

2022-03

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<http://hdl.handle.net/10026.1/20503>

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10.1111/bjc.12315

British Journal of Clinical Psychology

Wiley

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# Organizational perspectives on outdoor talking therapy: Towards a position of ‘environmental safe uncertainty’

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**Objectives.** There is growing support within the therapy professions for using talking therapy in alternative environments, such as outdoor spaces. The aim of the present study was to further understand how the organizational culture in clinical psychology may prevent or enable practitioners to step outside the conventional indoor consulting room.

**Design.** Informed grounded theory methodology was used within a pragmatist philosophy.

**Methods.** Participants ( $N = 15$ ; nine male, six female) were identified using theoretical sampling. The sample consisted of experts and leaders within the profession of clinical psychology (e.g., heads of services, training programme directors, chairs of professional bodies, and developers of therapy models;  $M$  years in the profession = 34.80,  $SD = 9.77$ ). One-to-one interviews and analysis ran concurrently over 9 months (April–December 2020). Mason’s model of safe uncertainty was drawn upon to illuminate and organize themes.

**Results.** The main themes comprised organizational factors that either support a practitioner in maintaining a position of curiosity and flexibility towards the environment where therapy is located (‘environmental safe uncertainty’), or push them towards adopting a more fixed position (‘environmental certainty’). Themes included influences from therapy traditions, accessibility of alternative environments, internalized risk, workplace subcultures, business models, biomedical approaches, and the COVID-19 pandemic.

**Conclusions.** Whether therapy is located in a consulting room, outdoors, clients’ homes, or digitally, practitioners, clients, and services are encouraged to maintain a position of environmental safe uncertainty.

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## Practitioner Points

- The therapy process and outcomes are influenced by the physical environment in which talking therapy is situated.
- Practitioners have often remained fixed in their preferred therapy environment, such as the indoor consulting room, without exploring the potential benefits of alternative environments or involving the client in this decision-making (i.e., 'environmental certainty').
- Outdoor environments, as well as other alternatives to the consulting room (e.g., digital, home visits, and public places), can support access to therapy, subsequent engagement, and therefore health care equity.
- Practitioners and clients are encouraged to adopt a position of 'environmental safe uncertainty', which is defined as having openness, critical curiosity, and collaboration regarding the therapy environment and the possibility of other environments being more conducive to therapy.

In 1983, the World Health Organization introduced the term 'sick building syndrome', which encompasses the psychological and physical health difficulties occurring through prolonged exposure to poor-quality indoor environments (Burge, 2004). An evidence base has since emerged on the redesigning of health care settings as 'healing environments' (Huisman, Morales, van Hoof, & Kort, 2012; Sadek & Willis, 2020). Drawing from environmental psychology, the physical characteristics of a healing environment (notably lighting, temperature, acoustics, air quality, furnishing, and aesthetic) are associated with a range of improvements to treatment processes and outcomes, such as patient satisfaction, mood, pain and stress levels, recovery time, staff errors, and staff well-being (Gaminiesfahani, Lozanovska, & Tucker, 2020; Huisman et al., 2012; Ulrich et al., 2008).

The same may be said for a consulting room used for talking therapy, where the physical characteristics of the room are positively associated with therapy processes, outcomes, and the therapist–client relationship (for reviews see Morrey, Larkin, & Rolfe, 2020; Pearson & Wilson, 2012; Pressly & Heesacker, 2001). To clarify, the words 'environment' and 'environmental' are used herein with reference to the physical space in which talking therapy is located.

Such considerations of the physical environment during talking therapy are not limited to indoor therapy rooms. Researchers and practitioners are also finding many positive influences when moving routine talking therapy into outdoor settings (Cooley, Jones, Kurtz, & Robertson, 2020). As an alternative environment for talking therapy, outdoor settings can offer the additional benefit of nature connectedness, with numerous studies demonstrating the reciprocal healing properties of time spent with nature (Twohig-Bennett & Jones, 2018; White et al., 2019). These healing properties conferred can be biological (e.g., physical health and physiological stress responses), psychological (e.g., awe, mood, and cognition), social (e.g., openness and connection with others), and spiritual (e.g., interconnectivity and life purpose) (Cipriani et al., 2017; Twohig-Bennett & Jones, 2018; Zhang, Mavoa, Zhao, Raphael, & Smith, 2020). These benefits can also arise during time spent in urban outdoor environments with less nature exposure, dependent on the unique interaction between an individual and their environment (Cooley, Robertson, Jones, & Scordellis, 2020).

Using the outdoors as an alternative space for talking therapy also supports the incorporation of physical movement. Studies in neuropsychology reveal that the cerebral blood flow underpinning our cognitions is gradually reduced during prolonged sitting and is increased during movement such as light walking (e.g., Carter et al., 2018). In turn, walking is found to promote positive affect (Miller & Krizan, 2016) and improved

cognitive performance (e.g., creativity, working memory, awareness, and problem-solving; Mualem et al., 2018; Oppizzo & Schwartz, 2014), which are valuable components of psychological flexibility required for effective talking therapy (Brandon, Pallotti, & Jog, 2021).

A recent meta-synthesis by Cooley, Jones, et al. (2020) was the first to collate existing literature specific to talking therapy in outdoor settings. The included articles ( $N = 38$ ) were mostly qualitative and comprised the experiences of 322 practitioners (e.g., counsellors, psychologists, and psychotherapists) and 163 clients. In these studies, clients and practitioners mostly engaged in talking therapy whilst sitting or walking in various outdoor locations, both private and public (e.g., gardens, parks, and footpaths). The review went on to identify a range of practical considerations to promote safety, effectiveness, and ethical practice when re-contextualizing conventional talking therapy outdoors (e.g., process contracting procedures surrounding issues such as confidentiality and personal suitability). The review revealed a range of benefits afforded by outdoor environments, including greater mutuality of the therapy space and relationship, freedom of movement and expression, reciprocal relationships with nature, holistic health benefits for clients and practitioners, and greater equity of care for those clients who feel unable to access indoor or digital alternatives (Cooley, Jones, et al., 2020). Indeed, to support safe and equitable mental health care during the COVID-19 pandemic, this review was developed into formal guidance on outdoor talking therapy from the British Psychological Society (Cooley & Robertson, 2020).

In addition to demonstrating the effectiveness of the outdoors as an alternative environment for talking therapy, the aforementioned review also identified a lack of organizational support as a barrier to stepping outside the conventional indoor consulting room (Cooley, Jones, et al., 2020). Organizational barriers included outdoor spaces being viewed as a poor fit in services where a dominant reductionist and biomedical treatment model prevailed, as well as a general lack of orientation, support, and guidance within professions in relation to alternative therapy environments (notably surrounding training, supervision, and policy). These findings are in line with implementation science in health care settings, with research revealing how the organizational culture (e.g., leadership, social support, resources, and readiness to change) is often the strongest predictor of service innovation and the adoption of innovation into routine practice (Nilsen & Bernhardtsson, 2019).

Practitioners who have previously offered therapy in outdoor spaces reported having to challenge perceived norms within the organizational culture of a nationalized health service, and some felt forced into independent practice, which potentially magnified health inequalities in respect of available therapy options within public health services (Cooley, Jones, et al., 2020). Differences in organizational cultures and subcultures have also resulted in a disparity across therapy professions, with outdoor spaces being more commonly used by counsellors and psychotherapists than by clinical psychologists (Cooley, Jones, et al., 2020; Jordan, 2015).

### **The present study**

Given the wealth of prior research in support of alternative outdoor environments, the present study addresses the question: Why do so few clinical psychologists, particularly those in public health services, offer talking therapy in outdoor spaces? As discussed, the existing research on outdoor talking therapy comprises the perspectives of those already working in this way, who typically held personal and professional biases towards outdoor

spaces (Cooley, Jones, et al., 2020). Whilst these accounts offer valuable insight into 'how it's done', they do not fully explain 'why more people aren't doing it?' and what the barriers are to implementation.

Given the suggested organizational influences, the aim of the present study was to further understand how the organizational culture in clinical psychology may prevent or enable a choice of therapy environments. This aim was achieved through interviewing leaders and senior figures within the profession. These participants were recruited for their knowledge, experience, influence, and critical faculties, not because they were known for having a specialist interest in the outdoors as an alternative environment for therapy. This sample was targeted because it comprised those operating at a strategic level, who were gatekeepers to accepted practices, and who had a longevity within the profession that enabled a reflection on how psychological therapies had evolved over time within a breath of services, client groups, and therapy models. Whilst the present study had a particular focus on outdoor environments, it was expected that these participants would also share views on alternative therapy environments more generally (e.g., alternative indoor spaces such as clients' homes and indoor public spaces), by way of comparing and framing their perspectives of the conventional indoor consulting room. It was anticipated that further understanding the organizational barriers and enablers to alternative therapy spaces from the perspective of these participants will support future implementation and expansion of equitable provision.

## Methods

The study was approved by the University of Leicester Ethics Committee (reference number: 22298). Prior to recruitment, the study protocol also underwent a formal peer review process, comprising a panel of academics, practitioners, and experts by experience. The methods described below were guided by the COREQ checklist for the reporting of qualitative research (Tong, Sainsbury, & Craig, 2007). Please refer to the appendices of Cooley (2021) for further details regarding the epistemological positioning, methods, and materials used.

### Study design

Informed grounded theory was used to capture organizational perspectives in clinical psychology (Charmaz & Thornberg, 2020; Thornberg, 2012). This approach to grounded theory, which was underpinned by pragmatist philosophy, acknowledges that data are co-constructed between the researcher and participants and that the research process is influenced by the researchers' prior knowledge and experience (Charmaz & Thornberg, 2020; Morgan, 2020). Informed grounded theory is considered to occur when 'the process and the product [theory or model] have been thoroughly grounded in data by grounded theory methods whilst being informed by existing research literature and theoretical frameworks' (Thornberg, 2012, p. 249).

### Sampling

Theoretical sampling was used concurrently with data analysis, which is defined as 'a process whereby the researcher samples based on the concepts that emerge in the data' (Timonen, Foley, & Conlon, 2018, p. 8). For example, as a tentative theme was developed

in relation to risk management, a consultant clinical psychologist with specialist expertise in risk was recruited to further explore this theme, and when a tentative theme was developed in relation to working within a business model, a hospital director was recruited to offer additional perspectives.

Theoretical sampling was also accompanied by purposive sampling, which was used to ensure participants were selected to represent varied demographics, attitudes towards the topic, prior experience, expertise, therapy approaches, and client groups. Collecting data from various vantage points enabled a form of triangulation, whereby, from a pragmatist standpoint, an assumption was made that the social reality of therapy outdoors will be context-specific and unique across participants (Charmaz, 2014; Morgan, 2020).

Participants were specifically targeted who were considered experts and able to provide high-quality data to support the ongoing analysis (Corbin & Strauss, 2008). Eligible participants were individually identified through online literature, networking, social media, and word of mouth, and were approached directly by the lead researcher (SC) via email. During the course of the study, email invitations were sent to a total of 24 eligible participants, of whom 15 agreed to participate (62.5%), two responded to say they were unavailable (8.3%), and seven did not respond (29.2%). Of the 15 who participated, the majority ( $n = 12$ ) did not have a pre-existing relationship with the lead researcher (personally or professionally) prior to recruitment. Prior to interview, participants were sent a participant information sheet, which outlined the aims of the study. They were also asked to return a signed consent form via email prior to taking part.

### **Participants**

The 15 participants had an average age of 58.14 years ( $SD = 8.67$ ), nine identified as male and six female. All were born and currently worked in various locations across the United Kingdom (UK), with 12 identifying as White British and the remaining three as Asian British, Black British, and White Irish. The majority were clinical psychologists ( $n = 13$ ) with the addition of a consultant psychiatrist and a director within a National Health Service (NHS) Trust. Participants reported working in their profession for an average of 34.80 years ( $SD = 9.77$ ) in general and specialist mental health services that spanned the ranges of age, cognitive and physical abilities, and presenting problems, including inpatient, outpatient, community, and forensic settings. The majority ( $n = 14$ ) held consultant positions in the UK NHS (employed at band 8c through to band 9), with nine as head of service. Over half were also employed in academic roles ( $n = 8$ ), with six holding a professorship and five being current or previous directors of clinical psychology doctoral training programmes. Most were involved in training clinical psychologists ( $n = 13$ ) and in contributing to the academic literature via books and journal articles ( $n = 13$ ), as journal editors ( $n = 3$ ), and in leading the development of therapy models ( $n = 4$ ). Some also worked in the third sector ( $n = 4$ ) and in independent practice ( $n = 4$ ). Several participants held chair and presidential positions in national and international professional bodies and committees related to clinical psychology ( $n = 6$ ).

### **The research team**

At the time of the study, the lead researcher (SC; white male, mid-30s) was a trainee clinical psychologist who, as part of clinical training in the NHS, had undergone placements within a community mental health team (CMHT), medical/health psychology, and child and adolescent mental health services (CAMHS). He had prior research experience having

previously completed a PhD and four years as a postdoctoral research fellow within the fields of sport and exercise psychology, positive youth development (specifically youth homelessness), and outdoor experiential learning. His research had been influenced by pragmatist philosophy, which often comprised action research and the use of mixed methods. When introducing himself to participants, he explained that one of his goals as a trainee clinical psychologist was to explore the extent to which his prior expertise in outdoor practice was applicable to clinical psychology. He acknowledged having a favourable bias towards outdoor settings, whilst at the same time utilizing his relative inexperience and 'trainee' status in clinical psychology to maintain a position of curiosity and encourage participants to critique and educate him.

The broader research team (NR, CJ, and DM) comprised applied and academic expertise in clinical and health psychology, organizational psychology, and critical psychology. Alongside the formal supervision provided by NR and CJ, collaborative reflexivity was also supported by other senior colleagues who worked on the clinical doctorate training programme, fellow trainees, placement supervisors within the NHS, and delegates at a number of academic conferences where this study, or aspects of it, had been presented<sup>1</sup>.

### **Data collection**

Data were collected using single, one-to-one interviews facilitated by the lead researcher. Interviews were guided by an interview protocol, which was unique to each participant and used flexibly to guide discussions. This protocol was initially expansive, including questions around personal and professional relationships with the outdoors, attitudes towards the indoor therapy room, the feasibility, benefits, and problems with working outdoors, perceived fit within the culture of clinical psychology, and organizational barriers and enablers to outdoor working, but was subsequently revised after each interview in line with theme development and theoretical sampling.

Interviews lasted an average of 68 mins ( $SD = 20$ ) and were held either by video call ( $n = 11$ ) or telephone call ( $n = 4$ ), over a period of 9 months (April–December 2020). These calls took place in private office spaces at homes or workplaces, and no other parties were present besides the researcher and participant. Audio recordings were later transcribed verbatim. The lead researcher also kept reflective notes during and after each interview, which were used to inform the next iteration of interview questions. The transcripts were not returned to participants for comment; however, at the end of each interview the researcher summarized the discussion and provided opportunity for further clarification. Participants were also encouraged to respond to the researcher within 2 weeks of their interview if they wished to amend, add, or redact any comments (no such correspondence was received).

### **Data analysis**

Transcripts were read several times to support familiarity and data immersion. Using NVivo (version 12), data were then divided, line-by-line, into small segments (open codes). These open codes were given short, simple, and precise labels that were closely linked to the data (e.g., incorporating the participants' terminology). This progressed to

<sup>1</sup> Participant confidentiality was maintained during reflective discussions held outside of the formal research team.

focused coding, where the initial open codes were synthesized and integrated into groups of codes that stood out from the data. Focused codes were considered to be early hypotheses that informed further data collection (i.e., theoretical sampling). Rather than 'member checking' these focused codes with existing participants, they were instead checked, critiqued, and further developed by continuously exploring the data with new participants (Charmaz, 2014). As these hypotheses were explored and further developed, the analysis moved into theoretical/axial coding, where relationships between focused codes were explored. Further data collection at this stage helped to work towards saturating and defining categories (i.e., the foundation of the emerging theory). Sample size was determined by the point at which the core themes were considered well established and conceptually rigorous (see 'theoretical sufficiency'; Charmaz, 2014; or 'pragmatic saturation'; Low, 2019). These phases of coding were iterative rather than linear to remain open and sensitive to the data.

Approaches were used to ensure that each code, concept, and theoretical idea was grounded in the data. Grounding techniques are considered particularly important when using informed grounded therapy, to retain the researcher's critical eye and ensure that categories and theories are true to the raw data and not solely framed by prior literature (Thornberg, 2012). Grounding techniques included constant comparison (i.e., an iterative comparison between the analysis and raw data) and memo writing (i.e., documenting the researcher's reflexivity around preconceptions, theoretical understanding, gaps, codes, links, and implications; Charmaz, 2014). Memo writing was also used to promote 'theoretical playfulness' (i.e., creative thinking that generates new possibilities and connections), 'theoretical agonism' (i.e., a critical stance towards pre-existing theories), 'theoretical pluralism' (i.e., holding and comparing different and sometimes conflicting theoretical perspectives), and constant reflexivity or 'self-monitoring' (Thornberg, 2012).

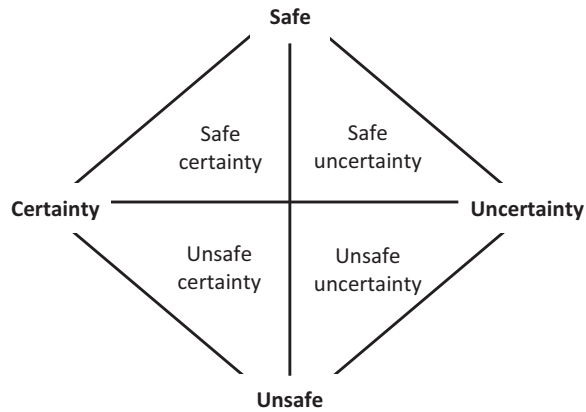
The analysis was carried out by the lead researcher; however, throughout the analysis, both raw and processed data were shared and discussed with the research team who took the position of 'critical colleagues' (Smith & McGannon, 2018) and supported collaborative reflexivity (Braun & Clarke, 2019).

### **Safe uncertainty**

At a later stage in the analysis, the safe uncertainty model (Mason, 1993) was chosen to further inform and illuminate the final theory and organization of themes (Thornberg, 2012). The safe uncertainty model (Figure 1; Mason, 1993) was originally developed in family therapy, in relation to a practitioner's (or client's) stance towards the client's presenting difficulties (i.e., the hypotheses or formulation). Mason (1993) suggested that this stance could be located in one of four positions, with the preferred position being that of safe uncertainty. Safe uncertainty is where the therapy work is structured and guided by a hypothesis or formulation (safe), yet remains open and curious towards new possibilities (uncertainty), although Mason warned that a position of uncertainty can feel uncomfortable and be difficult to contain, which draws practitioners to a position of safe certainty. Safe certainty is likened to a more expert-led position, where the practitioner holds the answers (Mason, 1993). However, safe certainty can easily slip into being unsafe, when the level of certainty causes important factors to be overlooked.

The model of safe uncertainty (Mason, 1993) was incorporated into the data because it was found to encapsulate the tensions and complexities of the data set. Rather than an indoor vs. outdoor dichotomy, the data instead reflected a more dynamic stance towards





**Figure 1.** The safe uncertainty model (Mason, 1993).

the choice of therapy environment, with organizational influences, traditions, and perceptions of safety acting in a way that pushes and pulls practitioners between a more fixed position (i.e., certainty) and a position of greater flexibility and openness (i.e., uncertainty).

## Results

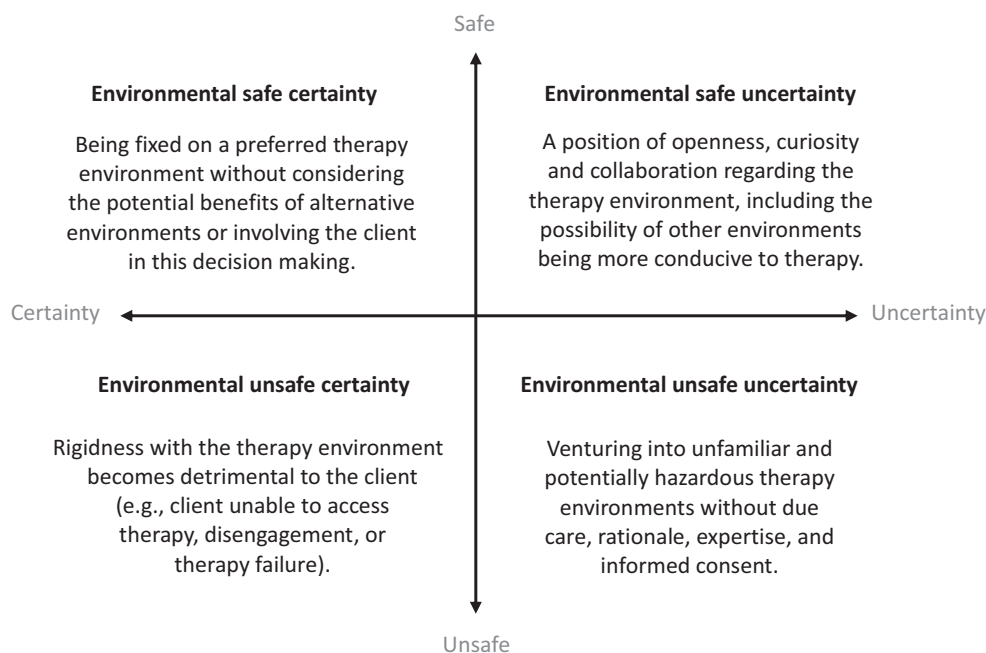
### *Environmental safe uncertainty*

Supported by the data, the safe uncertainty model (Mason, 1993) was revised in the present study to reflect the stance taken towards the chosen therapy environment (Figure 2). The term ‘environmental’ is thus used here to refer to the environment in which therapy is located, be it natural, manmade, or virtual; an indoor therapy room, outdoors, or a client’s home, for example.

Similar to Mason’s original model, a position of ‘environmental safe uncertainty’ is desirable as it maintains an openness and critical curiosity towards the available therapy environments and their dynamic impact on the therapy. Available environments must be deemed safe and conducive to therapy, and discussed openly with clients, to avoid entering a position of ‘environmental unsafe uncertainty’. However, a practitioner’s lack of exposure to alternative environments, or fear that all alternative environments are unsafe, for example, may lead practitioners to adopt a single, default environment that remains fixed (environmental safe certainty). This chosen environment remains effective so long as the client is well aligned; but when there is an incongruence and therapy continues regardless, the level of certainty towards the environment at best fails to provide the client with the most effective form of support, and at worst causes harm (environmental unsafe certainty).

The following themes represent organizational influences that either support practitioners in maintaining a position of ‘environmental safe uncertainty’, or push them towards safe, and potentially unsafe, positions of ‘environmental certainty’ (Figure 3).<sup>2</sup> In

<sup>2</sup> In the example quotes provided, participant numbers correspond to the order in which they were interviewed.



**Figure 2.** Towards a position of environmental safe uncertainty.

the following sections, the comprehensive categories are indicated by headings and focused codes are described within the text.

### ***A push towards environmental certainty (safe and unsafe)***

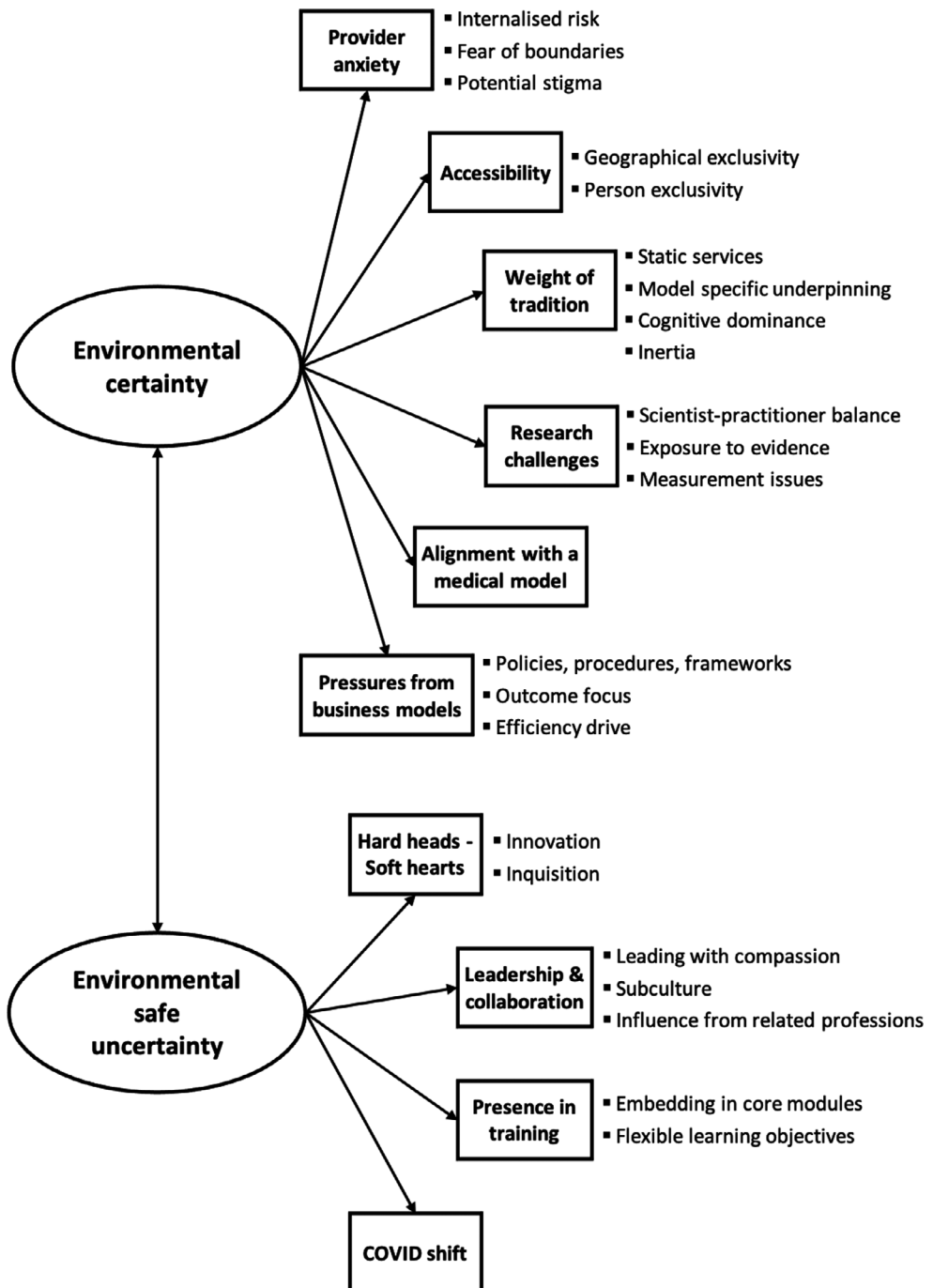
#### ***Provider anxiety***

A change in therapy environment was often associated with risks to confidentiality and boundary violation. Risk-averse cultures were felt to become internalized within some practitioners who become ‘self-disciplinarians’ (Participant 14) and enforce their own boundaries.

I think we are quite risk averse, often in a way that’s not actually helpful to clients . . . the idea that you can do psychotherapy without risk is complete nonsense because it’s a very—if it’s done right, it has the power to transform someone’s life and change it for the better. But any intervention with that degree of power, you know, if you make mistakes or you get things wrong, it can cause harm . . . But a lot of people internalise the barriers and they imagine that, ‘oh no, they wouldn’t like that, I better not do that’ . . . you become your own policeman [and] have this internal finger wagging ‘oh you mustn’t, no, no, it could go horribly wrong, what if something happened’. (Participant 11)

This risk aversion was at times felt to take decisions away from clients and lead to positions of environmental unsafe certainty.

Mental health is extremely murky with how much we should be controlling people and how much we should be allowing people to develop . . . we’re working on that legacy from the



**Figure 3.** An overview of comprehensive categories and focused codes.

asylum concept and have slowly but surely moved away from it but we're still some way off a strength-based— 'people have the right and the responsibility for themselves'—kind of concept and that mental health isn't by default binary. And that 'people who have mental health issues that they're working through have no right to choose'. (Participant 2)

Others felt that the way in which boundaries are understood within the profession is too rigid and causes practitioners to fear boundaries rather than use them constructively and flexibly in support of the therapy process and outcome.

I still find that a lot of clinical psychologists would, in my opinion, hide behind this notion of 'no, you can't do that because it's a breaching of a therapeutic boundary'. You know, even down to giving a, if somebody makes you laugh, giving a really authentic response, rather than loading up the professional self ... we talk more about boundaries saying 'they must be protected' and 'we must be extremely careful about any breach of it' ... If you've got a very fixed understanding of boundaries, it [therapy outdoors] probably doesn't feel very contained. Whereas couldn't we teach people and say, actually, it's about being real and establishing a real alliance with somebody. (Participant 4)

I get people [clinical psychologists], you know, new people coming who think they're only going to be allowed to do six sessions and they've got to demonstrate the paperwork. And that's where I think we've lost ourselves. It's no fun if that's what you're doing, it's just fear that you've crossed the boundaries. (Participant 6).

Provider anxiety also included an avoidance of alternative, more public environments due to concerns that society and media portrayals associate mental health difficulties with 'problem-focused narratives' (Participant 8) and may result in 'unwanted attention' (Participant 2). However, others argued that public environments were not an issue (e.g., 'What are they going to see? Two people walking down the road?' Participant 9).

### *Accessibility*

Despite alternative therapy environments having the potential to improve equity of access to care (e.g., outdoor talking therapy benefiting those for whom indoor and digital approaches are inaccessible), the profession was described as reluctant to invest in new environments that may not be available to all, citing concerns that outdoor environments may be available only to those living in certain geographical areas (e.g., with greater access to safe and therapeutic outdoor spaces).

Is it only going to be rolled out to, you know, to clients in middle class areas or areas which are more remote, where natural environments are much more accessible? I guess that would be a concern. (Participant 3)

A related concern was the risk of therapy outdoors being limited to particular person characteristics.

We have, and should expect to, provide services as equally as best we can to our populace—which would include people who have limited mobility. Who might be susceptible to other risks in terms of temperature, weather, or illness that might be associated with being outdoors. (Participant 2)

Whilst these issues around accessibility were considered a driver towards the certainty of the consulting room, several participants felt therapy outdoors 'could be accessible to everybody' (Participant 10), and others highlighted, 'we've always known that certain approaches are acceptable to and perhaps accessible to only certain groups' (Participant 8). An alternative environment for therapy therefore could be another 'tool in one's

armamentarium' (Participant 5), particularly given that the conventional indoor therapy model itself is not mutually accessible (e.g., 'a very Euro-centric way to do your business isn't it? And maybe it's just not culturally relevant for some people'. Participant 14; 'lots of people have clearly put on their "Sunday best" . . . trying to be equal to the moment, but that shows the power differential and I think walking outside removes that'. Participant 6).

### *Weight of tradition*

It was suggested that 'the most common reason that people do what they do is because it's the way they've always done it' (Participant 2). This weight of tradition was said to deter innovation, with busy health services often operating reactively to risks and problems. Adopting a position of environmental safe uncertainty may be challenging when the status quo of a more fixed and conventional therapy environment appears satisfactory.

It needs a lot of energy . . . the proof of concept is not that the way we've always done it is actually any good. The proof is on the opposite . . . You are constantly working with the assumption that what we do is safe and good. And, therefore, everything that you're trying to change people to, you've got to prove overwhelmingly that it's somehow significantly amazing. Whereas we could be sitting delivering something that is inherently bad, and people wouldn't see that, because they're already doing it. (Participant 2)

What happens when we're institutionalised is, we're either passively or actively encouraged to stop asking outside the box questions. And in a way that's, on a literal level, what you're trying to do is get outside the box of the therapy room. (Participant 14)

The weight of tradition was also felt to operate differently across therapy models, and, despite integrative practice, practitioners appear to be influenced by certain models more than others (e.g., psychodynamic vs. behavioural). Different models were considered to differ in their emphasis, focus on, and usage of the external therapy environment, thus shaping different tolerances for environmental uncertainty (e.g., 'You just don't change the model because the "great one" said it needs to be like this'. Participant 14). It was also suggested that behaviourism's decline, alongside growth in cognitively dominant approaches to therapy, draws attention away from more holistic considerations of the environment, with greater focus on a client's interior world. In other words, safe certainty is often maintained in the surrounding therapy environment and safe uncertainty reserved for the cognitive exchange.

One of the amazing things that was being done and this is about behaviour therapy specifically, was all about getting your hands dirty. It was all about going into situations with the patient. It wasn't about sitting in a therapy room. That really wasn't it, it was the opposite. I mean that's what the psychoanalysts did . . . And I think even with CBT, I regret the fact that there's a lot more emphasis on the cognitive within CBT than the behavioural. And I would argue on the basis of evidence that it's the behavioural components of CBT that have always been the most potent. (Participant 5)

Other participants highlighted that overtime, practitioners can lose sight of the legacy for why things are done in a certain way, which can make it more difficult to enter into environmental uncertainty in a way that feels safe and measured.

I've always been very struck by the fact, you know, why do we have the 50-minute therapy hour? Well it kind of goes back, it's like 30, 40 years ago where psychotherapists would do that and that's how you did it. And in fact, if you didn't do it that way, you were doing something weird and wrong . . . it's like a lot of things we do as therapists, we've lost sight of the legacy. (Participant 9)

The weight of tradition was also alluded to as a degree of inertia emerging as the profession became more established and radicalism was tempered. It was felt that in the past, clinical psychologists defined themselves through being distinct from related professions (e.g., 'you had to innovate because there wasn't anything'. Participant 12). However, as clinical psychology became more aligned within a socio-political context where evidence-based practice is privileged, the delivery of modern psychological therapy was viewed as more conservative, with less impetus for innovation.

As we've succeeded as a profession we have been incorporated if you like. I mean I think way back we were a lot more kind of maverick oddball. Nobody quite knew what we did and there was a lot of freedom and autonomy . . . as we developed, our profession's been stupendously successful. We've got healthcare psychologists all over the place doing lots of different things at different levels of work. We are probably more part of the establishment if you like . . . So, perhaps there are fewer mavericks and people coming in leftfield and doing crazy things. I mean, that may be a good thing, I don't know. (Participant 11)

### *Research challenges*

Clinical psychology often identifies with the scientist–practitioner model. Participants therefore suggested that an evidence base for alternative therapy environments is critical for justifying resource allocation and encouraging environmental safe uncertainty (e.g., 'I think it will give people more confidence about doing it. And it also brings a greater kind of validity to it, as well as alerting people to it as a possibility'. Participant 1). However, participants suggested that a careful negotiation was needed between the roles of 'scientist' and 'practitioner'. Whilst a drive for evidence can support safe and effective practice, when applied too rigidly, it can impede creativity and marginalize practice-based evidence (e.g., 'sometimes, for example, the term evidence-based is used as a kind of governance stick to beat people with because you can say to a practitioner, "well there's no evidence for that kind of approach"'. Participant 14).

It divides into camps, and there's people that think that any kind of empirical grounding is anathema and you just go with what you feel and be a reflective practitioner and that's it. As opposed to the kind of other extreme end which is total rigidity. (Participant 9)

Others argued that even where evidence does exist, a lack of awareness may sustain practitioners in a position of environmental certainty. Familiarity with alternative practices was often described as being accessed through less formal forms of communication (e.g., media, professional practice forums, and leadership figures).

On the whole, they're not spending their weekends reading research papers. What they really like is professional contacts and networking and people saying, 'Oh, I tried this, I went on this workshop' or 'I had a fantastic idea' or whatever, and those sorts of lines of influence, cultural

shift and influence are quite powerful in professional life— more than just evidence. Well, evidence meaning randomised trials. (Participant 11)

Another research challenge was that the incremental gains from relocating therapy may be objectively small and difficult to measure, particularly within a positivist paradigm. Whilst some argued this type of evidence is not necessary, others suggested it remains favoured by some practitioners, services, and commissioners.

Another problem, which is to do with the thing that cyclists call incremental gains . . . we should evaluate these things but it's quite hard to do this for a fairly obvious reason— because we have some very good treatments . . . if we considered, say, treating patients with OCD with CBT, which is a pretty effective treatment, and we wanted to compare doing that with where you also took walks in the woods and connected with nature or went to the seaside or whatever it is. The difference is going to be quite small . . . it's really hard to detect because of the power issues. (Participant 9)

Participants were also alert to the limitations of problem-focused measures commonly used in services, which may be unable to capture the benefits to well-being, engagement, and self-actualization accrued from outdoor environments (e.g., 'What are the constructs or concepts that we're targeting here? Because they probably do go beyond alleviation of symptoms'. Participant 8).

#### *Alignment with a medical model*

Clinical psychology at times was felt to align itself within a biomedical approach, underpinned by a belief of increased integration, respect, and influence within multidisciplinary teams (MDTs) and medically dominated health care systems (e.g., 'if you want power you have to use the power system that exists, you can't set up a separate one' Participant 6). This alignment was felt to cleave towards the safe certainty of more 'medicalized' consulting rooms, from which therapy in alternative environments may be viewed as unacceptable and less scientific.

I think people will fear not being taken seriously as a therapist, as a member of the MDT. 'I've sent them to the psychologist because then they can go for a walk'. Well, I'm not sure how many people would be able to tolerate that kind of view of themselves in a team. (Participant 10)

We're so wanting to be part of the MDT and I suppose longitudinally, I remember when there wasn't an accepted practice that there was a psychologist in an MDT. So, for my first CAMHS post in 2001, I was the first psychologist in that CAMHS team. And I was, you know, treated with suspicion . . . they were already seeing people in rooms, there was that medical feel to it . . . I think if I'd have gone in and gone, you know, 'oh let's'— 'I'm going to walk around with the kids rather than go into the therapy room', I would have been sort of even more suspicious. (Participant 12)

#### *Pressures from business models*

Mental health services were often seen as situated within a business model. Whilst the associated policies, procedures, and frameworks were considered important to mitigate risks and promote efficiency, they were also felt to constrain clinical activity to 'narrow

definitions of what people do' (Participant 2), leaving little room for creativity and environmental safe uncertainty (e.g., 'I do feel we are a bit, well, more than a bit constricted really by the Trust I'm working in'. Participant 10). Participants intimated that prevailing business models solely prioritized outcomes rather than the process by which these outcomes are achieved, and rendered innovation of interest only if improving outcome measures (e.g., 'we are so results-driven that it kind of quashes any creativity potential which is a shame'. Participant 10).

From a business perspective, if you're seeing it from that angle, then you know, it's a bit more stoic, if you see what I mean, rather than from the emotional response to if we're outdoor or indoor, 'what pressure points?' more about 'is it going to be better?' As in, 'are we going to need less therapy?' 'Are the outcomes going to be better for the service user?' And the collateral costs of outdoor working, either savings or additional costs? (Participant 2)

A business model was felt to generate a drive for efficiency (e.g., "how many people have you seen this week" type culture'. Participant 12), with some services described more as a 'production line ... modelled on a kind of factory rather than a place of creativity' (Participant 14). Consequently, time-pressured employees were felt to gravitate towards expediency (e.g., 'it's convenience isn't it? It's quite convenient to sit in a room and have three people trek up to see you, one after another'. Participant 1), as well as interventions that are consistent and repeatable all year round (e.g., 'working in Britain of course you've got the whole issue of the weather', where on certain days or time of year it may not be 'practically easy to do outdoor work'. Participant 11).

For many managers and senior staff they've got their hands full and they've got more than enough to worry about ... and the idea that—'oh I know, let's add an extra dimension to your complex job like work out how to do outdoor therapy'—I think it would be dismissed. So, it would be a barrier of 'Oh, come on', you know, 'We don't need it, What's the problem?' (Participant 11)

In seeking efficiency, a clinical psychologist may also be prevented from working more holistically with clients. Practitioners are often required to reduce well-being into component parts (e.g., absence of distress, behavioural activation, and self-actualization) and allocate components to the client's time outside of therapy, or share them with other members of an MDT who hold different levels of responsibility (e.g., 'management might say "well if you're just going for a walk with them, just get one of the Band 4's to do that." But it's not about that alone is it?' Participant 10).

### **Supporting environmental safe uncertainty**

#### *Hard heads—soft hearts*

Despite the aforementioned barriers to safe uncertainty, the professional culture and training in clinical psychology was seen as fostering high levels of curiosity and practitioner innovation (e.g., 'we have a history of questioning convention. And I think that's been a strength actually of the profession'. Participant 5). With a focus on integrating multiple approaches to therapy, whilst maintaining a questioning and reflective stance, the culture was felt to support practitioners in exploring new therapy environments in a safe and measured way.



The really important ambition in being a clinical psychologist is to have a hard head and a soft heart, but don't get them the wrong way round. What that means is you have compassion and an ability to reflect and think about what's going to help the person you're working with, but you don't give up your critical faculties. So, if you follow that through, it means that you're confident enough to leave the consulting room, if you're keeping a critical eye on whether it's going to work and whether the client is responding and wants to do it. (Participant 3)

### *Leadership and collaboration*

Clinical psychologists were felt to regularly adopt roles embracing compassionate leadership, which enable them to hold risk, promote innovation, and influence organizational culture through harnessing support from both managerial and front-line staff groups.

Maybe it's about the person who will be taking the risk, the head of service, what is their attitude to risk? To moving the boundaries? ... How much are they prepared to put themselves out there as a change model? ... I will always take [responsibility for] the risk. The very first day I meet anybody new— what I always say to them is, 'I know it will be hard to trust right from the beginning but I will always have your back. Whatever you do, I will be the one that will front that for you because what I want you to do is to be able to work out what sort of therapist you want to be'. (Participant 6)

In turn, the subculture within a particular team was considered one of the strongest influences on choice of therapy environment (e.g., 'I think so much depends on the context. You know, the NHS is not just one thing, is it? It's multiple tiny little subcultures and subservices'. Participant 1). For some subcultures, a position of environmental safe uncertainty is more familiar.

There have been outreach services in the third sector for a long, long time, trying to engage people who are hard to reach or hard to gauge by meeting them in environments that are more acceptable to them. Especially people that have really struggled with the formality of the therapy room or the clinic or actually what being referred into services means for them. And that was my first experience of being outside of the therapy room. (Participant 8)

Clinical psychologists were also felt to be positively influenced when working alongside related professions (e.g., art therapy, occupational therapy, counselling, nursing, physiotherapy, and support work), where alternative environments and community outreach are more common.

I think perhaps for some professions, this comes as a more kind of natural way of working. So, thinking about our occupational therapists, I think they would probably feel pretty comfortable about this, 'cos they'll be doing things like gardening groups or outdoor activities. Our physical therapists the same. (Participant 1)

### *Presence in training*

Considerations of alternative environments was felt to already feature in some clinical psychology training courses, usually embedded in core competencies or models (e.g., mindfulness, behavioural, and community psychology).

You have some time thinking about the context in which you're working, or the modality through which you're working. So, whether it's in a clinical room, whether it's in a community centre, whether it's in someone's home. Whether it's face-to-face, whether it's online, whether it's outside. They are all things that may require slightly different protocols. (Participant 1)

Whilst training courses might not explicitly promote use of alternative therapy environments such as the outdoors, they were felt to be responsive to emerging approaches, with mutual influence from local practitioners, research, and course team specialities.

You are free to do those kinds of things, but it has to be in a framework and the framework is provided by the learning objectives part of the course. But how you achieve those learning objectives is actually up to you either as a course director or as the person doing the particular teaching. (Participant 9)

### *COVID shift*

The COVID-19 pandemic prompted a rapid consideration of alternative therapy environments that would enable therapy provision to continue safely. This process demonstrated that a substantial organizational shift towards a position of environmental safe uncertainty can happen quickly.

Up until Covid, nobody considered working in a different way . . . If you'd asked me pre-Covid, I probably would have had more reservations [about therapy outdoors] . . . it's got me thinking more about the boundaries of therapy and how you maintain those and how you set those up . . . if somebody had said to the NHS you can start doing your therapy online, they would have put up every barrier known to man. Whereas out of necessity we very, very quickly got going . . . So they can turn it around. I'm not saying they couldn't, but it took a pandemic to do it. (Participant 12)

It was also felt this shift may underpin more enduring changes in the choice of therapy environments available to clients.

You can't help feeling, can you? Give it another decade especially with Covid and the way that we've been forced to operate differently. Are we really going to go back to getting people to park in a God-forsaken car park, put money in the machine, come through, be all formal and—Surely, we're going to get better than this? . . . [If I were a client], who is going to be able to persuade me that it's better to sit with them in a room, than it is to go out to [a national park] and go and sit there for an hour with somebody who's willing to talk to me there. I can't help thinking my money is on the latter. (Participant 4)

## **Discussion**

Following the organizational barriers to outdoor talking therapy identified in a prior review of the literature (Cooley, Jones, et al., 2020), the aim of the present study was to further explore how the organizational culture or subcultures in which clinical psychologists work can influence the choice of therapy environment. The 15 senior figures who participated in the study provided rich accounts of a number of key

organizational factors that influence the choice of therapy environment. Although this study set out with a specific interest in outdoor spaces, participants considered this environment to be one of the several alternatives to the conventional indoor consulting room (e.g., client homes, urban outdoor environments, public venues, and digital therapy), each of which have the potential to support access and engagement. Many of the themes were therefore applicable across a range of these alternative therapy environments.

### ***Environmental safe uncertainty***

Rather than advocating for any one of these therapy environments, the overarching theory supported a position of environmental safe uncertainty, which was defined as an openness, critical curiosity, and collaboration between client and practitioner regarding their choice of therapy environment. This theory is in line with much of the prior research on outdoor talking therapy, which does not make generalized claims that the outdoors is *better* than conventional indoor therapy rooms, instead suggesting that the outdoors offers an alternative space that may be more suitable and effective for *some* clients (see Jordan & Marshall, 2010; Revell & McLeod, 2016). It is therefore the degree of openness and curiosity that determines the position of environmental safe uncertainty, not the chosen environment per se. For example, two client–practitioner dyads could both be working in an indoor therapy room, with dyad ‘A’ having explored a choice of available therapy environments and concluded that the indoor therapy room was the most appropriate environment for the work they were doing at that time (environmental safe uncertainty), whereas dyad ‘B’ are located in the indoor therapy room out of organizational habit or unconscious bias, without having considered the alternatives (environmental safe certainty). The theory of environmental safe uncertainty (Figure 2) therefore supports practitioners and clients in reflecting on and articulating decisions around alternative therapy environments, in a thoughtful and person-centred way.

In maintaining safety, it is important that the choice of therapy environment is founded on collaboration, so that both client and practitioner feel safe and comfortable. For example, a client and practitioner may have considered an alternative outdoor space that one of them regularly visits in their leisure time, and decide against its use for therapy due to it feeling too uncontained. Again, this would still be an example of environmental safe uncertainty as this position enables alternative environments to be ruled out and adopted.

Whilst necessary for both parties to feel comfortable, this collaborative approach may require the practitioner to provide support and draw from their expertise when considering alternative environments that remain within a client’s ‘zone of proximal development’ (Vygotsky, 1978). Indeed, in his original writings, Mason (1993) advised that a position of uncertainty does not mean a practitioner cannot own their expertise. That is, a practitioner may have significant experience regarding the potential impact of different therapy environments, and the client may wish to draw on this expertise when selecting an appropriate environment. Mason therefore recommends the practitioner holds a belief of ‘authoritative doubt’, as a way of encompassing both expertise and uncertainty and avoiding the pitfalls of premature certainty (Mason, 1993).

### ***Challenges to the use of alternative spaces***

Although a practitioner may have strong internal motivation towards maintaining a position of environmental safe uncertainty, they also need to feel safe that their choice of

environment will be supported within the organizational culture they are working. The present study identified a tension between organizational factors that impede positions of environmental safe uncertainty (i.e., provider anxiety, accessibility, weight of tradition, research challenges, alignment with a medical model, and pressure from business models) and those that support it (i.e., hard heads–soft hearts, leadership and collaboration, prevalence in training, and COVID shift). This tension may explain why previous research finds outdoor practice to be relatively uncommon in clinical psychology and public health services (Cooley, Jones, et al., 2020; Shillito-Clarke, 2008).

In line with previous research, these findings suggest that practitioners wishing to explore alternative environments for therapy may at first be required to overcome a degree of dissonance as they challenge organizational norms (Jordan, 2014; McKinney, 2011; Revell & McLeod, 2017). However, practitioners often vary in their assertiveness and response to organizational conflict and anxiety (i.e., ‘avoid’, ‘accommodate’, ‘compete’, ‘compromise’ or ‘collaborate’; Thomas, 1992), which may explain previous findings that ‘professional confidence’ is prominent among those who have previously offered therapy in alternative outdoor spaces (Cooley, Jones, et al., 2020).

These findings could be contextualized within the work of Lyth (1988), who formulated how health care organizations have historically used hierarchies, fixed roles, and rigid adherence to procedures to defend against high work-related stress, doubt, and uncertainty. Whilst these health care environments were found to be containing and supportive for staff, they also limited creativity and human contact with patients. Such an organizational culture would be in direct conflict with a position of safe uncertainty, which Mason (2019) described as often comprising inherent feelings of apprehension, discomfort, doubt, and constant evolution. These ideas are supported by more recent research and theories on the implementation of innovation in health care systems, which suggest novel practices carry an inherent anxiety due to the risk of harm and/or failure (Greenhalgh & Papoutsis, 2019).

### **Clinical recommendations**

Prior research suggests that a culture of psychological safety is necessary for creativity and innovation within teams (Edmondson, 2018; Kessel, Kratzer, & Schultz, 2012; O'Donovan & McAuliffe, 2020). To achieve a sense of safety, Mason (2019) advised that the discomfort found within positions of safe uncertainty can be supported through safe experimentation with small differences. Incremental approaches to health care innovation are also recommended following studies in quality improvement and implementation science (Greenhalgh & Papoutsis, 2019). In relation to environmental safe uncertainty, this incrementation approach could, for example, involve spending small amounts of time in alternative environments to increase familiarity. This safe experimentation could also incorporate ‘plan–do–study–act’ cycles (PDSA; Leis & Shojania, 2017), which document the impact and can be used to support buy-in within an organization before expanding the practice (Côté-Boileau, Denis, Callery, & Sabeau, 2019).

Whilst the present study identified a number of sources of organizational conflict, it also suggested that clinical psychologists, by the very nature of their training, are well equipped to contend with these challenges (i.e., ‘hard heads–soft hearts’). Together with this, it seems that the present climate may provide a catalyst for outdoor talking therapy. For example, the COVID-19 pandemic is creating a new culture within the NHS that appears more open and responsive to new ways of working (i.e., ‘COVID shift’; also see Palanica & Fossat, 2020). Underpinning this shift are national policies to improve access to

mental health services, whilst also promoting green spaces and nature restoration (e.g., Gov.uk, 2020). This could create a facilitative context and mechanisms for adoption and spread of outdoor talking therapy, including the use of quality improvement methods to test and refine the approach. Should the outdoors attract greater acceptance as an alternative environment for therapy, the organizational conflict associated with its use may also be lessened, further enabling its accessibility for a broader range of practitioners and clients.

The model of environmental safe uncertainty (Figure 2) proved useful in the present study as a practical model for guiding action. That is, when applied clinically, this model can be used during therapy to: (1) reflect on and discuss the client and practitioner's position towards the therapy environment, bringing the potential impact of available environments into more conscious consideration; (2) reflect on what might be driving the choice of therapy environments (or lack of), including whether these drivers are in the best interest of the client (e.g., appropriate fit with their preferences, risk management, therapy model, formulation, and/or therapy goals), or influences that may be outside the client's best interest (e.g., convenience, tradition, practitioner or service-level discomfort with uncertainty, lack of client engagement in decision-making, and lack of resources); and (3) identify what action could be taken to further support environmental safe uncertainty (e.g., client consultation, staff training, evaluating the impact of alternative spaces to develop service-specific evidence, revising policies and procedures, and improving access to alternative environments).

### **Limitations**

A sample size of 15 has previously been considered below average in grounded theory research (Thomson, 2011). Whilst the present sample size was justified and mitigated somewhat by the quality of data obtained, it remains likely that further participants would have revealed additional insights. Theoretical sampling was used until the core themes were considered well established and conceptually rigorous ('theoretical sufficiency'; Charmaz, 2009); however, the idea that a true and absolute point of 'saturation' exists is thought to be something of a logical fallacy, as there are 'always new theoretic insights to be made as long as data continues to be collected and analyzed' (Low, 2019, p. 131). Data analysis will also have been influenced and shaped by the biases and unique frames of reference held by the research team. As a result, readers may construe the present findings differently according to their own frame of reference.

The present study did not adopt 'validation' and 'reliability' procedures (e.g., interrater reliability and member checking) given their contested association with realist ontology, including the assumption of a single external reality and the need to eliminate researcher bias (see Smith & McGannon, 2018). Nevertheless, such methods could have instead been incorporated to encourage additional perspectives to those obtained through theoretical sampling, thus serving as an additional form of collaborative reflexivity (Braun & Clarke, 2019).

### **Research implications**

Although it is not the purpose of qualitative research to strive for the statistical-probabilistic form of generalization associated with quantitative research, there are other forms of qualitative generalizability applicable to the present study (see Smith, 2018). Given that the data within this study were presented to and discussed with multiple

audiences prior to the present publication, the authors had already been privileged to indications of such generalizability. For example, numerous practitioners and clients have discussed how the organizational barriers and enablers to outdoor practice reverberate with their own experiences (i.e., 'naturalistic generalizability'; Stake, 1978), as well as ways in which the present findings could be transferred to their contexts (e.g., services, client demographics, presenting difficulties, and therapy models used; i.e., 'inferential generalization'; Lewis, Ritchie, Ormston, & Morrell, 2014). In applying the present data to the model of safe uncertainty (Mason, 1993), the present study also supports 'analytical generalization', which occurs when the researcher generalizes their findings to a concept or theory that 'later makes sense and has significance in other research, even if the contexts or populations are different' (Smith, 2018, p. 141).

Future research is now required to examine the implementation of environmental safe uncertainty within services. Further understanding is needed in how best to support services and practitioners in adopting this position, as well as measuring the impact of environmental safe uncertainty compared with more conventional, fixed offerings. Given that the present study had a specific focus on outdoor environments, it could be useful to explore environmental safe uncertainty in other alternative settings, such as the current shift to online therapy and whether this will be sustained post-COVID-19.

## Conclusion

Prior research has demonstrated that the physical environment in which talking therapy is located can fruitfully support access, therapy processes, outcomes, and equity of care. The present study identified a range of influences within the organizational culture of clinical psychology that either facilitate or impede a practitioner's ability to explore and use alternative therapy environments. The model of environmental safe uncertainty is presented to support clients, practitioners and services in maintaining an open, safe, and critical curiosity towards the therapy environment. A person-centred approach to the choice of therapy environment is consonant with 'evidence-based practice', which is defined as an 'integration of the best available research with clinical expertise *in the context of patient characteristics, culture, and preferences*' (American Psychological Association, 2005, p. 5, emphasis added). This amalgamation of empirical evidence, clinical judgement, and client characteristics is why therapy is best described as both an art and a science.

## Acknowledgements

We would like to thank the Churchill Foundation, Ringwood, Hampshire, for their charitable grant that contributed to the funding of this research.

## Conflicts of interest

All authors declare no conflict of interest.

## Author contributions

SC contributed to conceptualization, formal analysis, funding acquisition, investigation, methodology, project administration, and writing of the original draft. CJ contributed to

conceptualization, formal analysis, supervision, validation, and writing, reviewing, and editing of the manuscript. DM contributed to formal analysis, validation, and writing, reviewing, and editing of the manuscript. NR contributed to conceptualization, formal analysis, methodology, supervision, validation, and writing, reviewing, and editing of the manuscript.

## Data availability statement

The data that support the findings of this study are available from the lead author upon request.

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Received 4 March 2021; revised version received 27 May 2021