

## **Walking groups for women with breast cancer: mobilising therapeutic assemblages of walk, talk and place**

### **Authors:**

Aileen V IRELAND, Research Assistant, Faculty of Health Sciences and Sport, University of Stirling, UK, [a.v.ireland@stir.ac.uk](mailto:a.v.ireland@stir.ac.uk); +44 1786 466392

Jennifer FINNEGAN-JOHN, Senior Research Officer, Breast Cancer Care, Kennington Business Park, Chester House, 1–3 Brixton Road, London SW9 6DE, UK; +44 20 7960 3424 [jennifer.finnegan-john@breastcancercare.org.uk](mailto:jennifer.finnegan-john@breastcancercare.org.uk);

Gill HUBBARD, Director of Research, Department of Nursing, University of the Highlands and Islands, Centre for Health Science, Old Perth Road, Inverness IV2 3JH UK; [gill.hubbard@uhi.ac.uk](mailto:gill.hubbard@uhi.ac.uk); +44 1463 255646

Karen SCANLON, Head of Research and Evaluation, Breast Cancer Care, Kennington Business Park, Chester House, 1–3 Brixton Road, London SW9 6DE, UK; +44 20 7960 3467; [karen.scanlon@breastcancercare.org.uk](mailto:karen.scanlon@breastcancercare.org.uk);

Richard G KYLE\*, Reader, School of Health & Social Care, Edinburgh Napier University, Sighthill Campus, 9 Sighthill Court, Edinburgh EH11 4BN, UK, [r.kyle@napier.ac.uk](mailto:r.kyle@napier.ac.uk); +44 131 455 2740

**\*Corresponding Author:** Dr Richard G Kyle  
School of Health & Social Care,  
Edinburgh Napier University,  
Sighthill Court,  
Edinburgh EH11 4BN,  
UK,  
Email: [r.kyle@napier.ac.uk](mailto:r.kyle@napier.ac.uk)  
Tel: +44 131 455 2740

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### **ABSTRACT**

Walking is widely accepted as a safe and effective method of promoting rehabilitation and a return to physical activity after a cancer diagnosis. Little research has considered the therapeutic qualities of landscape in relation to understanding women's recovery from breast cancer, and no study has considered the supportive and therapeutic benefits that walking groups might contribute to their wellbeing. Through a study of a volunteer-led walking group intervention for women living with and beyond breast cancer (Best Foot Forward) we address this gap. A mixed-methods design was used including questionnaires with walkers ( $n=35$ ) and walk leaders ( $n=13$ ); telephone interviews with walkers ( $n=4$ ) and walk leaders ( $n=13$ ); and walking interviews conducted outdoors and on the move with walkers ( $n=15$ ) and walk leaders ( $n=4$ ). Questionnaires were analysed descriptively. Interviews were audio-recorded, transcribed verbatim, and analysed thematically. Our study found that the combination of walking and talking enabled conversations to roam freely between topics and individuals, encouraging everyday and cancer-related conversation that created a form of 'shoulder-to-shoulder support' that might not occur in sedentary supportive care settings. Walking interviews pointed to three facets of the outdoor landscape – as un/natural, dis/placed and im/mobile – that walkers felt imbued it with therapeutic qualities. 'Shoulder-to-shoulder support' was therefore found to be contingent on the therapeutic assemblage of place, walk and talk. Thus, beyond the physical benefits that walking brings, it is the complex assemblage of walking and talking in combination with the fluid navigation between multiple spaces that mobilises a therapeutic assemblage that promotes wellbeing in people living with and beyond breast cancer.

**Keywords:** Breast Cancer; Psychosocial support; Walking; Volunteers; Walking Interviews.

## INTRODUCTION

Geography has been on the move. At the heart of the wider ‘mobilities turn’ in the social sciences over the past two decades (Cresswell & Merriman, 2016), geographers have shifted their attention to the ways in which bodies move through space by empirically examining, for example, dance (McCormack, 2013), yoga (Philo et al., 2015), jogging (Cook et al., 2016), running (Bale, 2016), and walking (Lorimer, 2013). Methodologically, this movement in geography has resulted in a renewed focus on experiential approaches where researchers participate in the physical activities they seek to study, or adopt autoethnographic approaches that turn their academic concerns towards those activities that have shaped their own lives and thinking. Such experimentation has seen geographers embrace the use of walking or ‘go-along’ interviews conducted outdoors and on the move with research participants (Doughty, 2013, Evans & Jones, 2011; Houlton, 2014) that, as a method, took its first steps in street phenomenology (Kusenbach, 2003). Health geographers have embraced these approaches to extend our understanding of therapeutic landscapes (Gesler, 1992; Williams, 2007) by exploring the ways in which playing in (Richardson et al., 2017), being near to (Bell et al., 2014), meditating on (Philo et al., 2015), caring for (Milligan et al., 2004), and walking through (Gatrell, 2013) green space is conducive to health and healing. However, despite such empirical and methodological shifts, the geographies of recovery for people who are faced with the complex physical and psychosocial challenges associated with rehabilitation after cancer have rarely been explored. Little research has considered the concept of therapeutic landscapes in relation to understanding the experiences of women affected by breast cancer (English et al., 2008, Liamputtong & Suwankhong, 2015), and, to our knowledge, no study has specifically considered the supportive and therapeutic benefits that walking groups might contribute to the wellbeing of these individuals. In this paper, we

address such concerns by sharing findings from a study of peer-led walking groups for women living with and beyond breast cancer in the North of England that examined the interplay between walking, talking and place.

We begin by briefly discussing existing research around the benefits of physical activity after cancer diagnosis, positioning this paper in a broader field of psychosocial-oncology and pointing to the lack of services and referral to physical activity interventions after cancer, especially in the United Kingdom (UK). Best Foot Forward, a peer-led walking group intervention designed by UK charity Breast Cancer Care to address this service gap, is then presented. A description of our research methods follows. We then present our findings in four parts. First, we examine the act of walking and, then, talking, separately, exploring their role as key enablers of peer support for women during the walks. The combination of walking and talking, together, is then examined. Here we reveal a distinct form of ‘shoulder-to-shoulder’ support that is contingent on the emergent geography of recovery. We discuss the interplay between three dialectical facets of landscape – as dis/placed, im/mobile and un/natural – that emerged in women’s accounts and that are entwined to form a therapeutic assemblage. We use the term ‘assemblage’ in the sociomaterial sense: that is, that these facets, collectively, are engaged in a complex “process of assembling” (Latour, 2005, p. 1) the enactment of recovery; a “set of relations which are not separable from each other” (Deleuze & Parnet, 1987, p. viii), and which yield a new entity that is more powerful than any of the individual parts alone (Lee & Stenner, 1999). This assemblage not only enhanced women’s health and healing, but also encouraged on-going engagement in physical activity. Finally, we suggest that the insights revealed in this study by introducing empirical concerns and methodological approaches from health geography to psychosocial-oncology should

inform the development of future physical activity interventions, and call for an ever-closer connection between these two fields.

## **Physical Activity and Cancer**

Breast cancer in women is among the most common cancers globally (Cancer Research UK, 2014), and is the most common cancer in the UK (Torre et al., 2015). Early detection, alongside increased and improved treatment options, have contributed to a rise in the number of women who survive breast cancer (Torre et al., 2015). Ten-year survival rates in England and Wales have almost doubled in the last 40 years, from 40% in 1971–72 to 78.4% in 2010–11 (Cancer Research UK, 2014). Engaging in physical activity is associated with increased survival after breast cancer diagnosis (Ballard-Barbash et al., 2012; DeSantis et al., 2013; Ibrahim & Al-Homaidh, 2011; Volaklis et al., 2013), and a Cochrane Review of 40 trials found that physical activity interventions have a positive impact on health-related quality of life and reduce anxiety, fatigue and pain over time in cancer survivors (Mishra et al., 2012). Additionally, physical activity interventions have been found to improve psychosocial aspects of quality of life (Spence et al., 2010). However, an extensive review of the literature relating to physical activity and the risk of breast cancer recurrence found that few studies have examined the effects of physical activity in women affected by breast cancer in particular, and, further, that psychosocial factors are largely overlooked, despite being instrumental in predicting physical activity behaviour and influencing decisions to establish and maintain a programme of physical activity (Loprinzi et al., 2012). In addition, a randomised controlled trial to determine the effects of peer support on the quality of life of breast cancer survivors determined that the psychosocial outcomes of peer-led physical activity interventions are poorly understood (Pinto et al., 2015). Furthermore, a recent examination of the emotional benefits of walking demonstrates positive affect, providing a

direct link between emotional and physical health (Miller & Krizan, 2016). Most importantly, a systematic review and meta-analysis of the evidence related to physical activity in breast cancer survivors found that the most successful physical activity interventions were those that were supported by counselling (Bluethmann et al., 2015). Together, these findings suggest that more emphasis should be placed on the psychosocial element in supporting women in undertaking physical activity and on psychosocial support during physical activity for people undergoing breast cancer treatment and beyond. In the UK, however, neither physical activity nor psychosocial support is routinely prescribed as part of the treatment pathway for cancer survivors, and the referral of women affected by breast cancer to such programmes is often made by community-based organisations and cancer charities.

### **Best Foot Forward**

Breast Cancer Care is a UK-wide charity providing care, information and support to people affected by breast cancer and is actively involved in providing ongoing psychosocial support to people affected by breast cancer. As part of their Moving Forward programme that supports people after breast cancer diagnosis and treatment, Breast Cancer Care developed and piloted Best Foot Forward, a peer-led walking group intervention, in three areas of the North of England. The intervention was offered to all those who had recently completed treatment for primary breast cancer in those areas, at all abilities and levels of fitness, who want to be more active and increase their wellbeing and energy levels. The walks were facilitated by trained Walk Leaders with a personal experience of breast cancer who had also been recruited through the Moving Forward programme.

The aim of the Best Foot Forward intervention was twofold: (1) to encourage physical activity; and (2) to enable psychosocial support. This aim was designed to be achieved by providing women with breast cancer the opportunity to undertake regular exercise outdoors in a supportive environment with other people with experience of breast cancer. Between 2013 and 2015 a concurrent evaluation of Best Foot Forward was conducted led by a team of academics at Edinburgh Napier University and The University of Stirling (RGK, AVI, GH). Evaluation processes involved members of Breast Cancer Care's in-house research team (J-FJ, KS) in data collection processes, but Breast Cancer Care were not involved in the analysis or interpretation of study findings. The aim of the research was to understand the perceived therapeutic and supportive benefits of Best Foot Forward through the experiences of volunteer Walk Leaders and Walkers affected by breast cancer.

## **METHODS**

### **Research Design**

A mixed-methods study was conducted in three steps: (1) a postal survey; (2) telephone interviews; (3) walking interviews. Walkers and Walk Leaders were invited to participate in each step in turn. Each method was purposefully selected to progressively close the geographic and relational distance between researchers and participants, and between participants and the location of the walks they took part in or led. Hence, there was a move from structured questions (in surveys) to unstructured discussion (during walking interviews), and from involvement with researchers at home (by completing a questionnaire or speaking on the telephone) to shared experiences with researchers (during walking interviews). This gradual process was used to enable sufficient rapport and trust to be established between researchers and participants to enable walking interviews to mirror (as much as possible) the



process of the walking group intervention itself. This meant that as individuals engaged in each step of the research process a deeper understanding of their experiences of involvement in Best Foot Forward was gradually revealed.

## **Intervention**

Best Foot Forward walks were led by volunteer Walk Leaders who had experience of breast cancer diagnosis and treatment, either personally or through relationships with family members or friends. Walk Leaders were recruited from the Moving Forward programme and were involved in the design and risk assessment of walk routes in conjunction with Breast Cancer Care staff. Each walk was designed to suit people of all abilities and fitness levels and to originate from a location that was easily accessible, such as a local park. Each walking route is described in detail in Table 1. Walks were facilitated by two Walk Leaders: one to lead the group, and one to act as a ‘back marker’ to monitor the group’s progress. Walks lasted between 30 and 60 minutes and concluded in a local café to encourage therapeutic conversation. All people affected by breast cancer who made contact with Breast Cancer Care and who attended the Moving Forward programme in the pilot area were offered enrolment in the Best Foot Forward intervention. At the time of the evaluation, walks had been organised in three locations across the North of England.

*[Insert Table 1 here]*

## **Data Collection**

Data were gathered from both Walkers and Walk Leaders using three methods: (1) self-report questionnaire survey; (2) telephone interviews; and (3) walking interviews.

### *Questionnaire Survey*

Walkers participating in Best Foot Forward between April 2013 and October 2014 ( $n=57$ ) were contacted by Breast Cancer Care by post and invited to complete a self-report questionnaire. Walk Leaders were provided with an information sheet, expression of interest form, and stamped addressed envelope when they volunteered to take part in Best Foot Forward. If the form was returned, they were contacted by a researcher to discuss the study further and, if willing to be involved, they were sent a consent form to sign and a questionnaire to complete and return. Questionnaires for Walkers and Walk Leaders were designed in parallel to enable comparison between groups. All participants were asked about their motivation for taking part in Best Foot Forward and a range of socio-demographic and health questions. Both questionnaires also invited participants to take part in a telephone interview.

### *Telephone Interviews*

Telephone interviews were conducted with Walk Leaders ( $n=9$ ) and Walkers ( $n=4$ ) and topic guides were developed in parallel to facilitate comparison and included questions around the individual experiences of Best Foot Forward walks, their motivations for being involved, and the perceived benefits of participation. For Walk Leaders, interviews also included questions that asked them to reflect on the design and experience of their specific walking routes, and the benefits they thought walking had for women taking part. Telephone interviews were between 25 and 60 minutes in length and were audio-recorded.

### *Walking Interviews*

To explore participants' experiences and perceptions of the therapeutic and supportive benefit of walks, 'walking interviews' were conducted with Walkers ( $n=15$ ) during three different

walks (walk 1, n=4; walk 2, n=5; walk 3, n=6) and Walk Leaders (n=4) on four separate walks. Walking interviews are a novel research method that involved a researcher talking with participants as they walked outdoors, in this case along their regular walking route. Walking interviews recognise the importance of place as relational and biographical: that people have a relationship with particular places and that these places shape people's lives and relationships (Evans & Jones, 2011). In this study, walking interviews were used to explore the significance of the specific walk routes in terms of conversation, emotion and place. Hence, discussion roamed freely and did not follow a set structure, but rather was guided by the interviewer to focus on these three topics by first asking: "Can you tell me about any significant conversations/emotions that you may have experienced while you were on the walks?" and "Is there something significant about the place where you walk?" Prompts were added when appropriate, such as "Can you talk a bit more about that?" Each interview opened with the same question and each subsequent topic was introduced as and when appropriate.

For the interviews with Walkers, one researcher (JF-J) interviewed each walker while participating in the walk. The interviewer carried a digital voice recorder to capture as many voices as possible. For interviews with Walk Leaders, one researcher (AVI) interviewed one Walk Leader while participating in each of the three walks. In these interviews, the Walk Leader was fitted with a lapel microphone attached to a digital recorder carried in the Walk Leader's pocket. This captured the voice of the Walk Leader and the interviewer. Walking interviews continued into the café ensuring that they mirrored as closely as possible the process of the intervention itself.

## **Data Analysis**

Digitally recorded audio files from telephone and walking interviews were transcribed verbatim. All transcripts were analysed thematically following principles of Framework Analysis (Ritchie & Lewis, 2003) through a three-stage process. First, transcripts were first read independently by two authors (AVI, RGK) to familiarise themselves with the data and to identify common themes. Second, emerging themes were then discussed by these authors to agree a common coding framework. Third, the lead author coded the data and developed thematic matrices to preserve the richness of the data and enable them to be categorised and compared thematically between individuals.

Socio-demographic data from self-report questionnaires of Walkers and Walk Leaders were analysed descriptively using SPSS version 19.0 (IBM Corp., 2010) and are shown in Table 2. In addition, analysis of routinely collected data held by Breast Cancer Care was conducted to compare the profile of Walkers in the study to all those who participated in Best Foot Forward walks (see Table 2).

*[Insert Table 2 here]*

## **Ethical approval**

The study was reviewed and approved by {anonymised for review} Research Ethics Committee.

## **FINDINGS**

Our findings are presented in four parts. The importance of *walking* to recovery and reshaping identity after cancer is first considered. We then turn to share the ways in which

*talking* enabled women in our study to access shared experience and support. After considering walking and talking separately, we then show how through their combination, *walking and talking, together*, reveals a form of, what we call, ‘shoulder-to-shoulder support’ that participants felt would not occur in sedentary support settings. Finally, through an explicit focus on place, we reveal how shoulder-to-shoulder support is made possible through three inter-related dialectical aspects of landscape as un/natural, dis/placed and im/mobile that form a therapeutic assemblage.

## **Walking**

During telephone interviews, all Walk Leaders spoke about the importance of physical activity as an aid to recovery after cancer and many described awareness of the benefits of fitness in preventing cancer recurrence. Walk Leaders also shared how walking had particular significance as a new and natural starting point after breast cancer diagnosis in two ways. First, walking marked a natural starting point for re-engagement with physical activity after cancer.

I think walking is just such a perfect start, it’s something that we learn at a very early age ... I think it’s probably an inspirational departure for Breast Cancer Care to recommend the ladies walk, and I just think it’s a starting point for anything else they want to go on to do ... I think it’s just the real best way to go forward in an exercise regime, so I couldn’t over-claim the benefit of starting by walking. (Walk Leader 4, Telephone Interview)

Walk Leaders also spoke about how walking is a safe and gentle activity, was one of the few activities that healthcare professionals give them permission to do, and how it established a routine, and helped women feel less isolated.

Second, walking was considered the best possible way to re-commence life after the biographically disruptive (Bury, 2005) event of a cancer diagnosis. Indeed, some Walk Leaders likened the act of walking to the symbol of starting a “new life” (Walk Leader 5, Telephone Interview; Walk Leader 6, Telephone Interview). Walkers described how participating in the walks gave them renewed confidence and how walking with other women affected by cancer gave them a sense of reassurance and normality in relation to their symptoms and treatment. Taking part in the walks was described as being therapeutic but it also provided a natural starting point to “try other things” (Walk Leader 4, Walking Interview) and was a regular activity that provided a “good reason to get out of the house” (Walk Leader 7, Telephone Interview). Walk Leaders, too, described how leading the walks contributed to regaining their own confidence after diagnosis and treatment and spoke about how it was a positive influence in their lives that helped them to build new relationships and friendships.

## **Talking**

All Walkers who took part in telephone or walking interviews said that their initial reason for attending Best Foot Forward walks was to meet people with a shared experience of cancer diagnosis. Engaging in physical activity was secondary to a need to establish social connections. Walking while sharing significant conversations fostered a sense of “fellowship” among walkers (Walker 4, Walking Interview), that was favoured over fitness.

I think more ... well fresh air, obviously, it gets me out ... but more than the actual walks I think the important thing for me is actually the cup of coffee and the chats with everybody afterwards, we find all sorts out – in the best possible way! We do. Because everybody has been in a similar situation and it’s nice to chat and compare

notes so I find the coffee and the chat afterwards very, very therapeutic. (Walker 9, Walking Interview)

Several Walkers spoke about how meeting up to walk and talk with others who were at different stages of their journey through and after treatment gave them motivation to continue to participate in the walks, as well as hope for their own future after cancer.

So if you can see that there's a woman at the front who's walking, who's laughing, who's full of energy and you're just starting your journey and you feel absolutely terrible you think to yourself, God, there is light at the end of the tunnel and then you get talking to all these other ladies that are walking that say to you I know exactly how you are feeling but look, look at me, hang on in because it gets better. (Walker 1, Telephone Interview)

Walking with others who had shared experiences of breast cancer diagnosis was described as being a very important aspect of the walks. Yet, no consensus was reached on whether it was important that Walk Leaders had a personal experience of breast cancer. Slightly more walkers agreed (45.5%) or strongly agreed that it was important that Walk Leaders have a personal experience of breast cancer than disagreed or strongly disagreed (39.4%), although around 1 in 7 (15.2%) were not sure. Only 4 women (11.4%) noted that the gender of the Walk Leader would influence their decision to take part in the walks.

### **Walking and Talking, Together**

Although walking and talking as separate activities were considered important, participants most often shared how the *combination* of walking and talking at the core of the intervention

was central to its supportive and therapeutic benefit. Walking and talking, together, was important in three ways.

First, the combination of walking and talking enabled conversations to move on easily during walks. Walking in a group facilitated supportive conversations because it provided opportunities for walkers to engage in several different types of conversations over the course of a walk, ranging from private one-to-one discussions, larger discussions with more people, or, indeed, walking without talking and having inner conversations with oneself. In this way, although groups formed and fractured, formality was removed through the act of walking. For example, participants observed that the absence of eye contact meant that talk flowed more naturally than the sometimes staccato turn-taking that tended to dominate support given and received around (or over) a table in traditional (often clinical) support group settings.

I would also say on a walk you're not making eye contact with people ... because you're walking side-by-side ... so what you're saying is almost going into the air, rather than specifically at somebody, and ... I think that's quite good because you can say things that you might not want to say if you were looking at somebody and engaged with them like that, you might not want to sort of say something that's a bit personal to you, but if you're walking along and there's just somebody who's a pair of ears at the side of you that you're not making eye contact with, you might say, "Oh well," you know, if you're unhappy about something, you know, because you're not saying it to their face, and I think that, I think that's quite ... quite good with the walking. (Walk Leader 6, Walking Interview)



One of the things I like about walking in a group is that you can move around a lot, so you're not sat in a seat trying to talk to everybody, people just naturally change pairings and change the conversations. (Walk Leader 11, Walking Interviews)

When you're walking and this might sound funny, you can be talking to somebody but then you can walk into somebody else's conversation and say, 'Oh yes, I know exactly what you mean'. (Walker 1, Telephone Interview)

Indeed, Walk Leaders spoke of how walking with others who have had a shared experience of breast cancer diagnosis and treatment provided a space where conversations did not need to take place because that shared understanding could be left unspoken.

The conversations just flow and you move in and out of them, and so you think, oh right, I'll talk to you now, and you can just walk a bit faster and go and talk to somebody else, or ... or you can walk off on your own for a while and be quiet for a while, or, and I think, I think there's something about walking in a group that gives you permission to just be, yeah, to be what you want to be, to be quiet, to be talkative, to talk about important things, to talk about light things, you know you can just have more choice than when you're sitting inside or in a room, or some cold interview or, support group or whatever it might be, yeah, so I do think it's more natural. (Walk Leader 1, Walking Interview)

Because they know they're coming to a Breast Cancer Care walk it doesn't matter, they don't have to explain it because everybody knows. (Walk Leader 6, Telephone Interviews)

Second, just as walking shifted the form of conversation that occurred, participants felt that walking and talking, together, shaped the content of conversation, thereby enhancing the social and emotional support they enabled. Conversation while walking frequently roamed freely from everyday chat to deeper cancer-related discussion.

It is so positive ... you're talking about your dog or your child, or something, and then something might come up about ... a conversation about an experience you've had about breast cancer, you know, or whatever ... or just how you're feeling, or afterwards, which is good, or just something comes in to the conversation, you know, when you're not even talking about cancer, cancer just comes in ... so I think that's really good, because you know that, because everybody's had it you're not worried about upsetting them or making them feel uncomfortable. (Walker 3, Telephone Interview)

Walk Leaders, too, shared how they felt able to have difficult conversations while walking without making Walkers feel uncomfortable and that talking while walking allowed them to be better listeners. All of the Walk Leaders spoke of the importance of providing social support through talking, both on the walks and afterwards in the café. Yet, there was a clear connection between the conversations that took place in these two spaces. Supportive conversations were described as being nurtured during the walks, but often continued on into the gathering of the whole group in the café afterwards. This “continuance” (Walk Leader 4, Walking Interview) was described as being important to the Walkers, both physically and psychologically. All of the Walkers and Walk Leaders described how everyone who had participated in the walks joined the group in the café afterwards. Indeed, one Walk Leader described the gathering in the café afterwards as a “reward” for having managed to attend the walk and to complete it (Walk Leader 4, Walking Interview).

Third, although continuance of conversation between the walk and café was considered important, equally vital was the transition from outdoor to indoor spaces. Crossing this threshold precipitated a shift in atmosphere that altered the affective and supportive quality of the conversations that ensued. For some, it was how the “physical effects” of walking, such as increased temperature and heart rate, released emotional energy that resulted in more open and, deeper, cancer-related conversation.

It’s the physical effects of the walking, that people are more open to talk and share perhaps at a different level ... more happens around tea and the buzz is totally different.

(Walk Leader 7, Walking Interview)

Others reflected at length on the way in which walking outdoors then moving indoors heightened awareness of the physical side- and late-effects of cancer treatment, sparking conversations around shared experience that had not been discussed while walking.

At the end of a walk when we have a cup of tea ... the ladies are talking about all manner of things, and often, just because with a change of atmosphere and temperature ... just because we’ve gone from a cold environment into a warm one, we get ladies stripping off because they’re having a hot sweat ... so that makes us discuss physical conditions ... And it’s really, really reassuring for the ladies to find the others are having the same experience ... and saying, “Oh, isn’t it annoying,” you know, “You have to get up in the middle of the night and change my nightwear,” or “Oh, it’s horrible at ... such a stage,” and “Do you find this ...” and “Do you find that...” and the conversation takes a departure that probably hasn’t been discussed during the walk.” (Walk Leader 4, Walking Interview)

Participants' reflections on the perceived benefit of walking and talking, together, thus revealed a form of 'shoulder-to-shoulder support' that was thought unlikely to emerge in sedentary supportive settings.

Walking does sort of open up the conversation, but it's more than just the walking somehow, it's the combination of walking – knowing that you're walking with a group of people with a shared experience – would that happen if we just went to a café? Perhaps not. (Walk Leader 7, Walking Interview)

It's more about the chatting afterwards, the talking to people, finding out different things somebody might say oh I had this, this and this last week and I was so worried and you'll say yes so did I and it just helps that you know you are not the only person suffering this particular thing. (Walker 5, Walking interview)

### **Walking and talking, together, through therapeutic landscapes**

Transition from outside to inside was only one way that an emergent geography of recovery was revealed through the women's accounts. Walking interviews pointed to three inter-related dialectical facets of the *outdoor* landscape that walkers felt imbued it with therapeutic qualities: landscape as un/natural, dis/placed and im/mobile. Women's shared sojourn through the landscape led to the frequent undulation of its aesthetic and affective qualities, being felt to varying degrees at different moments. In this way, place, walk and talk combined to create a therapeutic assemblage that enhanced – or, indeed, made possible – 'shoulder-to-shoulder support'. Each facet is considered in turn below.

First, landscape was *un/natural*, revealing a tension between nature and unnatural states of health. As noted, all of the walks started in an urban location, at a place that was on a

frequent bus route and could also provide free parking (see Table 1). As a result, each of the starting-off points were in busy spaces with lots of traffic, pedestrians, and other urban noises, such as power tools, construction noise and helicopters. However, each walk traversed the urban space, then left it behind for a more green space, one that included ancient woodland or at least parts of it, overgrown abandoned railway lines, a traditional mill and surrounding farmland that had been converted into a country park, and fields of cows surrounding a fishing hole, themselves surrounded by ancient trees. Even the Victorian park, which at first seemed very manicured and well ordered, concealed a deep gully with unpaved paths through rough and rocky woodland that, once surrounded by it, removed all sense of being situated within an urban space. Each of the walks had this element to it: starting in an urban space, moving through the wilderness, with the sounds and sensations of the urban retreating into the distance and the sights disappearing altogether or reappearing occasionally – a church spire, a dome – and finishing by emerging back in the urban space. In women’s accounts, this movement from the urban to rural – unnatural to natural landscape – with all its attendant sensations, was conducive to feelings of calmness, healing, and freedom.

I do think that being in nature has a calming and healing effect of its own, yeah, I think it’s good for your eyes to look at green, I think it’s good to see animals and birds and flowers, and all that, I certainly feel that for myself ... I think there is something about nature and being in nature that is particularly therapeutic.” (Walk Leader 1, Walking Interview)

It gives you a kind of feeling of freedom, disconnected from work life, or family life, or the telephone, or email, driving, motorways – everything that comes in to your daily life – and it just gives me time to reflect on ... how, how calming an experience it is. (Walk Leader 4, Walking Interview)

Yes it's made me feel better in myself in getting out. While you are in you are thinking about things more, you think more deeply into things. (Walker 4, Walking Interview)

Yet, more than this, entering 'wilderness' refocussed women on their sense of future.

Alongside movement through space came increased awareness of the passage of time, adding fearful poignancy to the realisation that cancer had forcefully disrupted the perceived natural course of life (Hubbard & Forbat, 2012). In this way, natural landscapes triggered reflection on a sense of an unnatural lifecourse.

I think it helps, I think it helps because ... the almost wilderness feeling that I get here – although I know it's very close, I can hear the motorway traffic and I know we're only ten minutes' walk from a café and the pub and the gift shop and the flour mill – I still feel a sense of being out in the wild and I think that's particularly poignant to people who've had a bad illness and had a life-threatening illness, and you suddenly realise that all those things may be taken from you, you worry about silly things like whether you are going to go on another country walk or whether you're going to actually see your grandchildren grow up, whether you're actually going to make the next Christmas. (Walk Leader 4, Walking Interview)

Second, landscape was *dis/placed*, revealing a tension between the prominence and absence of place. Each walk was situated within an area that was once an industrial space – canal towpaths, a traditional water mill, and a Victorian park that was once a simulated ruin but which now had become part of the overgrown landscape. These are places that were once built up and devoid of green space, but which had now been replaced or displaced by nature, reclaimed by tangled wilderness. Walking through such landscapes was imbued with memory – the lost rural or industrial heritage – triggered processes of remembrance and

forgetting among women. Imagining lost or forgotten rural or industrial landscapes had the potential to enable women to forget the experience of living with cancer, if only fleetingly.

Somebody suddenly shouted, “God there’s sheep over there, sheep in [the city]!”

“What?”, and there were, there was a field of sheep ... well I think walking in a, I don’t mind where I walk, I can appreciate industrial architecture, you know, but I think possibly this is more pleasant than walking round [the] inner city; if you’re walking round [the] inner city you need to be, you know, you need to be knowing what the buildings are and knowing the history of it and all that sort of thing, whereas here you can just walk and it be green and pleasant, you know. (Walk Leader 6, Walking Interview)

But there’s so much to take in, and yes, I do think the place, eh, contributes tremendously because I think it gives you that peaceful calming feeling which you can’t really get in the urban park because, you can always see too much, too much domesticity and, civilisation and you know you’re on the verge of everything, whereas here you can imagine, you know you’re in the middle of some almost forgotten landscape [laughs] which I find quite, helpful, on Wednesday afternoons. (Walk Leader 4, Walking Interview)

This process of forgetting cancer was also enabled through the temporary loss of the landscape itself. Walking enabled individuals to melt into a curious tension with the landscape that enabled them to overlook cancer and recover aspects of life often overlooked. Hence, place moved between being powerfully present (placed) or absent (displaced) during walks and it was this process of moving between these two states that gave rise to its therapeutic qualities.

I think that, really that, this sort of path that, you know this one that we found last time, that's what has become quite exciting about this, it really takes you into a whole different feel, the park becomes something else. (Walk Leader 7, Walking Interview)

Here it's just a little bit more remote than the urban setting, and you can just enter a little world of your own, even if you're speaking to other people you can still be having your own thoughts and just taking in all the therapeutic qualities of the walk, whether it be the fresh air, or the cool frost, or the sun, sunny vista or the sounds of the water lapping or the birds singing, and the smells of the garlic or the fragrance of whatever is currently in bloom; I think it does make a big, big difference, because it gives you a little bit of a sense of detachment, but a pleasure to be experiencing it, because... because the very... the very simple pleasures in life are the ones you overlook. (Walk Leader 4, Walking Interview)

Third, landscape was *im/mobile*, revealing a tension between the pace and place of recovery. Walking at a slower pace was associated with a slowing of the mind, introducing *calmness* (Walker 1, Walking Interview), stillness, and letting nature into the experience, which was believed to be conducive to healing.

What I experienced was that my mind speeded up when my legs speeded up, so I think there's something about, walking slowly in nature that slows you down and calms you down that makes you feel better. (Walk Leader 6, Walking Interview)

'Cause there would be a drop in the pace then, when the people would sort of really experience a sense of peacefulness ... It's just for ten minutes, or five minutes even ... I think that does let nature in more. (Walk Leader 7, Walking Interview)



Combined, these three facets of landscape – as un/natural, dis/placed, im/mobile – revealed through women’s accounts create the conditions necessary for the emergence of the unique form of shoulder-to-shoulder support. Shoulder-to-shoulder support is accomplished through a therapeutic assemblage of the practices of walking and talking and the experiencing and imagining of place. Walk, talk and place assemble to produce a geography of recovery, realising therapeutic benefits through a process of alignment between actors and agents. In this way, place becomes more than a setting for the delivery of a physical activity intervention but, rather, an active ingredient and potent catalyst in its realisation.

This is what they want the chatting, the walking, the fresh air, the lovely scenery. It’s better than any pill. (Walker 1, Walking Interview)

## **DISCUSSION**

Walking interventions have gained prominence as an approach to promote recovery and prevent recurrence after cancer. This is the first study to examine the therapeutic agency that the combination of walking, talking and place might have and how such conversations can promote therapeutic peer support in women affected by breast cancer. Importantly, the participants in our study considered both walking and talking – separately – as beneficial aspects of Best Foot Forward. Walking marked a new and natural starting point for re-engaging with physical activity and re-commencing life after breast cancer diagnosis. Talking with others with shared experience of breast cancer enabled the sharing of experience and a sense of fellowship that was frequently favoured over fitness. Yet, it was the *combination* of walking and talking that participants identified as the vital element of the intervention. Walking and talking, together, enabled conversations to roam freely between topics and individuals as mobility meant that groups formed and fractured over the course of

a walk, enabling conversation to ‘move on’ and cancer to ‘come in’ to those discussions. Further, the format of walks, comprising walking *then* talking, was crucial to the perceived benefit. Physical activity prior to discussion in a sedentary setting was observed to release emotional energy and heighten awareness of the physical side-effects of cancer treatment, profoundly shifting the nature of the conversations that occurred in the café at the end of the walks. Hence, involvement in physical activity alone might not result in supportive conversations because these effects are not immediately experienced, but recalled some time later. Also, immediacy had the effect of normalising these feelings and aided development of supportive care strategies that might not be discussed in other forums. Walking interventions for people affected by cancer should therefore include both time spent walking outdoors and time afterwards gathering indoors to encourage the changes in the nature of supportive conversations that were found to result from the transition from outdoor to indoor spaces, and from mobile to sedentary activity.

Walking and talking, together, were perceived as being both mutually beneficial and co-constitutive, but also inseparable, creating supportive relationships that were greater than the sum of these constituent parts. Our findings support previous research around women’s experiences of peer support after cancer diagnosis that found that psychosocial support given and received by peers through action-oriented approaches was preferred by some women, challenging gender stereotypes (Emslie et al., 2007). However, our research goes further, revealing a form of ‘shoulder-to-shoulder support’ that Walkers and Walk Leaders believed would not emerge in sedentary (clinical) settings. In this sense, our study alerts us to the therapeutic potential at the heart of the ‘mobile-social arrangement’ (Lorimer, 2013) of walking side-by-side. Seldom given second thought due to its pedestrian nature, Lorimer (2013, p. 29) describes the embodied experience of walking in twos:

For the most part eyes are cast downwards and forwards [...] and simultaneously, if momentarily, faces turn inwards allowing brief moments of eye contact or to observe facial expressions or physical gestures. But, for the greatest part, talk happens outwards, to the world. (p. 29)

For the women in our study it was talking outwards to the world that enabled the supportive conversations that promoted recovery. However, it is only by paying greater attention to the potency of place as an active agent in the realisation of walking groups that, we suggest, such shoulder-to-shoulder support is made possible. The therapeutic benefits of combining walking, jogging, or running with counselling have been well documented in providing psychosocial treatment for other conditions, such as mental health conditions (Dixon et al., 2003; Dubbert, 2002; Hays, 1994; McKinney, 2011; Norman & Mills, 2004; Sykes, 2009) and behaviourally challenged adolescents (Doucette, 2004). Moreover, combining ‘walk and talk’ therapy (Doucette, 2004) with the outdoors, particularly in rural settings, has also been shown to be more effective in such psychosocial interventions (Berger & Mcleod, 2006; Berman et al., 2008; Fletcher & Hinkle, 2002; Mayer et al., 2009; Orchin, 2004). Our study points to the therapeutic ‘mechanics’ through which the environment becomes an effective element of such interventions. Nature, like cancer, came into women’s conversation, moving it on, or momentarily pausing its flow. With its frequent interruption, it carried a sense of perspective or peace for an albeit disrupted and distorted future (English et al, 2008). The world talked back. In doing so, rather than merely traversing landscape, women’s walking and talking, together, is located at the nexus of the socio-material and affective, becoming part of an always emergent geography of recovery. Considering these interventions in this socio-material way will allow people affected by long-term illness to “attune differently” (Mol, 2010, p. 255) to their lived realities and thereby open up possibilities for them to

benefit from the therapeutic qualities of the landscapes through which they are walking. Thus, in developing walking group interventions for people with cancer, as well as other illnesses, particular attention should be paid to the specific walking routes followed to enable individuals to encounter the diverse therapeutic benefits that accrue through this complex assemblage of walk, talk and place.

Finally, throughout our study, walking was often used as a metaphor for moving on in the cancer journey, and taking part in walks was described as an important way to start the transition from being a patient to becoming a 'person' again. In previous research, the embodied metaphor of the cancer journey has been found to be a positive force in allowing women to cope with their cancer experience (Gibbs & Franks, 2002), and the cancer journey itself can be seen as a diversion from the life journey (Reisfield & Wilson, 2004). Walking was perceived as the best way to begin to return to the larger life journey and it also represented the physical act of beginning that journey. However, walking was also described as a good starting point for talking about experiences of diagnosis and treatment, particularly for new walkers, and these conversations were described as a way to initiate them into the group and make them feel more comfortable on their journey. In this sense, involvement in Best Foot Forward represented a shift from a figurative to a physical cancer journey, often marked with real milestones, and from a solitary walk to travelling together through shared experience.

### **Study Limitations**

Our study has several limitations. The sample size poses an issue; however, our response rate was high; our research involved more than half of all Walk Leaders (52%) and Walkers (61%) enrolled in the programme during the study period. In addition, although the setting was based in an area with significant numbers of black, Asian and minority ethnic

communities, our sample comprised predominantly white participants. Indeed, white, British women make up the majority of the total number of women affected by breast cancer who do engage with this service. This raises issues related to how factors relating to class and culture might influence women's likelihood of engaging and should be examined in future studies. In addition, the issue of gender was not fully explored but warrants further investigation in this particular group. The analysis was conducted by only two members of the research team, however, one of the researchers conducted most of the interviews and the emerging themes were discussed amongst the whole research team and the interpretation of the data presented here was agreed. Another limitation is that the experiences of the Walkers and Walk Leaders were mostly positive. This might be because the sample mostly comprised individuals who had an interest in walking and walked regularly before diagnosis.

Despite these limitations, our study has several strengths. Choosing an experiential methodological approach that situated the researchers in the same physical landscape, participating in the same physical activity that we sought to study, allowed them to gain a deeper understanding of the participants' own experiences of that activity. Because the researchers participated in the same way as the other walkers, their influence on the walking groups was minimal. Moreover, because, as we found, the interviews took place while walking and talking, the research assemblage of experience, conversation and walking allowed a more natural discussion to take place and a greater depth of information to emerge than would have in a traditional interview setting. To our knowledge, this is the first study internationally to use walking interviews to gain insight into the therapeutic and supportive benefits of a walking group intervention for women living with and beyond breast cancer. This is also the first study to examine the therapeutic agency of walking, talking and place as an enabler of psychosocial peer support for cancer survivors. Our study has therefore

pioneered the use of walking interviews in psychosocial oncology, providing a platform for researchers to embrace ethnographic approaches that involve researchers engaging in the physical activity under study.

## **CONCLUSION**

Walking group interventions, such as Best Foot Forward, that combine a period of physical activity outdoors with discussion indoors, can be considered an effective means of encouraging peer-led supportive conversations that might not otherwise occur in sedentary (clinical) supportive care settings. To realise this ‘shoulder-to-shoulder support’, the design of walking group interventions for people living with and beyond cancer should include both time walking and talking outdoors – and, ideally, walking *then* talking – to bring the benefits that occur in the movement from physical to sedentary activity, and from outdoor to indoor settings. Such conversations could conceivably be foreclosed by favouring fitness over fellowship, contrary to the preferences of participants in this study. Place, however, came in, proving to be a potent ingredient catalysing this form of ‘shoulder-to-shoulder support’ and revealing an emergent geography of recovery. Hence, in closing, we call for ever-closer collaboration between health geography and psychosocial oncology to ensure that the concept of therapeutic assemblage of walk, talk and place described here can be mobilised both in further research and to inform the design and delivery of walking group interventions for individuals living with and beyond cancer.

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**Table 1:** Description of walks and locations

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Walk 1: Country park and mill	<p>Walkers meet in the car park of a country park that is situated on a busy main road. The walk starts from the car park, moving away from the urban area, and follows a path through the woods to the edge of a large water reservoir of approximately 1 km<sup>2</sup>. The walkers follow the path on the edge of the reservoir for 1 km and then walk through woodland paths that are bordered by fields and marshland for approximately 2.5 km. The landscape is flat but is surrounded by trees and the view is mainly fields and woodland, and the water of the reservoir. For most of the walk, urban buildings are not visible, apart from the occasional tower or church spire. Despite being surrounded by built-up areas, the walk feels remote. The path eventually arrives at the opposite edge of the reservoir and the walkers follow the path along the side of the reservoir for a further 1.8 km, past a weir and then over a footbridge. There are ducks in the water and the area is full of songbirds. The walk ends at a working mill and the walkers walk through the building housing the mill. The mill is next to a café and is located in a group of buildings surrounded by trees and approximately 0.5 km away from the car park. The walkers have coffee and tea in the café and walk back to the car park together.</p>
Walk 2: Victorian park and gardens	<p>The walkers meet at the entrance of a Victorian park and gardens which is situated on a busy residential road. The park is set on the edge of a wooded escarpment. At the top of the escarpment, there are formal gardens and paved paths surrounded by mature trees with a view of the valley below and urban and industrial areas beyond. Stepped paved paths lead gently down the escarpment to an area of mature woodland. The walk begins at the entrance to the park and follows the main paved paths for approximately 700 m to the top edge of the escarpment. The walkers then move down the hill and follow the paths to a Victorian folly built to resemble the ruin of a castle ramparts. The paths are paved with steps and handrails. The walk then moves off the main path onto an unpaved path through the woods and up a smaller outcrop at the bottom of the hill that forms a steep ridge, surrounded by the rock face of the escarpment and covered with trees. The trees provide sufficient cover so that there is no urban landscape in view. After walking approximately 1.5 km along the bottom of the escarpment, the walkers join the main path again at the other end of the park, which moves back up the hill to the top of the escarpment. The walk continues another 1 km along the formal gardens and finishes back at the entrance to the park. The walkers then have coffee and tea in the café at the visitors' centre and leave together afterwards.</p>
Walk 3: Canal and woodlands	<p>The walkers meet in the car park of a pub situated on a main road and backing onto an industrial canal. The walk starts on the towpath of the canal and follows the canal for approximately 1 km. There is a mixture of new-build houses and old industrial buildings along the towpath. The walkers cross the canal by taking steps up to the main road and crossing a bridge, and then walk approximately 1 km along the busy road. They turn into a field and walk along a farm track bordered by trees on one side with new houses being built behind them. This transition from urban road to countryside is sudden but provides a profound contrast in the landscape. There is a herd of cattle in the field and there is also a small circular fishing pond surrounded by a high hedge, and a brook runs through the field. They walk along the field for 1 km into woodland that has gravel walking paths. The walkers follow the paths for 0.5 km and then turn onto a disused rail line bordered by thick woods and walk along for 0.5 km. They then turn onto a golf course and walk across it on a footpath, and then along the far edge of the golf course along a rough path through trees that are bordered by houses for approximately 2 km. At the end of the path, they walked through a residential area until meeting the main road. They walk along the busy road for another 0.5 km until crossing the canal again and taking steps down to the same towpath but at the opposite end. The walkers then followed the towpath for 3 km until reaching the pub where they started. The walkers go into the pub for a drink and leave together afterwards.</p>

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**Table 2: Walk Leader and Walker Socio-demographic Characteristics**

Variable	Walk Leaders		Walkers			
	Respondents (n=13)		Surveyed (n=57)		Respondents (n=35)	
	%	n	%	n	%	n
<b>Gender</b>						
Women	92.3	12	100	57	100	35
Men	7.7	1	0	0	0	0
<b>Age</b>						
31-40	-	-	7.0	4	2.9	1
41-50	7.7	1	12.3	7	8.6	3
51-60	76.9	10	24.6	14	37.1	13
61-70	15.4	2	21.1	12	17.1	6
71-80	-	-	8.8	5	22.9	8
81-90	-	-	1.8	1	0	0
Missing	-	-	24.6	14	11.4	4
<b>Ethnicity</b>						
White British	84.6	11	71.9	41	91.4	32
Other White	15.4	2	1.8	1	5.7	2
Mixed	-	-	0	0	2.9	1
Missing	-	-	26.3	15	0	0
<b>Employment Status<sup>†</sup></b>						
Employed full-time	7.7	1	-	-	-	-
Employed part-time	23.1	3	-	-	-	-
Self-employed	7.7	1	-	-	-	-
Retired	46.2	6	-	-	-	-
Disabled or too ill to work	15.4	2	-	-	-	-
<b>Cancer Diagnosis</b>						
No	23.1	3	0	0	0	0
Yes	76.9	10	100	57	100	35
Primary*	-	-	71.9	41	91.4	32
Secondary*	-	-	1.8	1	8.6	3
Missing	-	-	26.3	15	0	0
<b>Time since diagnosis</b> (months at survey date)						
Mean [Standard Deviation (SD)]	99.6	[73.3]	47.5	[46.1]	38.5	[48.9]
<6 months	-	-	0	0	8.6	3
6-12 months	-	-	1.8	1	14.3	5
13-18 months	10.0	1	5.3	3	5.7	2
> 18 months	90.0	9	68.4	39	40.0	14
Missing	-	-	24.6	14	31.4	11
<b>Current Cancer Treatment<sup>†</sup></b>						
Yes	15.4	2	-	-	-	-
No	61.5	8	-	-	-	-
Missing	23.1	3	-	-	-	-
<b>Walk Locations</b>						
Manchester	53.8	7	49.1	28	37.1	13
Calderdale	38.5	5	28.1	16	28.6	10
Barnsley	7.7	1	22.8	13	34.3	12
<b>Time since first walk*</b> (months at survey date)						
Mean [SD]	-	-	12.5	[4.5]	9.3	[6.9]
<6 months	-	-	0	0	34.3	12
6-12 months	-	-	64.9	37	34.3	12
13-18 months	-	-	12.3	7	20.0	7
> 18 months	-	-	22.8	13	2.9	1
Missing	-	-	0	0	8.6	3
<b>Best Foot Forward is first-time ever volunteered with BCC<sup>†</sup></b>						
Yes	84.6	11	-	-	-	-
No	15.4	2	-	-	-	-

Notes: <sup>†</sup> Data not collected for Walkers. \* Data not collected for Walk Leaders.