assessment guidance [web page]. Retrieved June 2020 from www.walkingforhealth.org.uk/scheme-zone/risk-assessment-guidance-new
- World Health Organization (2017). *Urban green space interventions and health: A review of impacts and effectiveness*. Available from www.euro.who.int/_data/assets/pdf_file/0010/337690/FULL-REPORT-for-LLP.pdf?ua=1&utm_source=The%20King%27s%20Fund%20newsletters&utm_medium=email&utm_campaign=8285918_NEWSL_HMP%202017-05-16&dm_i=21A8,4XLGE,OWYH5H,IQELO,1

FURTHER READING AND PRIMARY RESEARCH

- Adevi, A.A., Uvnäs-Moberg, K. & Grahn, P. (2018). Therapeutic interventions in a rehabilitation garden may induce temporary extrovert and/or introvert behavioural changes in patients, suffering from stress-related disorders. *Urban Forestry & Urban Greening*, 30, 182–193.
- Bandoroff, S. & Scherer, D.G. (1994). Wilderness family therapy: An innovative treatment approach for problem youth. *Journal of Child and Family Studies*, 3, 175–191.
- Berger, R. & McLeod, J. (2006). Incorporating nature into therapy: A framework for practice. *Journal of Systemic Therapies* 25, 80–94.
- Berger, R. (2007). Choosing the 'right' space to work in: Reflections prior to a nature therapy session. *Australian Journal of Outdoor Education*, 11, 41–45.
- Berger, R. (2008a). Going on a journey: A case study of nature therapy with children with a learning difficulty. *Emotional and Behavioural Difficulties*, 13, 315–326.
- Berger, R. (2008b). Building a home in nature: An innovative framework for practice. *Journal of Humanistic Psychology*, 48, 264–279.
- Berger, R. (2009). Being in Nature: An innovative framework for incorporating Nature in therapy with older adults. *Journal of Holistic Nursing* 27, 45–50.
- Berger, R. (2010). Nature therapy: Thoughts about the limitations of practice. *Journal of Humanistic Psychology*, 50, 65–76.
- Bettmann, J.E. & Jaspersen, R.A. (2008). Adults in wilderness treatment: A unique application of attachment theory and research. *Clinical Social Work Journal*, 36, 51–61.
- Burns, G. (2000). When watching a sunset can help a relationship dawn anew: Nature-guided therapy for couples and families. *Australian and New Zealand Journal of Family Therapy*, 21, 184–190.
- Christian, D.D. & Perryman, K.L. (2018). Adventures in supervision: Implications for supervision of adventure based counseling. *Journal of Creativity in Mental Health*, 13, 19–30.
- Conn, S.A. (1998). Living in the earth: Ecopsychology, health and psychotherapy. *The Humanistic Psychologist*, 26, 179–198.
- Corazon, S.S., Stigsdotter, U.K., Jensen, A.G.C. & Nilsson, K. (2010). Development of the nature-based therapy concept for patients with stress-related illness at the Danish healing forest garden Nacadia. *Journal of Therapeutic Horticulture*, 20, 33–51.
- Corazon, S.S., Stigsdotter, U.K., Moeller, M.S. & Rasmussen, S.M. (2012). Nature as therapist: Integrating permaculture with mindfulness- and acceptance-based therapy in the Danish Healing Forest Garden Nacadia. *European Journal of Psychotherapy & Counselling*, 14, 335–347.
- DeMille, S.M. & Montgomery, M. (2016). Integrating narrative family therapy in an outdoor behavioral healthcare program: A case study. *Contemporary Family Therapy*, 38, 3–13.
- Doucette, P.A. (2004). Walk and talk: An intervention for behaviorally challenged youths. *Adolescence*, 39, 373–388.
- Ferneer, C.R., Mesel, T., Andersen, A.J. & Gabrielsen, L.E. (2019). Therapy the natural way: A realist exploration of the wilderness therapy treatment process in adolescent mental health care in Norway. *Qualitative Health Research*, 29, 1358–1377.
- Hartford, G. (2011). Practical implications for the development of applied metaphor in adventure therapy. *Journal of Adventure Education & Outdoor Learning*, 11, 145–160.
- Hooley, I. (2016). Ethical considerations for psychotherapy in natural settings. *Ecopsychology*, 8, 215–221.
- Jordan, M. & Marshall, H. (2010). Taking counselling and psychotherapy outside: Destruction or enrichment of the therapeutic frame? *European Journal of Psychotherapy and Counselling*, 12, 345–359.
- Jordan, M. (2014). Moving beyond counselling and psychotherapy as it currently is—taking therapy outside. *European Journal of Psychotherapy & Counselling*, 16, 361–375.
- King, B. & McIntyre, C.J. (2018). An examination of the shared beliefs of ecotherapists. *Ecopsychology*, 10, 117–126.
- Kyriakopoulos, A. (2010). Adventure based counselling, individual counselling and object relations: A critical evaluation of a qualitative study. *European Journal of Psychotherapy and Counselling*, 12, 311–322.

- Lambie, I., Hickling, L., Seymour, F. et al. (2000). Using wilderness therapy in treating adolescent sexual offenders. *Journal of Sexual Aggression, 5*, 99–117.
- McBride, D.L. & Korell, G. (2005). Wilderness therapy for abused women. *Canadian Journal of Counselling, 39*, 3–14.
- McKinney, B.L. (2011). *Therapist's perceptions of walk and talk therapy: A grounded study* (Unpublished PhD thesis), University of New Orleans.
- Milton, M. (2009). Waking up to nature: Exploring a new direction for psychological practice. *Ecopsychology, 1*, 8–13.
- Portrie-Bethke, T., Hill, N. & Bethke, J. (2009). Strength-based mental health counseling for children with ADHD: An integrative model of adventure-based counseling and Adlerian play therapy. *Journal of Mental Health Counseling, 31*, 323–337.
- Revell, S., Duncan, E. & Cooper, M. (2014). Helpful aspects of outdoor therapy experiences: An online preliminary investigation. *Counselling and Psychotherapy Research, 14*, 281–287.
- Revell, S. & McLeod, J. (2016). Experiences of therapists who integrate walk and talk into their professional practice. *Counselling and Psychotherapy Research, 16*, 35–43.
- Revell, S. & McLeod, J. (2017). Therapists' experience of walk and talk therapy: A descriptive phenomenological study. *European Journal of Psychotherapy & Counselling, 19*, 267–289.
- Santostefano, S. (2008). The sense of self inside and environments outside: How the two grow together and become one in healthy psychological development. *Psychoanalytic Dialogues, 18*, 513–535.
- Scheinfeld, D.E., Rochlen, A.B. & Buser, S.J. (2011). Adventure therapy: A supplementary group therapy approach for men. *Psychology of Men & Masculinity, 12*, 188–194.
- Shillito-Clarke, C. (2008). Journey into the natural world of the counselling psychologist. *Counselling Psychology Review, 23*, 81–90.
- Tarrant, N. (2019). A walk on the wild side: Nick Tarrant reflects on the risks and benefits of talking therapy outdoors. *Therapy Today, 30*, 21–22.
- Tucker, A.R., Widmer, M.A., Faddis, T. et al. (2016). Family therapy in outdoor behavioral healthcare: Current practices and future possibilities. *Contemporary Family Therapy, 38*, 32–42.
- Wiggins, E.C. (2018). *A phenomenological study: The lived experiences of holistic counselors and their development of self-efficacy*. Unpublished Doctoral thesis, Adams State University.
- Wolsko, C. & Hoyt, K. (2012). Employing the restorative capacity of nature: Pathways to practicing ecotherapy among mental health professionals. *Ecopsychology, 4*, 10–24.



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