Exploring How Psychologists in Aotearoa New Zealand Perceive Adventure Therapy: A Qualitative Study

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Abstract

Adventure Therapy (AT) is gaining prominence in Aotearoa New Zealand (NZ) as a mental health intervention practice that can address a wide range of client presentations. Against a backdrop of pressing mental health needs, it offers to be an effective tool to improve client outcomes. AT combines adventurous group activities in the outdoors, with a therapeutic intent. As an approach, AT has its roots in the early twentieth century with Outward Bound, Scouting and tent therapy. While the research base has provided evidence of AT's effectiveness, it is considered limited due to the absence of randomised controlled trials and the diversity of programmes. Practitioner perception research into AT is growing and is important for ongoing practice development. However, despite psychologists being an important part of mental healthcare delivery, they have not featured in previous literature. This study seeks to fill this gap by answering the question: How do psychologists in Aotearoa NZ perceive the practice of AT? It seeks to identify key perceptions, to explore the utility, effectiveness, and uncover barriers with psychologists using AT.

Using a qualitative research design drawn from a critical realist perspective and applying reflexive thematic analysis, data was gathered from psychologists across Aotearoa NZ who had experience in using AT in their practice.

Findings showed that AT is seen to be a milieu of therapeutic elements that embraces physical and psychological risk. Notably, it was observed that for AT to have a lasting impact, focus was required on pre/post transitions and follow up. Needs for additional skill development were outlined with collaboration from outdoor instructors a preferred model to acquire outdoor skillsets. Its unique characteristics provide tension in delivering AT to efficiency standards inherent in traditional talk therapy and, although AT provides successful outcomes, it is relatively unknown in psychological circles.

The insights from this research contribute to the ongoing refinement and expansion of AT as a valuable mental health intervention.

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Table of Contents

Chapter 1: Introduction

Background

Adventure Therapy (AT) is a therapeutic approach that combines adventurous activity in nature with group work, to address mental health needs (Alvarez et al., 2020; Stich & Senior, 1984). AT is adaptable and can cater for a wide range of presentations (Crisp, 1998). The approach has its origins with Outward Bound, Camp America, the Scout movement and tent therapy in the early twentieth century (Gass et al., 2020). Today it has grown to be practiced around the world encompassing many formats and philosophies (Priest, 2022). Yet, this heterogeneity has been limiting as AT has struggled to get acceptance in the mental health professions without a consistent research base (Mohan & White, 2022). While not yet achieving the status of empirically supported treatment, AT continues to grow internationally, as an evidence base of effectiveness gathers scale (Beck & Wong, 2022; Bettmann et al., 2016; Bowen, 2016).

The connection of physical activity and nature with psychological wellbeing was highlighted recently when global populations were restricted to their homes during the coronavirus pandemic (Jenkins et al., 2021). During that time, public health messaging in Aotearoa New Zealand (NZ) was focused on highlighting this connection. There was active messaging through well-being tips that highlighted the benefits of going for walks outside, and spending time in nature (The Mental Health Foundation of New Zealand, 2023). Against this background, nature prescriptions, where patients are prescribed periods of time in nature, are gaining popularity. These prescriptions have been found to have benefits for both anxiety and depression. Furthermore, the growing popularity of nature prescriptions appears related to holistic health approaches that supplement traditional, standard, biomedical approaches (Nguyen et al., 2023).

There is recognition that outdoor focused academic work is gaining more currency. Research on the effect of nature prescriptions, such as that carried out by Nguyen et al. (2023)

has produced popular press headlines like, “Take a walk not a pill - nature prescriptions on the rise” (TVNZ1 News, 2023; Lu, 2023). Nguyen et al. showed evidence through a meta-analysis and systematic review that nature prescriptions benefited cardiovascular and mental health. AT is one approach that combines outdoor activities and nature and is being increasingly researched and validated (Beck & Wong, 2022; Gillis, 2021; Kraft & Cornelius-White, 2020; Mohan et al., 2022).

There continues to be a pressing need for solutions to address the increase in mental health problems (Lake & Turner, 2017). Mental health statistics show pre coronavirus pandemic levels of 13% (970 million) of the world’s population living with a mental disorder. Coronavirus related increases of depression and anxiety levels drove these numbers up to 14% with over one billion people living with a mental disorder (World Health Organisation, 2022). In Aotearoa NZ, mental health issues are on the increase with 11.2% of adults (aged over 15) experiencing high or very high levels of psychological distress over 2021/2022. Additionally, 23.6% of young people (aged 15-24) were in the high or very high category of psychological distress (Ministry of Health, 2022).

AT is considered as an “emerging intervention” in Aotearoa NZ (Jeffery, 2020, p. 109). When set against the landscape of increasing mental distress and a growing knowledge of holistic connections between wellbeing, nature and activity, AT appears poised for growth. Recent research involving practitioners of AT, identified “who belongs in the AT community” (Jeffery & Hensey, 2022, p. 16). Participants’ qualifications in this research included counselling, psychotherapy, social work, occupational therapy, teaching, outdoor education and nursing. Psychologists were not represented though the reason(s) for this is unknown.

Nevertheless, there is still a need to hear the perspectives from psychologists, as important contributors to the delivery of mental health services. The absence of psychologists from AT research may impact on its validity. Psychologists can, “deliver evidence-informed and theoretically nuanced therapy that takes into account both the relevant psychotherapy outcome

literature and factors relevant to the personal and situational factors of the client, as identified in the formulation" (Stewart et al., 2014, p. 12). Psychologists' perspectives in research would serve to strengthen AT approaches within Aotearoa NZ.

Rationale for this Research

Much of the existing research has been focused on establishing an evidence base through quantitative or qualitative studies involving programme participants (Conlon et al., 2018; DeMille et al., 2018; Kraft & Cornelius-White, 2020; Vankanegan et al., 2019). In addition, there is a growing research base that looks at therapists and clinician's perceptions and use of AT. Notably, this work excludes psychologists or, where psychologists have been part of a study, their responses have been indistinguishable from other mental health clinicians (Jeffery & Hensey, 2022; Tambyah et al., 2022).

The need for research into current models of AT practice in the South Pacific region has been identified by Carpenter & Pryor (2004). They reviewed the discussions of AT practitioners at the South Pacific Regional gathering in 2002 and made recommendations for future pathways. These calls for further practice research have been supported by Horn (2021) in her study of counsellor, psychotherapist and social worker perspectives of nature-based therapy. Jeffery and Hensey (2022) made similar recommendations for research in their study of the AT community and practice in Aotearoa NZ. In addition, Jeffery and Wilson (2018) made recommendations for Aotearoa NZ, discipline specific research, focused on perceptions and practice in AT. Jeffery and Wilson's proposals for further research came from their investigation into the use of AT by occupational therapists. These research requests are underscored by worsening mental health statistics and growth implications for AT. However, they reveal a deficiency in the research where AT perspectives from psychologists in Aotearoa NZ are missing.

Research Question

Mental health concerns amongst the community remains a priority in Aotearoa NZ (Ramalho et al., 2022). The role of psychologists in mental health is critical to improving the health and wellbeing of the community. With ongoing calls for more innovative and creative solutions to respond to mental health concerns, existing research has shown the usefulness of AT (Bowen & Neill, 2013; Lake & Turner, 2017). This current research proposes to explore psychologists' views of AT, and whether there may be opportunity for its increased use within psychology in Aotearoa NZ. Therefore, this research attempts to explore the question:

How do psychologists in Aotearoa NZ perceive the practice of Adventure Therapy (AT)?

In doing so, the objectives are that this research: (a) identifies the perceived utility, effectiveness and barriers with psychologists using AT practice; (b) highlights AT as a potentially valid treatment strategy for mental healthcare; and (c) grows the knowledge base of AT in Aotearoa NZ.

The significance of this study is in exploring an area of AT research that is currently lacking (Jeffery & Hensey, 2022). Through understanding psychologists' perspectives of AT practice this study highlights new implications for policy and practice or reinforces existing research.

Thesis Organisation

The organisation of this thesis report follows that proposed by Hammond (2022) as a standard format and consists of six chapters. The background and rationale for the research has been described earlier in this Chapter One: Introduction.

Chapter Two: Literature Review consists of a review of the research on AT covering seminal works and academic journals, books and other academic works. The review is organised around areas of definition, history, theory, effectiveness and practitioner perception research. Together these concepts give a comprehensive background and context to the research question.

In Chapter Three: Method, the design for this qualitative research and its rationale for selection are covered. This includes the method of semi structured interviews, the methodology of reflective thematic analysis and the ontological and epistemological basis of critical realism. The processes of participant definition, sampling and recruitment, data collection, and details of the subsequent analysis are outlined. Additionally, sections are presented on ethical issues and the quality processes that were employed to ensure the integrity and value of the study.

Chapter Four: Results outlines the outputs from the data collection and analysis processes. Four themes and seven subthemes are described with supporting extracts from the data providing context.

Chapter Five: Discussion makes sense of the information that has been collected and covers the details of the analytic process supporting the four themes and seven subthemes. Here the results are interpreted and related to the research question. A comparison is made to the literature and theoretical knowledge base, and implications from this research are explored.

Chapter Six: Conclusion includes a summary of the main findings and recommendations from this research project. Strengths and limitations of the study are explored with an agenda for further research proposed. The chapter closes with a final reflection.

Chapter Summary

AT involves adventurous activity, nature and group work to achieve mental health outcomes. Against a backdrop of mental health deterioration and impacts of coronavirus disease, growing recognition of the benefits of physical activity in nature offers AT robust growth prospects. In Aotearoa NZ, psychologists have been absent from inclusion into participant pools for research into AT practice. Calls for discipline specific research in AT spur a need to investigate perceptions of AT from psychologists in Aotearoa NZ. In answering this need, this study aims to: understand the perceived utility, effectiveness and barriers with psychologists using AT practice; highlight AT as a potentially valid treatment strategy for mental healthcare; and grow the knowledge base of AT in Aotearoa NZ.

Chapter 2: Literature Review

Chapter Introduction

This chapter reviews the relevant literature to the research question:

How do psychologists in Aotearoa NZ perceive the practice of Adventure Therapy (AT)?

It first explores the definitions, history and theoretical foundations of AT. It then reviews the literature on the effectiveness of AT within an international and domestic context. The review of literature shows how this study contributes to the body of knowledge regarding AT in Aotearoa NZ.

There is a large volume of research regarding AT. Therefore, the focus has been towards reviewing more recent research with earlier pioneering studies included where appropriate. Databases that were reviewed for information include, Business Source Complete, ERIC, Google Scholar, Health Databases on EBSCOhost, Mental Measurements Yearbook, NZ Research, Web of Science, PsycINFO, PubMed, and Scopus.

Definitions of AT

Historically, the definition of AT has been a point of discussion, and remains confusing (Itin, 1998). AT is an umbrella term, encompassing a wide range of outdoor interventions (Crisp, 1998). For example, it can be a specific treatment, a milieu, a therapeutic partner with adjunct therapies, or a strategy that a community of practice engages through their own expertise (Crisp, 1998; Gass et al., 2020; Jeffery & Hensey, 2022; Pan & Zhuang, 2022; Russell & Farnum, 2004). AT encompasses different therapeutic forms including therapeutic adventure, adventure-based counselling, adventure-based therapy, community based adventure therapy, bush adventure therapy, therapeutic adventure, outdoor recreation therapy, surf therapy, wilderness therapy, wilderness adventure therapy, wilderness challenge programmes, wilderness experience programmes and outdoor behavioural healthcare (Crisp,1998; Dobud, 2019; Gass et al., 2020; Gomes et al., 2020; Harper et al., 2019; Pretorius, 2020).

The drive for a specific definition originates in the United States, a major contributor to AT research. The nature of the legal system and funding for therapy driven by private insurance companies, requires that therapies be defined exactly (Gass et al., 2020). The definition that is standing the test of time in the United States is: “the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinaesthetically engage clients on cognitive, affective, and behavioural levels,” (Gass et al., 2020, p. 1). Yet, because AT subscribes to such general principles as adventure, activity, fun, relationships and nature, then it may be impossible to identify an all-encompassing statement of meaning.

The various aspects of AT definition have been advantageous to the Aotearoa NZ community in that it has allowed a more contextual meaning to be developed. Jeffery and Hensey (2022), noted that AT sits on a continuum with client population, intent of programme and practitioner qualifications as variables. Jeffery and Hensey’s continuum is useful in that it specifies a range of practice. AT becomes a strategy that can be employed across a band of therapeutic approaches. This therapeutic band includes personal development through to therapy but excludes education and recreation.

For the purposes of this research, AT is defined as a “diverse field of practice combining adventure and outdoor environments with the intention to achieve therapeutic outcomes for those involved” (Australian Association for Bush Adventure Therapy Inc., 2023, para. 1). This definition was adopted by Horn (2021) for her Aotearoa NZ research. Horn also defined a therapeutic process as, “any structured engagement that is intended to improve mental health outcomes” (p. 7).

History

International Origins

It could be said that AT has its origins in biblical times when in the Book of Genesis, Abraham’s mistress and son were banished into the wilderness (New International Version Bible, 2011, Genesis 21:14). On the other hand, it may have originated from the ceremonies

that indigenous peoples traditionally used to mark the passage from child to adult by spending time alone in the wilderness (White, 2011). Plato, the ancient Greek philosopher, also upheld the value of outdoor experiences for both the body and the soul (Hattie et al., 1997). In a more modern sense, the early nineteenth century United States Summer Camps that were instituted as a means of character formation for wealthy and idle youth are indicated as some first examples of AT (White, 2011).

Other originators of AT often referred to are, Robert Baden-Powell, who began the Scouting movement in England in the early 1900s. Baden-Powell noted that youths were underperforming in the military because of poor outdoor skills and a disrespect for authority. (Gass et al., 2020). Educator Kurt Hahn began Outward Bound (OB) to reduce the loss of lives in young seamen from wartime sinkings of their vessels. The month-long course focused on resourcefulness, fitness and self-reliance. Hahn is often held up as the originator of modern adventure educational approaches (Hattie et al., 1997; Schoel et al., 1989).

In contrast to personal development roots, another proposed origin of AT has been tent therapy. Medical director A.E MacDonald moved his isolation units outside a hospital into tents in 1901, when he feared the spread of a tuberculosis outbreak. (Caplan, 1967). The physical and mental improvement of patients was so surprising that tent treatment became a minor fad. The treatment's success was initially attributed to fresh air, sunlight and diversity of events. Subsequently its use waned as costs rose and the adventure and group cohesion disappeared.

The popularity of OB and scouting type residential camps grew through the 20th Century, particularly in the United States. Adventure as a specific therapeutic tool was first used by Project Adventure in 1974. The framework used a psychologist, a social worker and an outdoor instructor who conducted a weekly two-hour adventure-based counselling outpatient group (Schoel et al., 1989). Wilderness therapy became the standardised terminology through this period. The first use of AT as a term was by Stich and Senior (1984) in their review of an OB therapeutic program. They found that four elements were required for effective experiential

influenced therapy with a motivated client. Firstly, a client needs-assessment; secondly a qualified and skilled therapist; thirdly, a wider comprehensive programme and lastly, the therapeutic relationship.

Wilderness Programs saw major growth in popularity during the 1980s through to the early 2000s. Accompanying this growth was a proliferation of poor practice including, intimidation, bullying, deprivation, violence and in some cases death (White, 2011). It took an influential article in Outside Magazine in 1995 titled, “Loving them to Death,” to expose the poor practices (Krakauer, 1995). The article helped to make the term “troubled teens” a name for an industry in the United States, which appeared focused on profit over humanity. A government investigation in 2007 found thousands of allegations of abuse and multiple fatalities (Government Accountability Office, 2007). These findings prompted calls for federal control, state licensing and a stop to the abuse (White, 2011).

In response, sector organisations refocused to support best practice and ethical approaches. The Therapeutic Adventure Professional Group (TAPG) was originally formed in 1980. By 2013, TAPG had in place a voluntary accreditation process that through to 2019 had 14 programs registered. In tandem the Outdoor Behavioural Healthcare Council (OBHC) was founded in 1996 as a collaboration of five wilderness programs. The OBHC had a focus on creating research to support the practice of AT. By 2019 this organisation had reached a membership of 22 programs and has been partially responsible for the growth in volume of AT research. The OBHC requires its members to reach accreditation with the TAPG framework (Gass et al., 2020). Notwithstanding the beneficial outcome research and best practice frameworks, ethical issues still exist with the application of AT in the United States (Magnuson et al., 2022). Ongoing practices such as involuntary transport and restraint, are problematic as they detract from AT’s ability to be considered as a supportive, valid, treatment approach.

Aotearoa NZ Origins

The forerunners of AT in Aotearoa NZ have existed in terms of learning, adventure and challenge from the original Polynesian migration in the fourteenth century through to European colonisation from the nineteenth century. Each of these groups had to overcome significant barriers to arrive in a country that was unknown but was rich in natural resources. (Cosgriff et al., 2012). Thus, the adventure tradition was born in Aotearoa NZ. Pursuits such as tramping, mountaineering and hunting were transplanted from England, serving as European masculine ideals. Adventure was propelled to a national identity zenith when in 1953, New Zealander, Hillary and Nepali Indian, Norgay, completed the first ascent of Mt. Everest. This event was highlighted around the world, as a celebrating feat for the coronation of Queen Elizabeth II (Boyes, 2012).

Outdoor education was introduced into Aotearoa NZ from the United Kingdom in the 1930s. It was known as school camping, a term that was predominantly used until the 1960s, when outdoor education became more common (Lynch, 2005). Although somewhat infused with physical education concepts, outdoor education emerged in the period through to the 1970s with permanent camp establishments. For example, Port Waikato Camp in 1956, the Tongariro Outdoor Pursuits Centre in 1972 and Boyle River Lodge in 1978. In tandem with the camps came progressive ideals, with objectives to bring the benefits of outdoor living and to teach self-reliance and a sense of community (Lynch, 2005).

During the 1980's and 1990's, a swing to more neo-liberal policies saw an increased focus on accountability in safety and risk. The new focus helped drive the professionalisation of the outdoor industry (Cosgriff et al., 2012). In 1987 this resulted in the inauguration of the NZ Outdoor Instructor's Association (NZOIA) and its framework of qualifications that subsequently, became the basis for outdoor instruction (Boyes, 2022). The focus has remained on safety, prompted by tragedies such as Cave Creek in 1995, Mangatepopo in 2008 and Paritutu in 2012 causing 25 deaths in total (Brookes, 2018). This continued focus on health and safety has

spurred further development in risk management, and qualifications (Cosgriff et al., 2012). Consequently, one of outdoor education's key contributions to AT has been a skill base of safety management and outdoor instruction.

A health sector forerunner of AT was demonstrated by Truby King at the end of the nineteenth century. He linked mental wellbeing with outdoor activity through his outdoor farming programme at the Seacliff Lunatic Asylum, Dunedin (Stock & Brickell, 2013). Predominantly though, AT in Aotearoa NZ appears to have emerged from international practice (Jeffery & Hensey, 2022). It has joined a continuum with personal development and positive youth development (PYD) platforms such as OB, the Spirit of NZ sail training and the Graham Dingle Foundation's Project K (Furness et al., 2017; Martin et al., 2020; Scarf et al., 2016). PYD has an emphasis on: "a) the strengths of young people; b) developmental plasticity; c) internal developmental assets (such as psychosocial competence) and external developmental assets (such as community influence)" (Shek et al., 2019, p. 132).

OB has been an important contributor to AT practice in Aotearoa NZ as it has been in an international context. The programme has used challenge and adventure to encourage people to step outside their comfort zone and uncover their future direction since 1962 (Outward Bound NZ, 2023). Although its origins lay in colonial and military traditions, OB in Aotearoa NZ has refined its values in line with developing cultural contexts despite the classic 21-day course not substantially changing since inception (Martin et al., 2020).

OB in Aotearoa NZ has made significant changes by adopting value sets more in line with responsibilities under Te Tiriti o Waitangi (the Treaty of Waitangi). A kaupapa has been developed that recognises kaitiakitanga (guardianship) and promotes close connections with local iwi (tribes). OB has developed a new course, that involves many principles of tikanga (customs) with te reo Māori, karakia, waiata and whakataukī (Māori language, prayers, songs and proverbs; Martin et al., 2020). OB integrates and has developed many aspects common

with AT such as experiential learning and wellbeing. These developments serve as examples of how aligning adventure related practice with Te Ao Māori worldviews can be achieved.

PYD has its origins in NZ with the YMCA starting in Auckland in 1855 and the Boys Brigade in 1889 (Harrington, 2023). Other youth development entities came into being during the latter 1900's. The Spirit of Adventure's youth sail training emerged in 1974 (Boyes, 2022) and the Graham Dingle Foundation's launch of their youth development and mentoring program Project K, took place in 1996 (Graeme Dingle Foundation, 2023). Both the Spirit of Adventure Trust and Project K continue to make strong contributions to PYD through an emphasis on, self-efficacy, skill building, group cooperation and self-development (Deane et al., 2017; Hunter et al., 2013).

In 1977, an early AT programme, Te Whakapakari Youth Programme (Whakapakari) was started on Great Barrier Island. As an initiative by the Māori Affairs government department to reduce youth criminal recidivism and break cycles of abuse, it ran under Māori principles of life. Using these principles, participants would work together to survive a one-month wilderness rehabilitation programme (Eggleston, 1998). Qualitative research by Eggleston (2000) showed that Whakapakari was successful in improving relationship skills and pro-social behaviour. However, participants struggled to transition learnings back to their home environments. The programme was later discredited through revelations of abuse exposed by journalist Matt Nippert (2015). It can now only stand as an example of the poorest of ethics.

Another early example of AT began in 1993 at Rolleston prison, Christchurch (Mossman, 1998). The programme spanned 3-weeks and consisted of fitness, skill development, challenge and a wilderness journey. Similarly to Whakapakari the programme had goals to reduce reoffending. Unlike Whakapakari, the programme was seen to contribute to objectives of humane containment. Despite the differences, both Whakapakari and Rolleston are significant. They stand as early Aotearoa NZ examples that exemplify a natural affinity of AT with clients exhibiting behavioural problems. Behavioural improvement has been explained by Mohan et al.

(2022) using specific elements. These elements are challenge that increases self-worth, group work that increases pro-social attitudes, and exposure to nature and safe environments that create therapeutic support.

The Aotearoa NZ government has used the concept of boot camps from time to time. Boot camps are often viewed as synonymous with AT programmes (Russell, 2006). While they may share some aspects, such as an unfamiliar environment, challenging activities and building successes they are in fact, quite different (Brookes, 2015). Military style boot camps are designed to break down the individual with aggressive practices and punishment. This process is followed by the rebuilding of compliant, more socially acceptable individuals. Russell has suggested that they are potentially cruel and ineffective environments. AT programmes in comparison have a therapeutic approach using a nurturing and empathetic relationship with qualified programme staff. AT involves modelling, practice, cooperation and communication to learn personal and social responsibility (Russell, 2006). Maxwell (2010) found some support for Aotearoa NZ style motivational boot camps with unemployed. Conversely, military style activity camps used for Aotearoa NZ young offenders, made little difference to reoffending rates (Andreson et al., 2013; Ministry of Social Development, 2013).

While there is no code of ethics that currently guide the practice of AT in Aotearoa NZ, Jeffery and Hensey (2022) have proposed that practitioners use AT from within their discipline boundaries. This works for disciplines that are regulated by the Health Practitioners Competency Assurance Act (2003) or the Social Workers Registration Act (2003) where health professionals operate to codes of ethics. But the regulations do not cover youth workers, or outdoor instructors and does not stop any person from calling their programme AT. This gap where any programme may use unlicensed professionals remains an ethical risk to the field.

Aotearoa NZ has maintained a core of AT practitioners. By 1997, interest in AT had grown to a point where an international conference could be held. This conference, held in Perth, Australia, featured presentations from Aotearoa NZ researchers as well as American and

Australian colleagues (Itin, 1998). International conferences have been ongoing since that time with regular Aotearoa NZ representation. While initially centred around the international sphere a revitalisation of the Adventure Therapy Aotearoa organisation in 2006 has led to a stronger, coordinated, community of practice (Jeffery & Hensey, 2022).

Theoretical Foundations in AT

The Outward Bound (OB) Model

Most researchers point to the OB model (Walsh & Gollins, 1976) as the starting point for AT theoretical models (Gass et al., 2020). Walsh and Gollins (1976) theorised that a motivated learner placed into a unique physical and group environment would move into a state of dissonance. Subsequently, the learner would adapt to the environment and experience mastery. The group would then be presented with a set of problem solving tasks which they would resolve collaboratively. Finally through reflection, the learner's experience and meaning were reorganised, fostering an ongoing orientation towards the 'outward bound' approach to living and learning.

Walsh and Gollins (1976) called on experiential learning to underpin this model drawing on the theory of experience by Dewey (1938). Dewey proposed that unlike learning with textbooks, the process of learning entailed setting a goal and using previous knowledge to create a plan designed to reach that goal. The implementation of that plan enabled more experiential learning and through reflection on outcomes, new knowledge could be created and retained for future use.

Furthering group experiential work, Lewin’s (1947) theory of change focused on a simple model. Unfreezing of current state complacency using emotional stirring would be followed by the change and re-freezing as the new norm was adopted. Lewin believed that this process was the best way to achieve change with group encounters (Burnes & Bargal, 2017). Experiential learning theory emerged from the principles of both Dewey and Lewin (Kolb, 1984). Kolb blended cognitive developmental thinking from Jean Piaget (2003) and proposed the process of

experiential learning as: a concrete experience followed by reflective observation and an abstract conceptualisation. New knowledge that resulted could then be applied in novel situations with active experimentation (Meyer & Seaman, 2021).

While not making specific reference to further theories, and in fact their model being referred to as atheoretical by some (Sibthorp, 2003), Walsh and Gollins (1976) referred to learner motivation and preparedness to change as antecedents to success. Gass et al. (2020), in their analysis of the OB model, linked these attributes to self-determination theory (SDT) and constructs of self-efficacy respectively. SDT as proposed by Deci and Ryan (2000) viewed motivation as the extent that people will strive to achieve desired goals. SDT conceptualised the desire to fill three psychological needs in the pursuit of those goals. Those needs were competence (mastery and effectiveness), relatedness (social connection with significant others) and autonomy (sense of control). SDT and the steps of the OB model are closely aligned.

Bandura (1977) theorised that self-efficacy was a key determinant in whether an individual would initiate, apply effort to and sustain action, when faced with challenges. He proposed that self-efficacy could be strengthened and defensive behaviour reduced by the achievement of activity and mastery. Bandura linked an individual's assessment process of self-efficacy to four sources of information: mastery experiences, vicarious learning, verbal (social) persuasion, and physiological or emotional states. Experiential learning, SDT theory and self-efficacy together remain important constructs supporting the therapeutic elements in current AT approaches (Mackenzie et al., 2018; Scarf et al., 2018)

The Wilderness Therapy Model

Critique of the OB model influenced the creation of the wilderness therapy model (Russell & Farnum, 2004). Russell and Farnum identified that firstly, the stage-based OB model did not reflect the reality of an AT process. They contended that participants did not step through the process in a logical and discontinuous fashion. Secondly, the OB model's approach indicated that attributes existing in one step were absent from the next. Thirdly, the OB model

ignored the cyclical nature of therapy where participants jumped forward, jumped backwards or revisited previous stages.

Russell and Farnum (2004) proposed a simpler concept. Using a concurrent framework they proposed three factors operating over the period of the AT milieu. The first was the wilderness factor, reflecting the natural environment and its inherent restorative elements. The second was the physical self factor, reflecting the challenge activities or feedback processes within the environment that promoted change and enhanced self-image. The third was the social self factor, reflecting the group processes that occurred, such as cooperative behaviour promotion and the formation of interpersonal relationships. In contrast to the OB model, the wilderness therapy process had all three factors operating contemporaneously throughout, although with varying intensity levels. The process was timebound between the initial wilderness contact and final wilderness contact.

The wilderness therapy model factors were supported with relevant theory from the literature (Russell & Farnum, 2004). Firstly, the wilderness factor was influenced by attention restoration theory (Kaplan, 1995). Kaplan proposed that exposure to natural environments could play a significant role in replenishing mental fatigue or directed attention fatigue. Natural environments could allow a state of involuntary attention to occur, termed soft fascination. Soft fascination enhanced recovery from mental fatigue. Directed attention fatigue was seen to be a modern living phenomenon that occurred when concentration on something important but not interesting was required. Kaplan connected lapses in directed attention and mental fatigue with, for example, aeroplane accidents caused by pilot error.

Secondly, the theories that underpinned the physical self factor were related to two aspects, physical wellbeing and wilderness living tasks. Physical wellbeing and its link to mental wellbeing theory were drawn from health psychology and related areas (Czosnek et al., 2019; Mason & Holt, 2012). The theoretical underpinning of wilderness living tasks, was related to improvements in self-efficacy as proposed by Bandura (1977). The use of Bandura's self-

efficacy theory is common with the OB model described previously. Lastly, the social self factor was underpinned by social cognitive theory (Bandura, 2006). Social cognitive theory recognises that people have agency reflected by four properties of intentionality, forethought, self-reactiveness and self-reflectiveness. One of the core propositions of this theory was on how we learn through observation. Thus, social modelling in the group, became an important part of behavioural changes that an AT programme targets.

The wilderness therapy model was a step forward from the OB model in that it moved away from a stage-based concept to a more fluid presentation that allowed contemporaneous changes in factors. However, there were some limitations noted. Russell and Farnum (2004) reflected that their model did not cover therapeutic elements that were present in traditional psychotherapy such as the therapeutic alliance and thus was focused on the additive component of AT. This gap was noted by Fernee et al. (2017) who substituted a psychosocial element in for the social self factor in their wilderness therapy clinical model.

The Wilderness Therapy Clinical Model

A review of qualitative AT studies to understand how the therapy approach worked, used the results to both test and refine the wilderness therapy model (Fernee et al., 2017). Through the analysis of seven studies, Fernee et al. proposed that to reflect the complete nature of therapy then a psychological element needed to be included. They acknowledged the strong interconnection between internal psychological concerns of a participant and the external socio-cultural contexts that influenced that participants life. Consequently, they elected to substitute the social self factor with a psychosocial self factor and renamed the model the wilderness therapy clinical model.

Fernee et al.'s (2017) model supported Russell and Farnum's (2004) original thinking but by adding the psychosocial element, extended the model into the clinical therapy domain. They proposed two practical actions to support the application of the new factor, psychological assessment and individual treatment plans. They also argued that, with extension to wider

therapeutic treatment formats, the temporal assessments of factor intensity might no longer apply. The new model, therefore, embraced a more cyclical format. Further research has confirmed the constructs in this model. It has also been suggested that the depth of the therapeutic process, the interconnectedness of the various factors and the role of nature, warrant further investigation (Fernee et al., 2019).

Ecotherapy Theory

So far, the wilderness or nature, has been shown as an important factor in the AT therapeutic mix. However, it has tended to function as a backdrop or stage against which the more active components of AT take place (Carpenter & Pryor, 2021). Nature has tended to be regarded as static and inanimate and something to be utilised (Harper & Dobud, 2021). Yet, criticisms of AT's position have arisen amongst researchers and practitioners where there is a rising recognition for the importance of nature and its active therapeutic role (Phillips et al., 2022). In fact, ecotherapy has been aligned with the term AT by some, as a growing recognition of nature's unique role (Harper et al., 2015).

Ecotherapy, with its background in ecopsychology, comes from a place where nature is more than simply good for you. In these spaces, nature is seen as a therapeutic setting itself that sits apart from clients' everyday lives (Berger & McLeod, 2006). Wilson (1984) suggested that humans had an innate drive to connect with other forms of life and natural environments, terming this daily need as Biophilia. This drive was further explored by Roszak (1992) who coined the term ecopsychology, defining it as, "1) The emerging synthesis of ecology and psychology. 2) The skilful application of ecological insights to the practice of psychotherapy. 3) The discovery of our emotional bond with the planet. 4) Defining "sanity" as if the whole world mattered" (Roszak, 1994, p. 8). Ecopsychology provides a synthesis between ecology and psychology and is intended to heal the emotional bond with the planet (Schroll, 2007).

Louv (2005) developed ecopsychology thinking further by considering the distress that was caused when the human-nature connection was broken through modern living. Louv

termed this break as, ‘nature deficit disorder’ and linked the disorder to such diagnoses as attention deficit hyperactivity disorder. Ecopsychology meshes the holistic health of humans with the holistic health of the planet and proposes that we are interconnected and interdependent (Clare, 2014). Ecotherapy is the logical practical extension of ecopsychology and has been defined as “applied or clinical ecopsychology” (Jordan, 2009, p. 26).

Two key theories underpin ecotherapy, attention restoration theory and stress reduction theory (Kotera et al., 2022). Stress reduction theory originated from work that was done by Ulrich (1984). He reviewed records from a 10-year period that showed patients in a hospital recovered faster after surgery if they had a room with a natural view. He later postulated that being exposed to nature, in the absence of threat, would result in a reduction in stress with a restorative influence (Ulrich et al., 1991). His stress reduction theory was linked to psycho-evolutionary theory where influences of nature restore emotional and physiological levels that are then accompanied by increased attention. This contrasted with attention restoration theory where cognitive processes were the focus (Ulrich, 1983).

AT is sometimes referenced as an ecotherapy practice (Jordan, 2014). In contrast, ecotherapy practice has placed an emphasis on nature as a co-therapist and principle therapeutic source (McGeeney, 2016). This is differentiated from AT’s tradition of using nature as a setting and indicates a nuancing of the wilderness factor in the wilderness therapy clinical model (Fernee & Gabrielsen, 2021). However, in ecotherapy the therapist’s primary role is to deepen the relationship between the clients and nature and for nature to act as a third party in the therapeutic relationship (McGeeney, 2016). Therefore, in ecotherapy, it is this relationship that takes primacy and AT elements such as challenge, experiential learning and group work become the context for this focus.

An Aotearoa NZ Approach

Jeffery and Hensey (2022) have recommended that for AT to thrive in Aotearoa NZ, “Bicultural practice is enabled and Kaupapa Māori practice supported” (p. 21). Bicultural practice

is a term that reflects partnership and self-determination for Māori (Macfarlane et al., 2011). Kaupapa Māori practice reflects the notion that programmes are based on Te Ao Māori (the Māori world view) and reflect Māori preferred practice and processes (Macfarlane, 2016). Wratten Stone (2016) has confirmed that, “adapting traditional practices to better reflect Māori values” (p. 24) in mental health services is a common success factor. Phillips et al. (2022) have proposed that, “grounding adventure therapy in a Te Ao Māori worldview favoring a cultural, communal, ecological, and spiritual perspective, could better align with the hauora needs of Māori” (p. 149). Hauora extends the concept of health to cover wairua (spiritual), te taha hinengaro (mental and emotional), te taha tinana (physical) and te taha whanau (family). The Te Whare Tapa Whā model of Māori health presents these interrelated aspects as the four sides of a wharenui (meeting house) standing on a base of whenua (land, roots; Durie, 1985).

An example of where western discourse dominated approaches have been addressed by infusing Māori tikanga (values and beliefs) is waka tētē (Guy, 2020). Waka tētē centred around the use of traditional watercraft, waka, to envelop a group into the traditional activity. The activity was surrounded by other practices such as, pepeha (introductions), te reo Māori waiata (songs in the Māori language), and spiritual connections with nature. This process produced an “intensity of emotion” and a “new understanding of the deep connection between Māori and the natural world” (p. 11). It was a counselling session where instead of a psychologist, Māori were able to communicate with tūpuna (ancestors) as part of the natural environment. In response, they received knowledge and understanding to resolve problems. Guy’s work appeared to parallel and extend some ecotherapy principles. He intertwined the importance of nature and humans in the process of mental health alongside the use of cultural elements for therapeutic gain.

In contrast, Hollis et al. (2011) found that infusing tikanga into programs to benefit Māori may not always be required. Hollis et al. explored Māori participant’ views on how effective a Project K programme was for them. This research showed that Project K did not directly

interface with their Māori identity but that this was not viewed as a negative. Rather, the participants reported that an environment of equality gave them the opportunity to just be young people. They were able to leave behind negative racial stereotype reminders and work within a multicultural environment that had elevated expectations for all group members to achieve.

However, Ape-Esera and Lambie's (2019) research on a rangatahi (adolescent) treatment programme for Māori engaged in harmful sexual behaviour, supported Guy's (2020) observations. The programme infused Māori tikanga into group and wilderness therapy enhanced treatment. Improved outcomes were seen by instilling values for growth (whānau support, relationship maintenance, identity security). The support from, and personal qualities of kaimahi (Māori staff) were also contributors to the programme's success. The need for more cultural initiatives was highlighted by their findings.

These contradictory findings suggest that Hollis et al., (2011) may have reflected the positive aspects of a "holiday" from racism. Although effective and pleasant in the short-term clients may have struggled to transfer back learnings to home lives with long term benefit. Interestingly, Hollis et al.'s study did report some cultural conflict when Pākehā (European) instructors were used. When Māori instructors were present participants felt culturally supported. It is not clear in the report how influential the culture of the instructors was over the findings. Still, Hollis et al. did go on to suggest ways of building a positive cultural identity in the programme, recognising its underlying importance.

When looking across the different theories of AT, some common elements become clear although the emphasis may be different. For example, the elements of physical activity, nature, relationships, and therapeutic intent are common. However Eurocentric models of AT have not traditionally placed an emphasis on cultural contexts or nature as a spiritual partner. While there appears to be a growing recognition of the value of indigenous approaches (Johnson & Ali, 2020; Ritchie et al., 2015) calls are still being made to further develop this perspective (Marques

et al., 2021). In Aotearoa NZ, there are commonalities with international thinking, yet the inclusion of Te Ao Māori elements introduces a distinctive approach.

The Effectiveness of AT

Empirical Evidence on AT

The research base on AT has significant volume. Nevertheless, the AT programmes that have been studied are highly heterogeneous in nature. This has led to ongoing problems in achieving required levels of quantitative data so that AT can be recognised as being empirically supported. Empirically supported is a designation that traditionally has required “at least two good between-group design experiments demonstrating efficacy” (Tolin et al., 2015, p. 319). Predominantly, randomised, controlled trials (RCTs) are interpreted to meet this standard of good design (Miller et al., 2013).

However, as noted by Gabrielsen et al. (2016) there are few RCTs in the AT world because they are challenging to implement. These challenges include cost (Rosa et al., 2023), and ethical issues where the process of randomisation introduces insecurity to participants (Gabrielsen et al., 2016). Gabrielsen at al. explored the ethical issues and found that assignment to a control group could be seen as a failure, adversely affecting a participant. Further, when measuring health outcomes, having a control group that would prefer AT as a therapy, and offering them less, contained shades of malpractice. Finally, measuring a control group that has not had their primary choice of health care, casts doubt on the data received. Gabrielsen et al. proposed some solutions to these issues such as staging all participants into AT at separate times. Still, they found in their own experience of an RCT with a Norwegian AT programme that the challenges resulted in the RCT being abandoned. Without RCTs, AT continues to battle impressions that it is not empirically supported and struggles to prove that confounding factors are not influencing research outcomes (Tucker et al., 2022).

While RCTs are rare, there are meta-analyses that cover a range of empirical outcomes with AT. Meta-analyses often report on Cohen’s d or Hedges g effect sizes. A small effect size

is considered as d=0.2, a medium effect size as d=0.5 and a large effect size as d=0.8 (Cohen, 1988). Bowen and Neill (2013) conducted a meta-analysis on 197 AT studies and 17,728 participants to assess pre-post effect sizes. They found an overall sustained moderate effect size of .47. These results confirmed that AT was an effective intervention. Despite this, the study did note that effect sizes were not as great as those for individual psychotherapy. Bowen and Neill referenced a meta-analysis that had produced mean pre-post effect sizes with psychotherapy treatments of .76 (Lipsey & Wilson, 1993).

Yet, a comparison between Bowen and Neill's' (2013) and Lipsey and Wilson's (1993) results is not straight forward. Bowen and Neill observed heterogeneity in their pre-post results that they were unable to explain, indicating that confounding factors may have been at play. On the other hand, Lipsey and Wilson's study contained results that also could not be explained. When they looked at studies that used alternate treatment or treatment-as-usual controls, they found average effect sizes had reduced to a mean of .34. This significant reduction cast doubt on the validity of their results. Arguably, based on comparing these two studies, the statement that AT has a smaller effect size than psychotherapy is unproven.

Bowen and Neill's' (2013) effect size results were further supported by Bettmann et al.'s (2016) meta-analysis of wilderness therapy outcomes using 36 studies with 2300 participants. Results showed that effect sizes across a range of outcomes were between g=.49 to g=.75. Many studies were pre-post designs without control groups and this was noted as a broader limitation in AT research, reducing ability to understand confounding factors. Yet, the trend of moderate to large effect sizes for AT programmes has continued to build.

Two further meta-analyses have offered moderate to large effect size support for AT. Fleischer et al. (2017) found, in their meta-analysis of AT effects on self-concept, an overall moderate, uncontrolled effect size (g = .51). Notably, there was little change in long term follow-up measures indicating successful transference home of learnings. Measures for self-concept were made up of, locus of control, self-efficacy and self-esteem. Fleischer et al. found a great

heterogeneity in individual effect sizes and indicated that this might be due to the variety of populations and program types. Moderator analysis could not identify any causal variables. Beck & Wong (2022) focused on studies that had a criminogenic measure so that delinquent behaviour could be isolated. Eleven studies were selected. Results showed that there was a large positive effect size (.83) supporting the use of wilderness therapy. The linking of these larger effect sizes with forensic measures has lent credibility to using AT in behavioural applications.

The meta-analytic literature reveals some interesting characteristics. There is a strong base of medium to large effect sizes supporting AT and indications that these are maintained in the long term. Research on programmes is not consistent in reporting programme detail, hampering comparisons and making programme strength difficult to determine (Bettmann et al., 2016). Descriptive statistics are not well covered which has hampered moderator analysis (Gillis et al., 2016). There is a high heterogeneity in individual results that has been difficult to explain (Bowen & Neill, 2013). Most of the research literature uses pre-post-tests without comparison groups which means confounding variables are difficult to identify. The ubiquity of research from the United States that uses predominantly white males, calls into question the applicability into other cultural or diverse contexts. Criticism of the use of pre-post tests and the non-use of RCTs goes unanswered (Gillis, 2021), and hampers AT from being perceived as evidence based.

Empirical Evidence on AT in Aotearoa NZ

Quantitative AT assessment literature in Aotearoa NZ is relatively scarce (Pretorius, 2020). Nonetheless, two adventure-based PYD (positive youth development) programme areas have created a body of literature that is relevant. The first is the Graeme Dingle Foundation's Project K and the second covers sail training delivered by various other foundations. Project K has a particular focus on participants with low self-efficacy (Deane & Harré, 2014). Self-efficacy theory (Bandura, 1977) has been identified as important in AT models such as the OB model

(Gass et al., 2020; Walsh & Gollins, 1976), the wilderness therapy model (Russell & Farnum, 2004) and the wilderness therapy clinical model (Fernee et al., 2017).

Project K has been theorised to have a positive effect on self-efficacy through a wilderness adventure experience providing competence and mastery opportunities (Furness et al., 2017). Furness et al. found in a quasi-experimental, non-equivalent control group design study with Project K clients, that large effect sizes were found on self-efficacy (d=.93). However, their positive results were affected by large unexplained differences in control and treatment groups in baseline self-efficacy measurements. Deane et al. (2017) conducted an RCT with Project K participants. This study had similar control and treatment group baseline scores for both academic self-efficacy and social self-efficacy measures. Deane et al. used culturally diverse participants in the intervention group (433) and in the control group (392). Between group effect sizes were calculated as moderate at program end for academic self-efficacy and social self-efficacy (d=.43, d=.44 respectively). Only a slight reduction in both measures was observed at the one-year follow-up timeframe.

While supporting the premise that the Project K programme had a positive impact on self-efficacy, this study showed evidence that Māori and Pacifika did not make the same gains in social self-efficacy as non-Māori and non-Pacifika participants. Deane et al. (2017) explained this result by noting that Māori and Pacifika average baseline scores for social self-efficacy were higher than for other participants. They also noted that Project K boosted self-efficacy more for those who needed it, bringing participants up to more comparable levels. Thus, the average change for Māori and Pacifika would appear less than for non-Māori and non-Pacifika participants. A previous study provided insight to this effect where high expectations from facilitators across all Project K clients, regardless of background, lifted self-perceptions to similar levels despite baseline measures (Deane et al., 2017; Hollis et al., 2011).

Self-esteem is also an important measured construct in terms of AT theory. Self-esteem exists within the OB model as a factor that is increased when mastery and competence are

exhibited and the learners meaning is reorganised (Walsh & Gollins, 1976). Self-esteem is also important in SDT, where it features as an internal reward for success (Ryan & Deci, 2020). Self-esteem growth has been shown to be a benefit of taking part in sail training (Scarf et al., 2018). Scarf et al. conducted two studies. The first was an assessment on 173 participants and the second with 171 participants. Compared to the control groups, they found that participants in both voyages had increases in self-esteem. Importantly, in the second study they were able to link self-esteem increases to an increased group sense of belonging. This is relevant to AT theory as it links individual outcomes to increases in social metrics.

Resilience is also associated with social constructs. Hayhurst et al. (2015) replicated resilience increase effects of sail training participants over two studies with resilience being maintained at the 5-month point following the voyages. The authors suggested that increases in social effectiveness and self-efficacy were predictors of resilience outcomes. Comparable results were demonstrated by Arahanga-Doyle et al. (2019) in their assessment of 54 Māori and 37 Pākehā adolescents on a 7-day youth development voyage. Changes in psychological resilience, self-esteem and positive outlook were assessed pre-post voyage with all measures increasing across both cultures. Arahanga-Doyle et al. found evidence to support the hypothesis that psychological resilience was formed from a foundation of collective/social identity. Yet, in contrast to Scarf et al. (2018), collective/social identity increases did not predict the changes for self-esteem. This result may have been weakened by the use of a single item self-esteem scale and was noted as a limitation in the research.

One unexpected finding by Arahanga-Doyle et al. (2019) was on baseline measures of resilience and self-esteem where Māori participants scored lower than non-Māori. The authors linked this finding to general evidence showing Māori adolescents facing more mental health challenges in society than non-Māori. Nevertheless, the study showed that by the end of the voyage the two cultural groups were at similar levels, mimicking Project K effects. Deane et al.

(2017) suggested that this type of phenomenon was linked to social group dynamics with individuals being influenced by more confident peers.

The Aotearoa NZ justice sector has been an area where AT has been of interest. An evidence brief has been created for the Aotearoa NZ government on the effectiveness of outdoor programmes to reduce crime (New Zealand Government, 2017). The brief reviewed a range of literature and noted, “the appropriate evidence rating for outdoor programmes is promising (short-term reductions for adolescent offenders)” (p. 5). The brief also noted that while “international research for short-term reductions for adolescent offenders is strong there is limited evidence for adult offenders and longer-term reductions” (p. 5). That being said, positive improvements on psychosocial outcomes were supported by all the research reviewed in the document.

Further supporting the government brief’s findings have been the results from a surf therapy programme, Tai Wātea. Pretorius (2020) conducted an evaluation of this programme in a pre-test, post-test repeated measures design. The 8-week community-based therapy programme with a significant Māori cultural focus was aimed at 16-24 year-old high risk males with 40% having prison experience. Pretorius found that overall the programme had a positive large effect on the functioning of participants ($d = 2.0$). The author concluded that the surf programme was highly promising and a valuable approach for improving the psychosocial functioning of high risk males in Aotearoa NZ. However, while short term results were impressive, possibly enhanced by counselling and mentorship additions, no long-term measurements were completed.

Yet while Pretorius’s (2020) study showed significant positive effects, this contrasted with earlier research completed on the outdoor adventure challenge programme at the Rolleston Prison. Mossman (1998) measured recidivism rates of 84 participants with a matched control group. While Mossman found that recidivism rates of those who had attended the programme had reduced by 46% there was no significant difference with the control group. Mossman also

surveyed a range of psychometric measures on randomly assigned intervention and control group participants. The study found that the intervention participants had significant positive changes in, interpersonal trust, self-efficacy, group cohesion and wellbeing. Surprisingly, there was no change in motivation to alter criminal behaviour although the motivation results were positive and approached significance. Mossman concluded that the adventure challenge programme was effective but that this study suffered from low statistical power, needing larger sample sizes and valid instruments. Mossman's programme structure differed from Pretorius's, in that it was not community based and it included a framework of assessment for recidivism. While short term results of both programmes were generally positive, the evidence is mixed whether AT improves long term behaviour.

AT's mixed results in Aotearoa NZ have also been reflected with a study on psychosocial wellbeing with youth participants who had a mental distress. Radford (2013) investigated the effectiveness of an AT group with 78 participants and a treatment as usual control group of 206 participants. All were attending an early intervention in psychosis service for 18-30 year-olds. A range of reliable, valid instruments were used and were applied at the six month, 18 month and discharge time intervals. In contrast to hypothesised outcomes no psychological measures were seen to improve because of the adventure-based intervention. Radford's result, stood in contrast to international literature where a significant improvement was seen in self-esteem and global functioning for participants with schizophrenia (Voruganti et al., 2006). Radford's results suffered from issues with group self-selection introducing confounding variables, and statistical changes that may have been swamped by other, therapy-related improvements across participants. However, despite methodological problems, the results, similarly to Mossman's (1998) create the impression that AT is not consistent in delivering, long term positive results in Aotearoa NZ.

Alternatives to Evidence-Based Approaches

Evidence-based therapies predominantly look to establish themselves through high quality RCTs (Bullen et al., 2020). However, as noted by Gabrielsen et al. (2016) these may be unethical to conduct in the AT area. The quantitative evidence presented thus far, suggests there is a weighting towards medium to large effect sizes for AT on a range of psychosocial measures. On the other hand, research methodology is continually pointed out as a weakness in approach. Studies producing inconclusive outcomes with methodological weaknesses undermine the presentation of a consistently successful therapy. Common areas identified for improvement include, study design, non-random assignment to groups, lack of comparison groups and a lack of reported information (Rosa et al., 2023).

There is an alternate view that proposes further work on the comparative evidence base is misplaced (Dobud et al., 2020; Dobud & Harper, 2018). Dobud and Harper have claimed support from the common factors theory (Rosenzweig, 1936). Common factors theory suggests that the effectiveness of therapies is driven by shared components. These components include the therapeutic alliance as well as client and therapist attributes rather than specific therapy techniques. Dobud and Harper have proposed that further quantitative proving of AT will benefit no-one because AT has equivalent outcomes to other therapies. They have suggested that the focus should now move to understanding how AT works and driving improvement through routine outcome monitoring. Such monitoring uses, “session-to-session measures of client progress to evaluate and improve treatment outcome” (Boswell et al., 2015, p. 7).

A more culturally informed argument against the evidence-based movement has been put forward from an Aotearoa NZ point of view. Evidence-based approaches come from a heavily Eurocentric, positivist perspective that privileges certain knowledge over others. This may have had the effect of promulgating existing disadvantage (Bullen et al., 2020). Bullen et al. have proposed that “cultural contexts, local resources and community needs” (p. 24) should be considered and that what builds program effectiveness included plurality. Bi-cultural discourse

needed to be highlighted, particularly if it ran counter to findings. Capacity and funding at government level for organisational skills was necessary to further context-driven evidence-based assessments.

Although there is a clear base of quantitative evidence that supports AT as a therapeutic practice, what drives therapists' views of effectiveness may not be related to that body of evidence. In a piece of qualitative research Weinberg (2013) sought to understand AT practitioner belief systems through interviews with eight AT facilitators. Weinberg found a consistent theme of belief in the effectiveness of AT but that the genesis of this belief lay in a personal transformative experience that the participant had, prior to working in the field of AT.

Belief systems have the potential to strongly influence therapists, exerting a comparable impact to that of an evidence base. Revell and McLeod (2017) found with walk and talk therapy, a deep therapist belief in effectiveness was key. The use of beliefs to drive professional action was seen as a way of aligning professional and personal identities. Aveline (2005) proposed that this alignment and engagement of the therapist was as, or more important than empirical research. Dobud (2020) endorsed this observation by recognising that the common factors of therapy attached effectiveness to therapist traits, as well as client traits, hope, and placebo. These factors are important elements of therapy, regardless of theory (Rosenzweig, 1936; Wampold & Imel, 2015). Together these points call into question what influences practitioners' beliefs on the effectiveness of AT. A question stands, as to whether the quantitative evidence base is as relevant, as might initially be thought.

Outdoor Therapy Practitioner Perception Research

International Perception Research

The literature on therapists AT perception research is limited and it has been necessary to expand this review outside of AT. The wider, related areas of walk and talk therapy and nature based therapies are relevant. Walk and talk therapy consists of therapists taking their therapy work and clients into outdoor spaces (Charbonneau, 2016; Lewis, 2017). Nature based

therapy includes AT in its scope and consists of practices guided by nature (Naor & Mayseless, 2021). Within this framework sit other such approaches as: ecotherapy, forest bathing, horticultural therapy and animal assisted therapies (Harper et al., 2019). Both walk and talk therapy and nature based therapy are grouped under the term outdoor therapy, consistent with the use of the terminology by Harper and Dobud (2021).

Therapists' perception research in outdoor therapies has resulted in some consistent themes emerging. The perception of nature's role in outdoor therapies, has been framed in two ways. Firstly, research has shown that practitioners involved in AT found a greater connection to the environment that included a deeper sense of self in relation to an ecological whole (Jordan 2014; Charbonneau, 2016). In addition, those who had a natural passion for the outdoors felt that it made them better therapists in AT. Contrasting views were also shared to acknowledge therapist bias for the outdoors pressuring clients (Jordan, 2014), though this bias could be managed with therapist self-reflection (Charbonneau, 2016).

Secondly, practitioners recognised that nature assumed the identity of co-therapist forming a therapeutic relationship triad. Nature provided both a safe refuge from difficult relationships and a bridge to therapy (Lane & Reed, 2023). Nature was seen as an active partner, providing insight into relationships and feedback into therapy, for example by sending animals or changes in weather (Lewis, 2017). These qualities were seen to be positive mediators to the relationship between client and therapist. However, challenges that might eventuate for the therapist in a triangular arrangement were not explored.

One change to the therapeutic relationship that has been identified is in power sharing. Schwenk (2019) used an interpersonal process recall methodology to investigate the experience of outdoor therapists. Schwenk found that nature as a neutral space allowed the therapist to be more real and to provide the opportunity for deeper intimacy in the therapist-client relationship. These changes facilitated a shift, allowing the client to become an equal partner in the relationship. This shift reframed the context of the therapist to a more holistic,

negotiated position. James et al. (2021) contrasted this holistic position with the clinical room where officiality and anxiety riddled senses existed. Outside, this feeling gave way to a sense of freedom and mutuality with therapists seeing a reduction in barriers and a more collaborative atmosphere.

Although the deepening of the therapeutic relationship was seen as positive, both Schwenk (2019) and James et al. (2021) raised a caveat. Power sharing changes needed some caution, as professional boundaries and client perspectives of the relationship, might become more friendship oriented than therapeutic. Harper et al. (2019) raised this duality in relationship as an ethical issue and suggested that maintaining professionalism was required despite informal spaces. In contrast, the evidence from Schwenk and James et al. suggested that a tone of professionalism might unbalance power sharing, countering a desired egalitarian model.

Therapists were seen to benefit from outdoor therapies in addition to clients (Revell & McLeod, 2017). Therapists bringing their life experience to therapy, enhanced motivation, commitment and performance. Therapist self-care and rejuvenation were also highlighted (Lane & Reed, 2021). In Lane and Reed's study, therapists found their own experiences in nature to be regulating and restorative. These therapists had a previous relationship with nature that was already intrinsically part of their identity. Therefore, it is not clear if the benefits would be as so pronounced with a therapist new to the outdoors setting. Lewis (2017) has recommended further research into therapists, who do not have a previous relationship with nature, who are practicing therapy outdoors. This research would aim to understand the therapists' motivation and interaction with clients.

Another common perception theme was related to the ethical challenges of managing risk in the outdoors. James et al. (2021) identified managing safety risk as a theme from three psychologists conducting outdoor therapy. Unpredictability of weather or even allergies to pollen were highlighted. However, while disrupting sessions at times, these issues were managed without incident. Pragmatic solutions to safety risk were described by Revell and McLeod (2017)

who highlighted that adaption in the therapeutic process was important. Maintaining unpredictability was also seen as important as it was part of the therapeutic framework. The sense from both studies is that risk was seen as a relatively minor issue to deal with. This may have been because the walk and talk form of outdoor therapy they were researching had a relatively low risk profile. It might be expected that risk features more prominently in research specifically on AT where adventurous activities are used.

Fuentes (2018) conducted interviews with helping professionals to understand perceptions of strengths and challenges in using AT. As expected, in this study perceptions of risk were more pronounced than in the research by James et al. (2021) and Revell and McLeod (2017). Fuentes found safety risk identified in challenging activities such as climbing, psychological risk in clients with trauma and severity of mental distress, and behavioural risk with young people. Although psychological and behavioural risk might be expected as common with James et al.'s and Revell and McLeod's work, they were only highlighted in the AT context. Lower therapist-client ratios in AT, where groupwork is the norm, and client interactions with a novel activity, may have resulted in accentuating those risks in AT compared to walk and talk therapy. Nevertheless, approaches to AT risk management have been well described and simple checklists have been developed to ensure sound risk management processes (Gass et al., 2020).

Aotearoa NZ Therapists Perceptions of AT

The AT and wider therapist perception-based literature being produced in Aotearoa NZ is growing and a more local context is now emerging (Jeffery & Hensey, 2022). While occupational therapy (OT) is not traditionally linked with AT, it has received some attention in Aotearoa NZ (Jeffery, 2017, 2020; Jeffery & Wilson, 2018). A volume of AT research has been produced from Te Pūkenga Otago Polytech School of Occupational Therapy that, in addition, offers a postgraduate course in AT. These OT-related studies have highlighted the importance to AT of the experiential learning cycle (Kolb, 1984). This perception of AT as an activity based

therapy is not surprising given OT's focus on using activity in a therapeutic way to reach planned goals (Jeffery & Wilson, 2018). The studies have found that AT has a useful fit with OT.

Using a broader practitioner base, Wills (2016) researched participants who covered youth work, counselling, community work and outdoor education. Key themes covered firstly, the outdoor environment, which was able to provide memorable and spiritual experiences. Secondly, the comfort zone/stretch zone model, which introduced risks when clients were pushed too far. Thirdly, the facilitator role and its impact on the experience. Finally, the connection to a wider system that helped build on AT work by facilitating integration. Wills also identified gaps in working with Māori, with a focus on practitioner knowledge and understanding of the significance of whenua (land) and tikanga (customs). This confirmed similar findings by Hollis (2011) supporting improved practitioner cultural competence.

There is a belief that, the importance of nature in the healing process of AT, while acknowledged, has not been given its due (Phillips et al., 2022). However, Horn (2021) has looked more closely at the role of nature in AT and nature based therapies. Counsellors, social workers and psychotherapists perceived nature as enhancing the therapeutic relationship by altering the power dynamics and empowering the client. Nature changed how therapists perceived their roles, from therapy provider moving towards a facilitator, tasked with connecting clients with nature. Nature was seen to provide therapeutic tools allowing space for mindfulness, and a framework for metaphor to connect to the client's everyday life. Finally, the natural environment was also seen to engage the body physically and spiritually in the therapeutic process leading to a more holistic approach.

In a useful state-of-play investigation, Jeffery and Hensey (2022) took a practice focused view of perceptions of AT from a wide range of practitioners. Participants included youth workers, facilitators, educators and health professionals, all who had been active in the field of AT. The wide practitioner skill base suggested that clarity was required in roles, skills sets and scopes of practice. Participants were passionate about AT and valued the integration and

cooperation of therapeutic specialists with outdoor facilitators. The perception of becoming an AT practitioner involved limited formal pathways but engagement with the community of practice was seen as critical alongside mentoring.

A consistent gap in the Aotearoa NZ AT perception literature is the absence of psychologists. Counsellors, social workers, psychotherapists, occupational therapists, nurses, youth workers, teachers and outdoor educators have all been involved as participants (Horn, 2021; Jeffery & Hensey, 2022; Wills, 2016). This gap sits alongside recommendations to do more discipline specific practice research (Jeffery & Wilson, 2018) creating a strong rationale for psychologist perception research on AT.

Chapter Summary

This literature review has explored the varying definitions of AT noting that there is no one accepted term. Scouting, OB and tent therapy were the forerunners of AT in the early twentieth century. AT has continued to grow to today where it is a widespread practice internationally and there is a strengthening community of practice in Aotearoa NZ. Its growth has been accompanied by some ethical challenges, with some international practices still in debate. International theoretical models underpinning AT have been contrasted. In addition, a perspective of how practice has been conceptualised in an Aotearoa NZ context has been outlined. The Aotearoa NZ approach has accentuated cultural and holistic aspects emerging from Te Ao Māori worldviews that better support a bicultural approach. The evidential base for AT has been explored and the difficulty of conducting RCTs noted. While the evidence base supporting AT is strong, there is research that shows mixed outcomes and casts doubt on AT effectiveness. The debate is now moving towards whether cross therapy comparisons are worthwhile. Common factors theory thinking is pushing measurement towards ensuring improvement of therapeutic elements that are common across most therapies such as therapeutic alliance. Finally, therapist perception research on AT and related areas was outlined. Some common themes such as nature, therapeutic relationship changes, benefits to

therapists and risk management emerged. Throughout the review, perceptions of AT from psychologists were either indistinct or missing.

Chapter 3: Method

Chapter Introduction

This chapter highlights the design and methodology undertaken in this study. Firstly, a rationale is provided for the research design responding to the research question:

How do psychologists in Aotearoa NZ perceive the practice of adventure therapy (AT)?

The quality considerations are then proposed governing the study approach. The research process is outlined with the selected techniques explained for participant identification, sampling, recruitment, ethics and subsequent data collection. The chapter concludes with an exploration of reflexivity from the researcher.

Research Design

Crotty (1998) has provided a useful way to conceptualise the research design process. He proposed that answering the following four questions would provide a robust study. Firstly, what are the methods that will be adopted to answer the research question; secondly, what methodology drives this choice; thirdly, what is the theoretical perspective that lies behind this methodology; and finally, what is the epistemology that references this perspective. Crotty proposed that these questions were basic elements to the research process. In addition, when they were consistent and aligned, the integrity of the research was ensured as well as making it compelling.

Method: Semi Structured Interviews

At the heart of the selected design lies the research question. Qualitative interviews are well suited to perception research because interviews can be used to explore opinions, perspectives and beliefs (Roulston, 2010). For example, Lazaridris et al. (2023) investigated the perceptions and experiences of adolescent students of a two-year adventure education program using semi-structured interview data. They used interview data as opposed to quantitative approaches because interviews had the ability to adjust questions to suit participants. This customisation resulted in more reliable outcomes. The semi-structured interview was preferred

as it allowed a better sharing of opinions and consequently, an improved understanding of perspectives.

Interviews as an approach to discovering knowledge is a historic practice stemming from Greek philosophers Plato and Socrates (Brinkmann, 2020; Kvale, 2002). There has been some critique of interviews as their ubiquity has led to observations that today's society can be termed an "interview society" (Atkinson & Silverman, 1997, p. 309). Although interviews can be approximated to everyday conversation, there are differences. These differences lie in the choice of subject, the recording of the interview and the public dissemination of produced information (Runswick-Cole, 2012). There is a risk that the familiarity of interviews pushes participants into a role play of their part as interviewee, producing inauthentic data (Brinkmann, 2020). In addition, there is the risk of an uneven power dynamic occurring between researcher and participant in the interview situation. Interviewers have control of the situation, a monopoly on interpretation and choice over how data is used (Kvale, 2002).

Despite risks with interviews, mitigating actions such as using codes of conduct, ethical reviews and reflexivity provide a framework to address the limitations (Chamberlain, 2015; Runswick-Cole, 2012). These actions pave the way to use interviews as a process of meaning co-construction, bringing the potential to access rich insight (O'Rourke & Pitt, 2007). For this study these risks were judged as low, given that the consent process described data use and abilities of participants to withdraw. As participants were registered psychologists being interviewed by a post graduate student, any interviewer power differential could be offset by the difference in professional status. In addition, the potential power dynamic was further mitigated by relationship building at the start of the interview.

Methodology: Reflexive Thematic Analysis

The methodology represents the analytic action generating information from data, relevant to the research question. The approach needs to be consistent with the theoretical perspective and epistemology of the research design (Willig, 2008). Thematic analysis (TA)

differs in this respect as it is defined to be transtheoretical, allowing TA to be a highly flexible tool (Braun & Clarke, 2022a). Braun and Clarke also noted that, because of its flexibility and usefulness as a methodology for analysing interviews, TA was widely used in qualitative research.

TA has three approaches, coding reliability, codebook and reflexive TA. Reflexive TA was selected as most appropriate to the research question. TA's focus on developing a pattern of shared meaning across participants was highly attractive. Additionally, recognising the highly influential role of the researcher in developing interpretive themes was appropriate for this study (Braun & Clarke, 2021a). Other aspects of the reflexive TA approach that are attractive are its ability to work with both inductive (driven by theory) and deductive (driven by data) approaches to coding. Reflexive TA also has flexibility in semantic code and theme development (explicit and meaning driven) or latent code and theme development (implicit and not stated; Braun & Clarke, 2021a). This orientation was useful for allowing comparisons of data driven themes from interviews to be compared with themes from the literature review. The fact that TA is transtheoretical means that care needs to be taken in selecting theoretical orientations (Terry et al., 2017). In addition, the selection and explanation of that orientation needs to be explicit.

Theoretical Perspective: Critical Realism

Crotty (1998) has outlined that it is important to explain the theoretical perspective and epistemology that has been chosen to lie behind and inform the methodology. In doing this the assumptions that are bought into the research process and are therefore reflected in the application of the methodology are elaborated. However, theoretical perspectives are inevitably bound up in issues of both epistemology (the nature of knowledge) and ontology (the nature of reality). Maxwell (2023) has suggested that the conceptual framework of a research project is a property of the researcher. While some of the reasons for selection are explicit, there are others that are implicit and may require reflection to understand. For this reason, reflexivity at the end of this chapter includes insight into the theoretical perspective selection.

Critical realism has been identified as attractive to researchers because of critiques of both positivism on one hand and of interpretivism on the other (Willis, 2023). For example, these critiques covered positivists' push for universal or governing laws in both natural and social domains. Alternatively, there was critique of interpretivists' views that social life was governed only by meanings, and that 'created meaning' could be applied to the natural sciences (Gorski, 2013). Critical realism offers an acknowledgement of an external reality while accepting that perception, context and interpretation are used to understand that reality (Willis, 2023).

Critical realism is suited to understanding psychologists' perceptions, which are constructed within a social environment, with an external reality, that of the practice of AT. Ontologically, critical realism acknowledges three levels of reality (Bhaskar & Hartwig, 2016). The first is empirical, observable events. The second is the actual, underlying mechanisms that cause those events. The third is the real, which exists independently of our perceptions. Acknowledging that views of this reality are socially constructed and interpreted leads to epistemic relativism. In turn, this allows a critical examination of the social structures and contextual factors that influence psychologist's perceptions. Critical realism also places emphasis on causal factors and allows a detailed discussion of analytic results with insights into contextual causation (Bhaskar & Hartwig, 2016).

However, there are some disadvantages to approaching this study from a critical realist perspective. Those with a positivist orientation argue that critical realists are open to bias as judgement is a part of the perspective. Responses to this criticism highlight that values underpin all research (Walsh & Evans, 2014). When used with Reflexive TA, bias is seen as a potential resource that the researcher brings to the analysis. So, as it is made explicit through reflexivity, researcher positioning can be seen as an advantage in promoting validity and research rigour (Braun & Clarke, 2022a; Wiltshire & Ronkainen, 2021). Critical realism is potentially also more complex than other frameworks, particularly across its partnering of traditionally different ontologies and epistemologies. Braun and Clarke (2022b) have emphasised that when using

the transtheoretical approach of TA it is important to be clear about underlying theoretical assumptions.

Critical realism was selected for this research because it allowed for an exploration of how psychologists perceived the efficacy and mechanisms of adventure-based therapeutic interventions. This exploration could be done while recognising that perceptions were influenced by both the inherent properties of AT and, cognitive and social contexts. The researcher was positioned as having experience in AT related work and a supportive stance towards AT. This perspective would bring a depth of understanding that added context and depth in the interpretation of the data. A critical realist approach would enable a sense of how psychologists constructed their views on AT, considering the complex interplay between the objective nature of the therapy itself and the subjective lens through which it is understood. These advantages were seen to outweigh any potential complexity, with the balance of ontology and epistemologies bringing a concept of “enlightened common sense” (Bhaskar & Hartwig, 2016, p. 2).

Quality Criteria

There were two key sources used for quality criteria guidance in this research. The first was drawn from Tracy (2010) where eight criteria were outlined as key markers of quality including “(a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence” (p. 837). Tracy’s approach to a universal set of quality criteria has been used extensively within sport and exercise psychology to underline quality (Smith & McGannon, 2018). Braun and Clarke (2022b) have also provided a useful 15-point checklist to use as a quality review for reflexive TA. This checklist covers the process areas of transcription, coding and theme development, analysis, interpretation, and the written report. To aid the quality of this research the criteria have been reviewed with appropriate reflexivity to provide assurance that a clear quality framework has been followed.

Participants

Participant criteria was restricted to registered psychologists in Aotearoa NZ. Registration in Aotearoa NZ supported a local knowledge and practices context that was fundamental to the study. No psychologist scope of practice was specified because AT, as inherently flexible (Flom, 2022), can be applied across many domains. To ensure participants could provide meaningful data, a selection criterion was used that required psychologists to have had experience of using AT. No timeframe for length of experience was specified as reliance was placed upon the ethical requirement for psychologists to "attain adequate levels of knowledge and skills to practise in a particular area" (New Zealand Psychologist's Board, 2002, p. 16). This knowledge of practice was considered enough for participants to form meaningful perceptions of AT.

During preliminary research preparation, a risk was identified that the recruitment process might struggle to find an adequate sample of participants. To address that risk, an alternative participant definition was formed, and was used in the ethics application. The alternate definition of a psychology professional was, someone who had a postgraduate qualification in psychology, had experience with AT and currently worked in mental health and/or AT. Initial internet searches indicated that this alternative definition should yield more than enough discipline specific participants if the first requirement proved to be too limiting. Nonetheless, by the conclusion of the study, a sufficient number of registered psychologists were successfully recruited.

Sampling

Determining a suitable sample size for a qualitative study has no easy answer (Braun & Clarke, 2022b). It is an area that is highly contested (Terry et al., 2017). One approach is to use saturation. Saturation occurs when the analysis on a dataset produces no new themes from additional data. Yet, using saturation to determine sample size is problematic. There are few methodologies to identify saturation, the process does not allow predictions of sample sizes and

justifications for sample sizes are often not reported (Bowen, 2008; Marshall et al., 2013). Fugard and Potts (2015) have also argued that new data will always bring more information. In terms of using data saturation concepts with reflexive TA, Braun and Clarke (2021b) have been emphatic that saturation is “not consistent with the values and assumptions of reflexive TA” (p. 201).

An alternative, simple approach to calculate sample size has been put forward based on project research type and TA. Terry et al. (2017) have suggested that between six to fifteen interviews are appropriate for masters’ degree-level research. Even so, the most important consideration is the collection of rich nuanced data. For this research eight interview samples were targeted. This number reflected a balance of estimated available numbers of participants, based on internet searches, and a likelihood of participation. The sample target of eight registered psychologist interviews was achieved.

There are two main strategies available for sampling in qualitative analysis, convenience and purposeful sampling, although the boundaries between these two approaches are increasingly becoming blurred (Meyer & Mayrhofer, 2023). Purposeful sampling enables control over sample characteristics such as homogeneity, so that data is information rich and relevant to the research question (Schreier, 2023). Convenience sampling, on the other hand, uses availability and ease of access as the selection criteria. While efficient, it has the risk of introducing hidden biases and can sometimes target populations not central to the research question (Braun & Clarke, 2022a; Etikan, 2016)

However, as Braun and Clarke (2022a) identified, there is no ideal sampling approach for reflexive TA and constraints may drive practice that differs from formal descriptions. In the case of this study, where the population of interest had a limited size, then convenience sampling was an appropriate approach. This sampling format covered practical criteria such as accessibility, availability and willingness. (Etikan, 2016). Snowballing consists of identifying potential participants using referrals from existing research participants or researcher identified

contacts. It is considered a form of purposeful sampling and can be a useful technique to reach hard-to-find participants (Chamberlain & Hodgetts, 2023; Leslie, 2021). Snowballing was employed as part of the sampling approach for this research when convenience sampling had not produced the required number of participants.

Recruitment

The recruitment phase revealed that earlier assumptions of the limited number of likely participants were accurate. Two conferences that happened to coincide with the recruitment process were useful recruiting grounds. The first, the Surf Therapy Aotearoa conference produced one psychologist that was willing to participate. The second, the Adventure Therapy Aotearoa conference had over one hundred attendees but there were no psychologists attending. Attendee professional identifications were obtained through a group exercise where people clustered themselves into professional areas in a room. Despite this, using contacts gained at this conference along with snowballing techniques produced two participants. A further two participants were recruited through personal contacts and internet searches. A recruitment advertisement placed in the NZ Psychological Society monthly newsletter did not produce any participants. A recruitment post on the Adventure Therapy Aotearoa Facebook site produced one participant and a recruitment post in the Psychologists in NZ Facebook group produced no responses (see Appendix A for advertisement posts). Snowballing using this study's research supervisor produced a further two participants. Attempts to further increase the participant base beyond eight were unsuccessful. Participant demographics are given in Table 3.1.

Potential participants when identified were provided with an invitation to participate and information sheet. These items introduced the researcher and the research, provided the research objectives, and details of the process including participants rights and ethics review details (see Appendix B). A consent form was also provided (see Appendix C). Massey

University Contact details were included if there were any concerns, either regarding the research project or ethical issues.

Table 3.1

Participant Demographics

Category	Measure
Gender identification	Female: 5 Male: 3
Age range and mean	31- 61 years Mean: 48.5 years
Range of years of psychological practice	3.5 - 31 years
Number of years of experience with AT	<1 year to 25+ years
Ethnicities represented	Indian, Jewish American, NZ Māori, NZ European, Samoan, Southeast Asian
New Zealand Regionality Representation	Auckland, Bay of Plenty, Canterbury, Otago, Southland, Taranaki

Ethical Considerations

The process used to identify ethical issues with this research included five-steps. The first four steps were based on an analysis of the intended scope of research against four core ethical guidance documents. These documents were, Code of Responsible Research Conduct, Massey University Policy Guide (Massey University, 2015), Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (Massey University, 2017), Te Ara Tika Guidelines for Māori research ethics: A Framework for Researchers and Ethics Committee Members (Hudson et al., 2010), and the Code of Ethics for Psychologists Working in

Aotearoa/New Zealand (New Zealand Psychologist's Board, 2002). The fifth step was to review the outputs of this analysis with the research supervisor.

As a non-Māori researcher conducting research in Aotearoa NZ, implications of Te Tiriti o Waitangi (the Treaty of Waitangi) were a core consideration of the research process design. In considering the three principles of partnership, participation and protection, this study was seen to be of interest to Māori. This interest reflected the disproportionate rates of Māori experiencing psychological distress (Ministry of Health, 2022). Therefore Māori were likely to be involved as clients in AT. There was also the likelihood that Māori could be involved as participants in the study. A review with Te Ara Tika: Guidelines for Māori Research Ethics showed that Māori participation was categorised as minor. Consequently, mainstream controls, methods and analysis were appropriate for this study.

Each ethical guidance document was reviewed and its ethical points contrasted with the approach and scope for this research to see if an ethical issue applied. If so, then an appropriate ethical mitigation was formulated. Only those issues that were identified as significant and relevant are reported below.

1. Consent: The consent document was explained and was signed prior to the interview session taking place.
2. Right to withdraw: Participants were given the right to withdraw themselves and any written or recorded data produced, at any time up until one-week after the interview session. No explanation was required. It was clarified that, because of the nature of the report that was to be written, withdrawal after the one-week period would impact on the researcher qualification achievement.
3. Confidentiality and anonymity: Data produced in this project was considered confidential. All data was anonymised with pseudonyms.
4. Cultural considerations: The project process was moderated to be more culturally compatible with the participants where appropriate or requested. For example, karakia were prepared for opening sessions.
5. Risks to participants: An outline of risks to participants was provided prior to consent being sought. Risks to participants included:

- Negative associations with mental health or AT surfacing.
- The interview process inadvertently prompting painful memories or associations.
- An uncomfortable feeling about the interview process during the interview.

All of these could trigger withdrawal, delay or the request for support. Participants were offered drafts of the interview transcripts to review and comment upon prior to analysis. Some participants requested deletion of video recordings and others requested minor alterations or deletions to transcriptions.

6. Data security: Data was held on password protected Massey OneDrive servers.

The project was evaluated by peer review and judged to be low risk (Application I.D. 4000027247). Consequently, it was not reviewed by one of the University's Human Ethics Committees. The researcher and supervisor were responsible for the ethical conduct of the research.

Data Collection

Semi structured interviews were undertaken with each of the participants. Seven interviews were done using the meeting software Zoom. One interview was in-person at the participant's request. Total interview length varied between 60 and 98 minutes. Before the formal part of the interview, some time was spent checking if there were questions about the project. Participants rights were underlined, such as the right to stop the recording at any time. Getting to know each other was done through establishing commonalities between the researcher and participants. This conversation allowed a connection to begin developing. The initial period varied between participants according to whether any questions surfaced or whether common ground for discussion was found. Sometimes taking more time 'felt right' to reach a point where the conversation naturally moved towards the recorded interview stage.

The structure of the interview was designed to elicit experiences, thoughts and perceptions regarding the utility, effectiveness and barriers with AT. Each participant naturally

explored certain areas in more depth that were relevant to them. The interview outline is included in Appendix D and broadly covered current roles, how participants came to AT, their definitions of AT and how they thought AT worked. Next participants' experiences of AT were explored. The conversations covered successes, challenges, risks, the role of nature and ideas regarding future directions. Conversations flowed easily with participants articulate in their responses and happy to share their points of view and emotions. Participants appeared comfortable in the one-on-one interview situation. This comfort level was thought to be a result of the situational familiarity given the similar structure to a traditional therapy setting.

Demographic questions were moved to the end of the interview after trialling them at the start, as asking for personal details flowed better once a relationship had been more firmly established through interviewing. An unintended consequence of this order change was that cultural identification did not occur until the end of the interview impacting on the use of cultural practices. Improvements to this approach might include collecting demographic detail, on the consent form, prior to the interview starting. In addition, approaching interviews from a bi-cultural perspective and implementing karakia, regardless of participant cultural identity, could be implemented.

Interviews were recorded in three formats. Firstly, Zoom facilitates recordings in two configurations, video/audio and audio only. A further backup audio recording was made during the session using a digital voice recorder. This recorder was the primary recording device during the in-person interview with a backup recording made from a smartphone. Recordings were downloaded to a computer hard drive on the completion of interviews and backed up to the Massey One-Drive servers.

Transcription from audio files used the Microsoft Word 365 transcription function. Microsoft do not retain copies of these files (Microsoft, 2023). The word error rate reported for the Word 365 transcription service is 16.51% (Taylor, 2023) reflecting that there was substantial rework required. However, editing also allowed the process of data familiarization to begin

which was an advantage. The transcription notation scheme was adapted from that proposed by Magnusson & Marecek (2015). Once transcription was complete, transcriptions were sent back to the relevant participant for validation. Only relatively minor edits eventuated from this process.

By way of thanking participants for their gifts of time and knowledge, a koha (gift) was sent out to each person once transcription review was complete. A $40 Torpedo7 voucher was chosen as a suitable thankyou to reflect the adventure and outdoor nature of the research. In addition, the convenience of an electronic voucher meant distribution via email was straight forward.

The Analytic Process

The eight interview datasets were explored using Braun and Clarke's six-phase approach to reflexive TA. This approach consisted of dataset familiarisation; data coding; initial theme generation; theme development and review; theme refining; and defining, naming and writing up (Braun & Clarke, 2006, 2022b; Terry et al., 2017). An important feature of this analytic approach was the process of immersion in the data and moving backwards and forwards through the phases of analysis. Iteration emphasised that the process was not linear and was one of construction of information between the researcher and the participants (Terry et al., 2017). The overall process took place across a three month period. The period also allowed a process of moving away from and returning to the data. Development of thinking from different contextual positions occurred as each reading or review produced further details or insights.

Dataset familiarisation, started with interview transcription and review. Familiarisation involved deep engagement and getting to know the data intimately (Terry et al., 2017). This procedure included relistening to the interviews line by line and transcription accuracy checks with transcription notation being added where required. Pauses in listening allowed a process of thinking, questioning and reflecting to take place that generated insights. Progress, although slow, gave an opportunity to delve deeply into the data and to form some initial notes on codes

and themes. A reread and recording review step offered a final transcription quality check but also offered the opportunity to engage with the conversation in a more flowing style, allowing thinking to develop at a broader level.

Data coding involved detailed review and thinking about the meanings in the datasets. A focus in the coding phase was to break down the data into building block chunks to allow initial theme generation to be effective (Braun & Clarke, 2022b). The action of assigning labels to meaning provided a vehicle to explore issues of ontology and epistemology and to assess how critical realism might operate. There appeared to be a natural leaning to identify semantic codes, where a summary or descriptive label was generated that stayed in line with participants meanings. This was a contrast with latent codes where a step could be taken beyond participants meanings to an interpretation at some deeper level (Braun & Clarke, 2012).

As critical realism is bounded in an ontology of realism and the research question was searching for psychologists' perceptions, a more descriptive approach was acknowledged. Regardless, codes were reviewed several times to test whether latent interpretations might be more appropriate in unveiling meanings that were being signalled. Within the code generation process lay considerations of how inductive (aligned with the data) or deductive (aligned with theory) the process would be (Trainor & Bundon, 2021). The literature review had produced a range of themes and theories yet the analysis leaned towards an inductive approach to establish a more contextual output.

Once the initial coding was completed a second round of code review was undertaken. The review process proved insightful, particularly when returning to the data after a break in time. Reflection on where previous thinking had established patterns, produced new insight prompting further work. For example, transcription that had been coded to one area, contained subtle detail that required new codes or recoding of smaller sections of interview. Coding consistency was also reviewed with code explanations clarified. The process of code review created patterns that were not obvious during initial work and enhanced access to nuances of

meaning. The space created allowed more developed interpretative thinking than in the first round. The disciplines employed, forged a strong transition process from the messiness of the data into more coherent patterns represented in the theme generation process.

Coding and subsequent analytic steps were assisted by the software package NVivo R1. This package allowed a simple efficient organisation of codes with the ability to manipulate them when looking for and creating initial themes. Ease of manipulation facilitated deeper data exploration and subsequent evolving insights to be recorded. Braun and Clarke (2022b) have raised concerns about the use of software such as NVivo. They highlighted risks around programmes having implicit assumptive structures embedded within them. Additionally claims of speed and efficiency undermined rich, deep contemplative processes. Software programmes risked decontextualising data and separating the researcher from the analysis. Acknowledging these risks, NVivo was used primarily for the organisation of data and to record codes and themes. The process of data contemplation, familiarisation and engagement still occurred in a comparable way to non-software methods. Using software to facilitate analysis as opposed to operationalising it, is an approach supported by Bulloch et al. (2017).

Initial theme generation; theme development and review; and theme refining, defining and naming, was a circular and iterative process that proved a challenging aspect of the research. Moving backwards and forwards from codes to themes, grouping codes under different headings and developing distinctive theme descriptions took longer than expected and required multiple reworking and reflection before the four themes and seven subthemes were settled on. The renaming of themes was an ongoing process that continued through into the writing up stage with care being taken to ensure that theme names reflected the essence of thinking across the relevant codes.

Writing up pushed some iteration back into the theme development cycle as the process of clarifying ideas through written structure revealed inconsistencies that needed further investigation. Linking what was found through the analytic process back to the literature base

uncovered subtlety in the literature not apparent previously, lending further colour to the research.

Reflexivity

I am writing this piece of reflection acknowledging that my subjectivity is a resource and a lens that I have brought to all aspects in this research. I have a Pākehā (European) background and as a cisgender, straight, middle-aged male, I come from and live within a Euro-normative nuclear family structure. I accept that these traits represent a Westernised norm reflecting the dominant colonial culture in Aotearoa NZ. Being a member of that culture has afforded me privileges not available to others with diverse backgrounds or membership of minority groups.

Initial training in engineering led me to embrace logic and an ontology of realism, where the truth exists as discoverable. In engineering there is always a correct answer that can be revealed by applying logic and theory. More recent learning in psychology has guided understanding of the social construction of knowledge, where we create knowledge through our discourse and experience. As a result I recognise that knowledge can be different for different people and we may never discover an objective truth. The consequences inform my understanding that multiple views of a truth exist which are heavily influenced by context, and that all of the views may be correct. These approaches to reality and knowledge have led me to adopt critical realism as a philosophical approach, influencing my decision to conduct qualitative research.

While my cultural background has grounded me in neo-liberal concepts my recent thinking has been altered through education, towards a more post-colonial orientation. This thinking recognises the damage my culture has done, and is doing, to others in Aotearoa NZ. I am only just setting out on this journey and am cognisant that I still have some distance to go to understand and find ways to counter my inherent bias.

From my early engagement with youth organisations, I have consistently gravitated to outdoor activities, becoming more involved in adrenaline sports from early adulthood. Through my involvement with adventure and my forming desire to help others, I have naturally been drawn to the field of AT. I have approached this study with an intent to contribute to the advancement of AT. However, I am mindful that the process of reflexive thematic analysis is akin to an adventure, bringing with it an element of uncertainty of outcome. Therefore, data analysis and reporting involved a journey into unknown territory.

The journalling process inherent in reflexive thematic analysis evolved throughout the research process. Initially journalling was descriptive and recorded ideas. Particularly, these thoughts and ideas were recorded both in the research journal and in chapter 'thoughts and ideas' files. While a little discontinuous it did mean that rereading of the files was regular as the process continued and evolved. As analysis progressed then the journal became a place where insight and questioning of approach, progress and thinking occurred. The journal became a place where insights could be recorded and then upon re-reading, different contexts became more apparent. Making time for journalling was one challenge that presented itself with a continual time pressure to progress the research. I found that as time pressure mounted my journalling decreased although the process of questioning my position of researcher continued.

The process that I followed in this research provided a fascinating journey of connecting AT with psychology. Recruitment was difficult because there were not many psychologists that had experience of AT but the process of interviewing evolved into an adventure of inquiry. As an insider in this research process it felt as though I could establish rapport relatively quickly as I was able to identify with the experiences that were being related. I found that this allowed for a deeper exploration of detail into participants' thoughts and experiences. As a result, I was able to reflect back an understanding of what was being described.

Analysis proved to be more challenging than I anticipated. While aiming to excel in my work, the complexity of handling a volume of data with multiple and sometimes conflicting

perspectives, made the task far from straightforward. I felt that when under pressure, I defaulted to more semantic analyses feeling more comfortable with this end of the latent-semantic continuum because of my engineering training. There was an overriding sense of wanting to do right by the gifts of knowledge and time that participants had provided me.

There were several times that I felt challenged by the data because it was presenting perspectives that I had not anticipated. Yet as I worked through clarifying and understanding the themes, these challenges started to fold into an appreciation of how AT was perceived by the participants. I hope that I have been able to reflect that understanding into this report.

Chapter Summary

This chapter has explored the research design and method for the study. Interviews, reflective TA, and critical realism as the design framework were explored and justified. The quality processes to ensure robust research were detailed. The method, participants, sampling, recruitment and ethical processes were explained. Data collection and analysis were outlined with the chapter closing with an exploration of researcher reflexivity.

Chapter 4: Results

Chapter Introduction

This chapter presents the reflexive thematic analysis (TA) results interpreted from the interview data. Its purpose is to present the themes analysed and to show how they were grounded in the data. Four interconnected themes and seven subthemes were identified and are summarised in Table 4.1. The research question driving the interpretation work was:

How do psychologists in Aotearoa NZ perceive the practice of adventure therapy (AT)?

Themes and subthemes are presented in overview and then described in more detail. Participants have been identified with pseudonyms that are reflective of gender only and quotes provided to illustrate key points.

Quotes have been edited to aid readability. False starts, hesitations, repetitions and filler words have been removed. An ellipse (…) represents areas where non relevant text has been removed to shorten excerpts. Occasionally, connector words or reference words are added in square brackets to aid comprehension. Care has been taken to ensure that these additions do not change the intent of the quote.

Table 4.1

Themes and Subthemes

Theme	Subtheme
1: A Canvas in Which to Do Your Work.	1.1: Transitions: To Adventure and Back.
2: Risk-Wise Therapy	2.1: Navigating Behavioural Complexity
	2.2: Evolving Risk Profiles
3: Beyond Four Walls: Psychologists in AT	3.1: Expanding Skillsets into the Outdoors
	3.2: Career Paths and Availability
4: Where to from Here?	4.1: Below the Radar
	4.2: A Bit More Than a Good Time

Theme 1: A Canvas in Which to Do Your Work

Participants conceptualised AT as creating a therapeutic space, somewhat separated from real life, where mental health and behavioural improvements could take place. The metaphor, "*then you've got a canvas in which to do your work"* (Earl) was useful in that it reflected that AT was not reality but that it was a constructed space. AT could paint a picture on the canvas, its details determined by the therapeutic environment, therapeutic elements and client characteristics.

The pattern of data that supported the creation of a separate space involved three main concepts. The first was a sense of movement whereby the client shifted from one reality to another. For most of the participants, this was a physical change where travel away to the programme setting was required. There were common references to travelling away *"they liked coming away,"* (Tasi) or *"you take people away"* (Earl). This sense of movement highlighted the physical separateness of this space. It formed a boundary and distance between the client and problematic issues through being *"taken away from all the devices"* (Dave) or in some instances travel *"took them away from their drugs"* (Earl).

The second pattern of data supporting the concept of a separate space, different from every-day-life, was created through the idea of novelty. Novelty was provided by the AT setting. Clients, normally immersed in urban surroundings, were presented with a natural environment as a part of their therapy. Clients expressed surprise because "*they've never seen scenery like that"* (Tasi). Novelty was also provided with how activities were crafted for clients or through the challenges presented in those activities. Activities were presented where "*the focus is more on trying something new"* (Emily), and experiences for clients were *"something outside of the norm"* (Mel), or *"outside the typical mental health kind of box"* (Emily). Ideas of novelty stood in contrast to ideas of normality in clients' home lives.

The third element in the data defined a perimeter associated with the therapeutic space that only existed for a *"limited time"* (Chris). This boundary was associated with a pattern of temporal references. Associations were made with the length of time that the programme ran which for some were *"seven or eight days at a time"* (Chris) or *"one day a week for eight weeks"* (Kelly). In general, time was equated with therapeutic power, *"more time is helpful for more trust"* (Kelly). However, time periods were constrained in that there were *"specific time limited focused interventions"* (Earl) and it was a *"concentrated amount of time"* (Chris). Finally, the endpoint of the AT programme was also another time related boundary where it became *"time to go home"* (Tasi).

Once formed, the space was imbued with therapeutic elements. Participants presented each of the elements as having its own separate therapeutic qualities. There was a connecting idea that these *"components"* (Mel), or *"streams of work"* (Chris) were modular and could provide positive benefit to clients either by themselves or in conjunction with each other. On the other hand some conversations worked to make these elements indivisible by using terms such as *"holistic"* (Emily) or *"whole model"* (Chris). Yet, it was common to have such opposing ideas as modular or holistic approaches expressed by single participants at various times in their conversations. This dichotomy of thinking was particularly prevalent in references to nature where at times it was related to use as an inanimate setting for adventurous activities:

> *"The key part of it is, getting outside, usually in nature and doing something that involves some level of challenge or risk."* (Emily)
>
> *"You're using adventure activities to build confidence and to challenge, (…) being out in nature has a lot of advantages as well."* (Dave)

When nature was conceptualised in a wholistic sense it was viewed within a relational web, sometimes connected with an indigenous paradigm:

"Like for example, [the] Te Ao Māori perspective that our well-being is us, connected to other people, connected to the environment. Being in sync with nature, understanding things." (Emily)

"A lot of people connect with nature spiritually rather than just all these functional ways." (Steph)

Consistent with the idea of a relational web, social relationships with others in the AT space were seen to be an important therapeutic aspect. Activities were not just a personal experience and the relationships formed within groups and with facilitators could provide valuable feedback:

"So there was a lot of, like, empathy and support building between group members, relational dynamics between the people that you were [with]." (Steph)

"The other people on your team, (…), well, they're gonna give you some feedback and they're gonna give you some support. And they're gonna tell you some stuff that I could never tell you." (Chris)

Participants also referred to fun and play as important therapeutic elements of AT. Fun and play worked to engage clients but also allowed a respite from harder therapeutic work.

"Let's have a break, for fun as well, after that big disclosure." (Tasi)

"I think that the aspect of play is really important in a therapeutic sense." (Mel)

"It's a combination of (…) having a bit of fun (…). A lot of our boys have never been in a kayak or done rock climbing and they love it. They go, 'we should do more of this'." (Tasi)

Cultural layering into the therapeutic space was seen as important for *"different cultures to get to know each other"* (Dave). Here, there was an idea that by bringing diverse cultural representation together, tolerance for differences would result. Culture was linked to the physical space when a kaupapa Māori approach was taken. AT might take place on a marae

with a focus "*to connect them to their culture"* (Chris), with the marae becoming part of the therapeutic space and part of the cultural therapeutic element:

> *"When we are working with young Māori, particularly taking them into a cultural space which actually begins to connect them, with their culture, sometimes directly with their whakapapa. (…) If they've been to their marae, if they've got a connection, then that increases their resilience."* (Chris)

Cultural practice was included as an important facet of activities. As described by Emily, approaches would include *"Tikanga Māori"* (Māori customs), "*te reo Māori"* (Māori language), *"whakataukī"* (proverbs), *pūrākau* (important stories), and "*carving and waka ama"* (canoeing in traditional craft). In the Pacifika cultural context, traditional activities such as cooking with an umu (underground oven), using a Pacifika language and sharing stories were part of the connection back to culture and identity.

> *"And our young boys wanted to learn, 'well, we wanna learn how to do a umu', (…) bringing in the cultural component. (…) You heard the laughter, a lot of narratives, a lot of stories were told (…) and so there was a lot of skills based stuff."* (Tasi)

Connection to land was another concept that was raised and has a connection with indigenous cultural thinking. Land was framed at times as rich in meaning or as an important aspect of identity through whakapapa (genealogy)

> *"It's his land, and he can talk about, you know, the chief's bones up on the hill and tell stories of that place around the campfire"* (Earl)
>
> *"The space and place we're going, they have [a] whakapapa link back to it. And so, there's definitely that link back to the whenua the land"* (Chris)

Talk therapy tended to be conceptualised as integral but another separate element of the AT programme. Therapy was presented as being like that practised traditionally by psychologists with the AT space as *"just another context for therapy"* (Chris). Participants regularly framed therapy as independent from the adventurous outdoor activities by using

descriptive phrases such as, *"talk therapy part of the program"* (Mel), the *"therapy component"* (Kelly) or where therapy was *"an adjunct to what was happening"* (Dave). For some, talk therapy was divorced from the outdoor adventure elements in AT to the extent of conducting it in *"the lunch hall of a camp."* (Steph). In this vein, therapy was depicted as indoors with other elements of the programme contrasted as *"getting out [and] doing some adventure work"* (Tasi).

In creating the separate AT space as a concept, participants recognised that transitions to its therapeutic environment and back to client's real lives were an area of focus.

Subtheme 1.1: Transitions: To Adventure and Back

The subtheme, Transitions: To Adventure and Back reflected the concept that preparing clients to enter the AT space and subsequently to leave it and return to their home lives was as important as the therapeutic process that occurred during AT itself.

> *"You have to really have a good build-up and really prepare the boys."* (Tasi)
>
> *"So any programme where you take people away, it's important how you put them back."* (Earl)

Transition work was framed as so important, that if not done, it was likely that clients would not transfer learnings and would *"go right back to the old behaviours"* (Dave). The transition to AT took the form of preparation of the client group. This might look like therapy or coaching them to be less dependent on their current environment, such as*, "Predominantly working on a theme, giving a go at reducing their cannabis use, but also building up emotion regulation skills"* (Emily).

The need for transitioning was also due to the stark differences that participants saw between client home environments and the AT environment. Participants drew distinctions noting that the *"influence of the environment is very strong"* (Dave). The AT space was seen as a *"really positive environment"* (Emily) but often language around clients' everyday lives indicated environments that were unhealthy, *"deprived"* with *"complex family dynamics"* (Steph) or *"dysfunctional"* (Dave).

The way that concerns around this transition were expressed, made the work in this area appear almost as important as the AT work itself, "*So I, I, do feel tension (…) to consider how to extend the experience they've had today into their life situations"* (Kelly). The process of linking the therapeutic space with the clients' day to day environment was seen as trying to provide an "*integration between whatever you do in the outdoors and, how you bring them back"* (Earl). The integration approach between these two spaces was variously described as, "*the right sort of support*" (Tasi), *"[therapy] sessions post journey*" (Emily), *"whanau work"* (Chris), or *"setting up a Facebook group"* (Mel).

Another approach to promote integration was where programmes were held in the community and clients *"do an activity and you go home and you come back next week"* (Earl). The approach helped soften the physical and temporal boundaries by having programmes as multiple events, closer to homes and for shorter periods of time.

Theme 2: Risk-Wise Therapy

Risk was a pervasive idea throughout participants conversations. Participants expressed accepting, managing and using risk in the process of therapy. *"Anytime you have adventure therapy, you've got risk"* (Dave). Risk was presented as a multidimensional state that was managed towards something termed as *"safe."* Here, there was a tension that existed, *"Number one, do no harm, you know, as most basic as, don't injure or kill anybody."* (Chris)

Despite the overwhelming drive towards the safe state, *"we've gotta make sure everything is safe"* (Mel), there was value seen in risk and challenge and in using *"activities that can be dangerous"* (Dave), to build confidence and trust. Balancing these aspects of risk and safety were seen to be a core attribute of AT. *"Holding that risk"* (Steph), was acknowledged to be a *"challenge"* (Steph) in the practice of AT. On the other hand, participants were also acutely aware of the consequences of getting the management of risk wrong in an outdoor environment:

"That tragedy up North, recently in that cave (…)it makes us all, take pause (…). You can't take your eye off that ball." (Chris)

Two different dimensions formed the basis of risks referred to by participants and for each of these dimensions there were various ways of managing risk towards a safe position. Physical risk was associated with being outdoors and participants tended to conceptualise the outdoors as *"not a safe environment"* (Earl). This was reinforced with notions of the outdoors being a place of *"so many deaths"* (Kelly). Physical risk was also associated with the outdoor activities themselves such as rafting, *"If they're on a big river, for example, it can be dangerous"* (Dave).

In addition to physical risk, the presentation of psychological risk was also referred to. Particularly risks around clients and what experience they might be bringing into an AT programme. Recognising the ubiquity of trauma and what that might mean was a key step in managing psychological risk, *"the therapist themself need to have the trauma informed understanding to be able to safely hold a young person"* (Kelly). Although therapists were expected to be trauma informed to manage these risks, there was an additional expectation that risk mitigation had to touch all levels of the programme:

"Trauma informed care starts from the top. It comes from the policy, from the structure, everything that you think about should be informed by the idea that some people have traumatic backgrounds." (Steph)

AT was seen as having some strong characteristics with which to address trauma. Part of it was the physicality of activity, fun and the use of challenge:

"In the trauma space there's some huge opportunities in terms of people getting the strength back in their bodies and backing themselves and, doing that physically as a step towards doing that emotionally." (Earl)

"Then the focus is more on trying something new, having fun, rather than, I don't know, traditional exposure therapy" (Mel)

> *"You don't want to trigger somebody (…) You want to find something that they could probably do within their limits, or slightly outside their comfort zone. You're making friends with your nervous system when you're doing something adventurous"* (Mel).

The risks of operating AT were well understood and respected by participants. There was a flavour in the conversations that exhibited confidence in the ways risks were managed. Being safe entailed making *"an investment in (…) the right safety management procedures"* (Chris) and the outcome was programmes, run by people who could, *"prove they are safe operators"* (Kelly). One effective model that was seen as preferable by participants was outsourcing the management of physical risk to outdoor instruction organisations or "*to outsource your programme to qualified outdoor people who have risk [management skill]"* (Kelly).

Subtheme 2.1: Navigating Behavioural Complexity

Interpreted from within ideas of risk was a thread reflecting that AT had a natural affinity with moderate to severe behavioural issues. Often clients exhibited high risk behaviour and some had already been involved with the justice system.

> *[The programme was] "a kaupapa Māori alternative to prison for youth. You know, there were some hard-core offenders out there"* (Earl)
>
> *"Our journeying, at this time, is actually targeted at young people experiencing some quite high degree of challenge"* (Chris)

Behavioural risk was highlighted with direct references to the clients, such as them being *"complex and risky"* (Chris) or those that *"had engaged in harmful sexual behaviour"* (Steph) and that exhibited *"dysregulated behaviour"* (Steph). AT was also cast as a way of dealing with this end of the behavioural spectrum with references to it being*, "drug-free"* (Emily) and in some instances a *"boot camp"* (Dave). In one instance AT was selected because there did not seem to be alternatives:

> *"A matter of the case manager being like, 'I don't know what else to do, maybe this is the thing that will work (…) there's nothing else, she's not ready for a more sit-down talking programme."* (Kelly)

AT journeys or camps appeared to be attractive for the more severe behavioural presentations because programmes had inbuilt behaviour risk mitigation. For example, there was an element of isolation *"[The programme] took them away (…) onto the island"* (Earl), and control *"Once they're there, they're contained"* (Dave), where camps were run away from urban settings and staffed 24 hours a day. In the worst case AT was simply a container to hold clients in a controlled environment, for a time, regardless of treatment:

> *"The director even admitted to me, he says 'well nothing else is happening, at least I've taken them out of their environment for a few years and they're safe'."* (Dave)

In working with these behavioural presentations, participants reflected *that "engagement I think is, is really important"* (Earl). Kelly also noted that clients had to have a *"readiness to change"* and that they had to be at a certain *"willingness to push themselves."* Dave noted that therapy was more successful when clients were *"motivated to make changes."* Stimulating this engagement was seen as a strength in AT and then, once engaged, a therapeutic path could be navigated:

> *"But how do you engage that person and I think one of the tools (…) is some outdoor activity."* (Earl)

> *"So they might get into a situation and really feel overwhelmed and that might be angry or it might be, you know, wanting to quit, or something. (…) if you have really skilled staff, then I think they can take that person on the journey and help develop better coping strategies, help them with emotional regulation."* (Kelly)

But sometimes programmes were unable to deal with the risk level and so the risk mitigation was to return the client home:

> *"There has been an occasion where one boy just went amok and so he was pretty much a high risk. And so the camp continued, but the boy had to be sent home."* (Tasi)
>
> *"Their disruptiveness was impacting on the quality of the day for the other five who were engaged and committed so we, we took those ones home."* (Kelly)

Subtheme 2.2: Evolving Risk Profiles

Another pattern in the data highlighted changing AT practices to reflect more modern approaches and society's lower tolerance to risk. For participants that had direct or indirect knowledge of the history of AT, there was an acknowledgement that past practices were unacceptable by today's standards. Yesterday's solutions no longer worked with the problems being experienced by clients today. Dave reflected on the *"complexity of modern life,"* by inference implying that the issues that were faced in previous times were simpler to deal with. Other historic practices were left behind as they *"didn't have the same value and impact anymore"* (Steph) or practices were changed *"based on some of the research"* (Tasi). These sentiments reflected AT keeping pace with evidence-based approaches and evolving its practice in parallel with new knowledge generation.

Sometimes hints of nostalgia were expressed for past practice and a higher tolerance of risk, implying that modern day health and safety practice had gone too far. There was tension in this space where participants recognised the need for improved practices but where nostalgia presented the past as a more golden age. These conversations focused on the positive aspects, perceived freedom and simpler environment, *"I didn't really care. I just did it. No one really knew and, and they loved it, kids loved it"* (Earl). References might be prefaced by comments such as "back in the day" or they might be rounded off with the comment such as "you'd never be allowed to do that now."

> *"Back in the day we, we had youth group leaders who were outdoorsy and so that's something that's changed as a result of so many deaths in the outdoors, the need to be a qualified instructor."* (Kelly)

"you'd never be allowed to do that now, but we, (…) had a little OPC-style confidence course outside in the hospital grounds using tree stumps they had to get between" (Earl)

Generally the discourse around historic practice acknowledged that previously, gaps in risk management existed, yet there was also a comment on the improved modern health and safety approaches as being stifling to AT practice:

"Now you would have to pair that with an instructor because you know, of all the, health and safety stuff. So, that just becomes a bit hard." (Earl)

"But it got to the point, like I mean health and safety and the way that regulations work at one of the camps, there's a flying fox and they used to be able to use that. But now you actually have to be like a trained person to put a kid on a flying fox." (Tasi)

In addition to physical risk management, some past psychological practices were seen in the light of modern improved knowledge as poor practice. For example, the use of conflict or some approaches to the treatment of harmful sexual behaviour:

"Like, made it almost certain there would be some sort of, you know, conflict, (…). Whereas we just don't do that anymore. We just think that's completely inappropriate." (Chris)

"If you looked at it now, you'd think it's atrocious. Like the model for intervention was just not, at the time it was correct and right, but now we know that actually those things are not effective." (Steph)

Theme 3: Beyond Four Walls: Psychologists in AT

A common idea across the data was how psychologists integrated AT in their practice. Participants categorised their own AT origin story in terms of a passion for the outdoors, or training in therapy. Participants also referred to commonly perceived notions of traditional psychologist's identities with references to the *"four walls and the therapy room"* (Tasi).

Origin stories of how participants came to AT were revealing in that they gave insight to the relationship that the participants had built with outdoor activity. This relationship impacted on how they saw approaches to AT practice. Origin stories were characterised by whether the participant had developed a relationship or expressed a passion for the outdoors.

> *"I did outdoor pursuits just out of personal interest in in my 20s"* (Kelly)
>
> *"Some of the coolest things I've done is like I remember taking Year Five primary school kids out on Black Magic on Whakapapa and, you just come back and you think that was just awesome."* (Earl)

And there were others that were not as comfortable the outdoor environment, *"I'm not overly fussed about nature. [laughing] I mean I it's so bad, it sounds bad. I'm a real city girl."* (Steph)

Passion for outdoor activity was an indicator of how participants related to working with AT. Those with an early passion tended to have been attracted to AT as a modality, and wanted to stay involved with AT because it combined two passions*: "This is a dream job because I can do both of them [outdoor activity and psychology]"* (Kelly).

Some participants framed AT as being preferable to psychologists with a passion for the outdoors in that it freed them from what they saw as the confines of professional identity, structure and space.

> *"I kind of jumped at that opportunity because that gets me outside of a therapy room"* (Mel)
>
> *"'Oh, yes, I'm a psychologist'. I just thought that would be really fun, nice thing to do because I love surfing and sharing that with other people and being outside and in nature and outdoors and doing something that way, just sounded like a really good idea."* (Mel)

However for those that had not built such a relationship there was support for the impact that AT had:

> *"So there's some magic work that, that is done and I would definitely endorse it"* (Tasi).

"I think the benefit of something like adventure therapy is that you are, focusing on, self-regulation, emotion regulation (…), being able to actually deliver, live messaging in a different context." (Steph)

Subtheme 3.1: Expanding Skillsets into the Outdoors

There was a thread of thought serving to highlight that to practice AT required psychologists to move beyond the standard skillset.

"You know, you've really got to be able to join the dots between the talk of the activity, the practice of it in session and the practice of it in an outdoor environment. (…) and I think that's probably a bit of a skill." (Earl)

The additional skillset of outdoor instruction was commonly identified as necessary for AT practice. This extra training was seen to take several years of work and for which there were no clear training paths. Participants framed those that had achieved the multi-skillset as rare.

"I think there are so few people who are psychologists and outdoor instructors. There's so few." (Kelly)

"People with a broad range of skills, not only like therapeutic kinds of skills, but also health and safety or the level of skill, whether it's biking or whatnot. So yeah, I think maybe that would be the challenge, that a lot of people don't have both." (Emily)

While there were examples with of where this had been achieved, predominantly participants referred to a skill split between therapy specialist and outdoor instruction specialist in a collaborative model:

"*If you've got the experts doing the psychology and doing the adventure therapy altogether, I think that is a nice mix"* (Kelly).

"For the talk therapy part, the surf instructors didn't participate. They were just there for the surfing component, but for me I was there facilitating the group therapy, mental health side of things" (Mel)

Even with collaborative models, new skills were required for psychologists which, while paving the way for improved therapy, could be uncomfortable at times. On an AT programme the therapeutic relationship was seen to be different and potentially more nurturing:

> *"Because you're also with young people longer and it's not in a room with the kind of, you know, I'm the clinician, they're the client, that kind of thing. You get to connect on a different level."* (Emily)

> *"I think in some ways it's a little bit like being a parent, how you need to be loving and encouraging and supportive. But you also need to have boundaries or limits, so that you're seen to be competent and caring."* (Kelly)

This personal involvement and maintaining boundaries could be uncomfortable with the disclosure of more personal details than was normal:

> *"You also need to have a separation of appropriateness and that actually, I'm the clinician and you're the client and we're not friends. Some of that is around professionalism and in the context of sleeping and staying over for three nights and being in casual clothes, is actually quite challenging."* (Steph)

Subtheme 3.2: Career Paths and Availability

Participants' conversations reflected notions that traditional psychologist career landscapes were not aligned with practicing AT. In gaining specialist training in psychology there was an indication that using highly trained psychologists for more generalist activities in AT was conflicting when the need for traditional psychologists and therapy was so great, "*Look, we don't have enough psychologists here"* (Dave). Some participants pointed to generalist roles, such as counsellors or social workers, that were involved in AT indicated that specialist psychology work might be limited. The use of psychologists in AT programmes seemed to come up against some consistent ideas regarding systemic barriers of accessibility and availability. Participants indicated that their specialisation pulled them away from AT work:

"If you do clinical [psychology] then you actually are becoming like quite a specialist tool and, you're really not going to be doing that [AT] work." (Earl)

There was also the line of thought that revealed that the high demand for clinical psychologists in the traditional roles meant that AT work could be done by other practice areas or other mental health professions:

"And actually, we're lacking. We need more clinical psychologists to do that [clinical role]. Maybe the question can be asked, well does a clinical psychologist also need to be doing adventure therapy or can other professionals do this?" (Emily)

Some participants observed that much of the work was not psychology and could be done by other professionals. They referenced advertisements for AT practitioners giving a range of professions that would be acceptable:

"If the job would employ a psychologist or a counsellor or a social worker. Then you know you're not going to be doing psychology in that role if anyone can do it." (Kelly)

Ideas of the limited abilities of non-governmental organisations (NGOs) to pay at market rates, led to a general impression that AT programmes might struggle to fund psychologists:

"It's not competitive for psychologists at all, so you have to take a massive pay cut. So yeah, that's because NGOs generally, unfortunately, are paying below [market rates]." (Emily)

"They might train, they might do their time in a DHB and then find themselves to private practise. So that might be another factor, that it's [AT is] less attractive from that point of view. It doesn't pay as well" (Chris)

There were also expectations of psychologists in terms of efficient time use that may not sit well with AT practice. This efficiency related to the pressure in a 50-minute slot for a client with multiple bookings and how to fit immersion in nature within that time:

"I mean, we have 50 minute sessions, trying to see, you know five people a day. Even walking somewhere to be around nature, you know, it's going to be challenging." (Emily)

"Then you're got a client. When you gotta practice and you've got back-to-back sessions, it's probably a bit impractical to take off to the beach." (Mel)

The pressure of efficiency was related to industrial mental health processes and served to exclude AT's use:

"We're so sort of focused on efficiencies and I have to account for 75% of my time, directly clinical work. So, if I was to go down to the mountain bike park, well, there's 20 minutes just getting there [laughs]. So we just become so driven by this factory efficiency thing that means that we work out of our offices." (Earl)

Theme 4: Where to from Here?

This theme was underpinned by participant references indicating that the practice of AT in Aotearoa NZ was still developing. It had not yet been formalised as a therapy where there was standard documentation or the presentation of defining research on underpinning theory and process. Steph indicated her practice consisted of a historic in-house model that *"we all had to follow."* This resulted in her not having knowledge of *"the mechanisms of what it [AT] is intended to do."* She compared AT to talk therapy in that with talk therapy *"we're all trained in that and we all find that really comfortable."* Her words constructed a comparison of talk therapy, where training and documentation gave certainty to process and expected outcomes while with AT there was little support. For Kelly this need for development and documentation showed as a *"big gap between our current practice and my ideal how adventure therapy, might be used."* Her reference here came about as there was no clear standard governing her AT delivery. Kelly's approach relied on past practice that conflicted with her ideas about how it might be improved.

There were concerns about having empirical evidence to prove what positive effects were being observed. Kelly raised that she didn't *"analyse the data that we have collected"* and this left her *"torn"* in that she didn't *"completely believe how effective it [AT] was."* Earl commented that he thought that AT got a *"mediocre effectiveness rating"* but that it was hard to

"compare apples with apples." Mel commented that she *"wasn't too familiar with the literature."* Most participants saw that further research was necessary to address these concerns and to document what Earl referred to as the *"secret sauce programme"* consisting of a presentation of *"this is the research, this is the technique, this is how you do it."* Kelly expressed a desire to understand *"what makes it effective"* and that she saw a more research-informed future with *"more work being done at that academic level."*

Many participants felt that there was room to develop the involvement of more psychologists in AT programmes. Science practitioner thinking, improved theoretical approaches and rigour underpinned some of the reasoning:

> *"Bringing the science to the practice is something that psychologists would be known for, and I think that's something that's sometimes missing."* (Earl)
>
> *"I think psychologists, we do a lot of training and we have a lot of knowledge of theory and we have good understandings of difficulties and formulation and best practise interventions."* (Kelly)
>
> *"So, I think what we're good at, as psychologists is having a really clear model of practice, a very clear rationale. You know, we're really hot on evidence-based [practice]. I think there's a degree of rigour that psychology can bring."* (Chris)

In addition, participants reflected that AT was a successful treatment approach and that they had seen improvements in clients on their programmes:

> *It was in their own words, life changing for them. The belief in themselves really, really changed. Like they started to think they could do things and they were hopeful and they were proud of themselves."* (Emily)
>
> *"You can see the difference. You can see the camaraderie. (…), they went out young men and came back more mature, taking responsibility as well. You know it's amazing*." (Tasi)

Participants saw that the ability to create a therapeutic intensity moved clients forward at a faster rate than might be achieved if the same therapy time was spent in weekly sessions. While the volume of available therapy hours was referred to, the milieu of therapeutic elements made the time more concentrated. This concentration of elements made progress *"far faster than what they would [do] just with traditional, talking therapy alone."* (Emily):

> *"We made an immense amount of progress quickly, (…). So that the progress that she made in that space was significantly quicker than we could have made if we'd have been working, one session a week."* (Chris)
>
> *"Because it's full on days, you're getting up early, you're, you're doing a lot of exercise, you're doing a lot of stuff."* (Emily)

Although there was a general pattern of conversation that AT needed further work to be more generally accepted, most participants believed that its future appeared to be one of growth:

> *"I, think the future is hopeful, I think there is more work being done at that academic level, (…) So there is more of a spotlight being put on it."* (Kelly)
>
> *"Everybody wants to keep maintaining their [surf] program or expanding it. (…) everybody's supporting each other, to keep going and be able to access funding or knowledge about how you do things. So I think it's probably going to get bigger in the future."* (Mel)

Subtheme 4.1: Below the Radar

The subtheme, Below the Radar, related to participants impressions that AT was not a well-known approach or was not even known by participants as AT.

> *"Not everybody really knows what, [AT] is and what that looks like."* (Mel)
>
> *"I'm relatively well connected with the psychology community. (…) I don't hear anyone talking about it [AT]."* (Steph)

"When I googled it and I was quite surprised that, you know, there was such a thing as adventure therapy. It, had just never entered my mind." (Tasi)

AT was compared with the dominance of CBT because of CBT's position in American research and Western framing. In comparison people didn't know about AT because it's hard to develop *"a robust standing in the field because of that [American] approach"* (Steph). The notion of dominance through power and funding allocation was also referred to by Emily. She saw that power structures determined the allocation of money to research and services and that this was shaped by Western models. *"I don't think there's any disadvantages of the therapy. It's just the disadvantages of our Western model of mental health and government"* (Emily).

To raise the profile of AT, communication about AT and its benefits were seen to be a key area to supporting the ongoing development of the practice:

"Actually, communicate more effectively about what it [AT] is and, and what [it] is not, and what its advantages are, and what it does and what it doesn't do. In a sense, demystify what adventure therapy is. So that it's no sort of magical, mystical kind of low level, loose, you know, go out and have a bit of fun, but that it's genuinely, therapy." (Chris)

Subtheme 4.2: A Bit More Than a Good Time

As shown by this previous quote AT was often framed as a recreation activity as opposed to a therapy. Sometimes AT was described as activities that schools or youth organisations provided:

"The kids would be able to play spotlight and stuff like that in the evening. So it was like a school camp, integrated with this idea of therapy." (Steph)

"Like all kids should be doing stuff that you can say is adventure therapy. For example, I did Girl Guides. You could say, Girl Guides is adventure therapy [laughs]." (Emily)

However, the flippant humour by Emily underscores the point that the concept of AT is still closely related to recreation, potentially devaluing it as a recognised therapeutic approach.

Participants often mixed the idea of AT with their own love of adventure or with recreation. Mel's initial attraction to AT was because of her passion for surfing and she thought it would be "*fun*." Dave referred to AT as a *"recreational activity that has a lot of advantages."*

Stories of outdoor recreation being mixed with views on AT occurred in other settings. For example in one account of AT, it had been badged as "goodies for baddies" reflecting one organisation's view that AT was a reward and not a therapy.

> *"I think that there becomes this whole goodies-for-baddies kind of thing with, when adventure based stuff is discussed, you know. When I suggested we put a high ropes course in the youth, offender [unit], that was definitely what came back."* (Earl)

At the other end of the recreation spectrum was some framing of AT with punishment, an alternative to prison that came from outdated ideas:

> *"A lot of damage can be done in bad programmes if kids are made to feel ashamed [hmmm]or worse, about themselves. Some of the so-called boot camp programmes, probably even make kids worse."* (Dave)
>
> *"Even if you look at the boot camps that were set up by the last National government and seemed to be coming back (…) first of all, it's about this attitude, which hasn't changed since the Second World War, which is what kids need, is discipline and structure, and the military is the place to do it. So, you know, that attitude hasn't changed."* (Earl)

Chapter Summary

This chapter presented the results of the reflexive thematic analysis. Four themes were interpreted from the data: A Canvas in Which to Do your Work, Risk-Wise Therapy, Beyond Four Walls: Psychologists in AT and Where to from Here? Each theme had up to two subthemes which further developed nuances in thinking of the four key areas. The themes were explored and relevant excerpts from data were drawn on to explain and demonstrate the details of interpretation by the researcher.

Chapter 5: Discussion

Chapter Introduction

This section provides an initial summary of results interpretation from Chapter 4 themes (see Table 4.1) followed by a discussion of how the findings are contextualised within existing research and theoretical models. Implications and contributions from the study in terms of utility, efficacy and barriers are then examined. The research question that guides the discussion in this section is:

How do psychologists in Aotearoa NZ perceive the practice of adventure therapy (AT)?

This chapter, unlike preceding chapters does not have a summary, as this function is contained within Chapter 6: Conclusion.

AT Forms a Therapeutic Space

The results from this research showed that participants perceived AT practice as creating a separate therapeutic space. The therapeutic space consisted of elements including adventurous activities, nature, group work, fun, cultural practice and talk therapy that each provided therapeutic outcomes. Talk therapy itself was used in an adjunct mode and could consist of traditional evidence-based psychotherapy approaches. The patterns in the conversations reinforced the notion that the therapeutic space was apart from a client's everyday reality. Transition concepts highlighted the importance of the way those two spaces were connected for the clients. Transitions to AT prepared clients, stimulated engagement and gave clients tools to use during their AT experience. The transition home was integral in terms of transferring learnings from AT back to clients' everyday lives. This process ensured that change was embedded into a client's behaviour or emotions.

The notion in the participants' conversations that AT's separate space, created through physical distance, novelty and temporal bounding has reflected similar thinking in the literature base. The OB Model (Walsh & Gollins, 1976) placed the client in a unique physical environment. This environment had to contrast with everyday life and be unfamiliar so that new

perspectives could be generated. The outdoors was referred to as “an excellent lab” (p. 4), the word lab accentuating the physical separation and novel discovery element of the AT space. Furthermore, the element of time boundaries was accentuated by Russell and Farnum (2004) in their presentation of the wilderness therapy model. They presented an intensity versus time plot where initial and final contact with the wilderness represented the time axis within which the model operated. Russell and Farnum described that “being away” was important because “attaining distance from daily stress allows the psyche to recover from cognitive overload” (p. 42).

Nature or the outdoors was represented in the participant conversations as having dual roles as an inanimate setting or a relational entity. Walsh and Gollins’ (1976) described the outdoors as “neutral” (p. 4), typical of the literature placing nature as a setting. As an inanimate setting, nature was considered to be therapeutic in of itself. Attention restoration theory posits nature as full of captivating objects and processes that provide opportunity for soft fascination. Soft fascination holds contemplation without effort and restores attentional fatigue (Kaplan, 1995). Stress reduction theory also positions nature as a setting, where exposure to natural environments helps restore emotional and physiological attributes, primarily due to evolutionary relationships (Ulrich, 1984). Using nature as a setting for AT, as outlined by attention restoration and stress reduction theories, is important because the theoretical constructs underpin AT models such as the wilderness therapy model and extend into ecotherapy models (Kotera et al., 2022).

On the other hand, the second representation of nature outlined in the results, as a holistic relational entity is assuming a rising prominence in the literature. The dual roles of nature, as a setting and a co-facilitator of change, is a developing concept when considering AT programmes (Brown et al., 2023). Brown et al. contended that an opportunity may be lost if only viewing nature as a setting. While this current study indicated that perceptions were formative in the relational entity space for participants, there is literature that outlines a more developed

view. Lewis (2017) found that some psychotherapists in Ireland and England positioned nature as another therapist representing “other-than-human” (p. 46). Those psychotherapists acknowledged the importance of nature in the therapeutic relationship. It is not clear how positioning nature as an “other than human” therapist fits with the scientist-practitioner model that exists for psychologists in Aotearoa NZ. However, research shows that nature-as-therapist is becoming accepted, is growing and is now starting to come into line with firmly established Te Ao Māori viewpoints (Horn, 2021; Phillips et al., 2022). These viewpoints, hold the interconnection of people with land and all natural things, and provide for spiritual relationships with those entities. These relationships establish a sense of self in a wider context and are fundamental to wellbeing (Boyes, 2010).

Participants identified adventurous activities as a core aspect of AT, consistent with existing literature (Crisp, 1998; Gass et al., 2020). Participants linked adventurous activities with challenge, risk and confidence. Walsh and Gollins (1976) placed the solving of challenges at the centre of the OB model as it produced mastery. Mastery results in the reorganisation of meaning and experience. The role of challenge is paralleled in Kolb’s (1984) experiential learning theory. Here, challenge is the context that allows previous knowledge to inform an approach, with the outcomes further informing new knowledge through reflection. Fernee et al. (2017) reflected that challenge, when resolved, acted within the physical self factor of the wilderness therapy clinical model to increase resilience, perceived competence and self-efficacy.

Newman et al. (2023), while acknowledging adventure as providing development opportunities, highlighted a modifying aspect in their characterisation of an adventure pedagogy. They proposed that to reap the benefits of adventure, the experience had to be intentionally processed and debriefed. The process involved facilitation where goals were,

> “to produce changes in peoples’ feeling, thinking, or behaviour (otherwise known as “learning”). These changes usually result from participation in some form of experience

ranging from passive (e.g., meetings, lectures, videos, books) to more active ones (e.g., simulations, role plays, action exercises, adventure activities)" (Priest et al., 2000, p. 6).

Facilitation was not a strong pattern in the participant conversations but has been enduring in the literature (Alvarez et al., 2020; Crisp, 1998). One likely reason for this omission in the findings is that in collaborative models referenced by participants, where a therapist and outdoor instructor work together, facilitation can be the responsibility of the outdoor instructor (Therapeutic Adventure Professional Group, 2023).

The role of groupwork was identified in this research as important for developing prosocial skills and receiving feedback. Groupwork is identified in the literature as being a specific element to support social development leading to behavioural improvement (Mohan et al., 2022). Groups are a key part of both the OB model and the wilderness therapy clinical model. In the OB model the group forms a unique social environment where individual decision making is supported. Group objectives, conflict resolution and reciprocity are key elements to facilitating higher levels of social interaction (Walsh & Gollins, 1976). Fernee et al. (2017) saw groupwork as a key influence on the psychosocial self factor in the wilderness therapy clinical model. Within this factor, group work operates to provide opportunities for self-expression, relationship development and the formation of trust. These in turn support pro-social thinking and are a wider support basis for treatment outcomes.

Interestingly, Fernee et al. (2017) identified that another principal element in groupwork was the relationship with the therapist. Yet, that relationship was not highlighted by participants in this current research. While the therapeutic relationship was a part of the conversation dataset, it did not assume the importance that it has received in the literature. The therapeutic relationship is presented as one of the more influential elements of any therapy approach (Wampold & Imel, 2015). One plausible explanation for this unexpected outcome in the findings is the power that the group situation brings to the therapeutic mix. Some meta-analytic work shows that the therapeutic alliance in groupwork, while still important, has less effect on therapy

outcomes than in individual work (Alldredge et al., 2021). AT literature also reflects the changing relationship and role of therapist towards being a facilitator (Horn, 2021).

Fun and play were identified by participants as another core aspect of AT. Participants saw fun as a way of clearing the air after difficult reflective work, engaging clients and as a therapeutic aspect in its own right. It has been recognised more widely that fun adventure activities can increase clients' motivation when compared to a traditional therapy approach (Wapple, 2013). Clinical applications of play in the outdoors have also been explored in the literature (Harper et al., 2019). Play has been connected to regulation and relationships through polyvagal theory (Porges, 2021). Polyvagal theory explores the role that the vagus nerve assumes in regulating the autonomic nervous system and its subsequent impact on social, emotional and wellbeing facets. The vagus nerve has a key role in determining reactions to perceived risk such as fight or flight responses. Harper et al. have noted that play is related to risk taking and can be an effective way of learning to deal with anxiety, grow social connection and regulate emotion.

Culture was identified as an important element in this current research. Participants recognised its therapeutic value in terms of cultivating a tolerance of diversity and fostering a connection to identity and place. These findings resonate more widely with the evolving recognition of culture as a therapeutic element in Aotearoa NZ. For example, research has established the links for Māori between a strong Māori cultural identity and improved mental health (Williams et al., 2018). The observations by Williams et al. regarding the detrimental impacts of racism on wellbeing align with the outcomes in this research supporting increased tolerance for diversity. In addition, literature has supported calls for the incorporation of Māori culture alongside Western techniques into AT to underscore values integral to adolescent growth and to provide an enhanced treatment approach (Ape-Esera & Lambie, 2019).

The findings of this current study outlined the use of traditional talk therapy in an adjunct mode with AT. This mode has received support from wider research showing that it produces

positive results (Pan & Zhuang, 2022). Pan and Zuang used an intervention based on cognitive behaviour therapy (CBT) principles alongside an adventure based program. The combination produced significant reductions in distress, stress, depression and negative affect. The approach was like that described by some participants in this study where therapy was conducted in a hall. CBT inside has also been paired with AT in weight loss programmes. CBT plus AT was found to be more than three times as effective as CBT plus exercise, for older adolescents (Jelalian et al., 2006). While ecotherapy models support conducting therapy outdoors because of nature's unique contributions (Revell & McLeod, 2017), the literature shows that an indoors approach to the therapy element of AT still adds value.

Conversations within this research expressed a duality of thinking about how the elements with the AT space interacted. The majority of data supported that these elements were separate and could act semi-independently. However, there was a persistent thread that called on these elements as acting in a holistic sense and were indivisible from each other. The literature reflects that reductionist thinking is typical of Eurocentric models of health (Feo Istúriz et al., 2023) and is pervasive in the models of AT (Phillips et al., 2022). Both the OB model and the wilderness therapy clinical model work to reduce the AT experience to a series of components. More worryingly, Eurocentric ideals work to extend colonial thinking and maintain privilege (Gauthier et al., 2021). In contrast, holistic thinking is one that is supported by Te Ao Māori worldviews and hauora (holistic health) approaches (Phillips et al., 2022). Phillips et al, have identified the Te Whare Tapa Whā model of health (Durie, 1985) as being a relevant holistic model. Te Whare Tapa Whā weaves physical, mental, family (or group) and spiritual elements together as the four walls of a meeting house on a foundation of whenua (land, connection to place). Phillips et al. are continuing to develop Te Ao Māori approaches to AT.

The notion of transitions to and from AT was highlighted as important to therapeutic success by participants. Concepts of transition from everyday life across a threshold to a special place where some transformation takes place and then a re-entry or homecoming has been

supported in the literature as the basis for rites of passage models. Transitions are also related to Joseph Cambell's Hero's Journey (Norris, 2011). The hero's journey represents the universal template across myths and legends for protagonists' journeys and transformations (Campbell, 2004). Rites of passage models are based on three steps, separation, transition and incorporation. These steps map neatly to the Hero's Journey stages of departure, initiation and return with both models represented in ongoing designs of AT programmes (Norris, 2011).

Participants have perceived the transition to AT as important from the perspective of engagement and provision of tools or skills such as debriefing and sharing. This concept of preparation is reflected in the OB model where building motivation and the ability to share sentiments is a pre-requisite to the course (Walsh & Gollins, 1976). Transitions home have been of interest to researchers (Tucker et al., 2016). Specific processes have been proposed to guide practitioners, clients and client families to preserve the changes and gains made in AT to the clients' home life (Hess et al., 2012). Transitioning home has been identified as an important consideration and as part of the whole treatment process. If follow-up is not comprehensive then gains are likely to be lost (Dobud, 2019). Despite the importance of transitions, some modern texts such as Adventure Group Psychotherapy: An Experiential Approach to Treatment (Alvarez et al., 2020), do not emphasise this aspect.

Risk Management in AT

The analysis of participant conversations highlighted the understanding that accepting, managing and using risk for the benefit of clients was an integral part of AT. It was conceptualised as physical, psychological or behavioural and was depicted as inherent. Risk was woven through the outdoor environment, the adventurous activities and within the clients themselves. Participants, through references to comfort zone models, perceived that physical risk could be split into actual risk and the perceived risk of the environment or activity. One psychological risk highlighted was trauma. The interplay between trauma and triggers was presented as an area to be treated carefully with trauma informed practice being essential.

Behaviour was seen as another common risk to work with because AT was a vehicle, in participants experience, used to address moderate to complex behavioural issues. These behavioural presentations meant that some clients had been involved in the legal system prior to their AT experience.

In addition, the results showed that management systems were key to running safe programmes by safe operators. Mixed within the data was a contrasting sentiment. There was a recognition that physical health and safety systems, driven by incidents and societal attitude changes, had needed to adapt. However, it was felt that safety related rules had, in some instances, gone to the point where they could be counterproductive. Despite this, it was acknowledged without argument, that psychological safety improvements had meant that fortunately, some undesirable practices had been left behind in history.

The premise in the results that risk is integrated throughout AT is well supported in the literature (Gass et al., 2020; Harper et al., 2019). Participants' perceptions that risk tended to be actual physical, perceived physical, psychological or behavioural is consistent with risk categorisations made by Gass et al. (2020). Ethical risk was not identified in the current study, as a strong area of focus across participants. This outcome was unexpected given the poor ethical practices associated with AT that have been highlighted in the United States and in Aotearoa New Zealand's history (Dobud, 2021; Nippert, 2021).

One viable reason for ethical risk not being highlighted is that, practicing psychologists in Aotearoa NZ are required to adhere to a code of ethics (New Zealand Psychologist's Board, 2002). Adherence to this code would be considered a high quality mitigation for ethical risk in practice. Participants may have considered that the ethical code ameliorated the risk to the point where it could be considered a low residual exposure. The approach of importing a therapist's own code of ethics into their AT practice through working within "their own professional boundary" (Jeffery & Hensey, 2022, p. 22) is suggested as an approach for all AT therapists in Aotearoa NZ.

Physical risk was the most referenced risk in the results. This appeared to be because the consequences of managing this risk poorly could be multiple injuries or deaths as highlighted by Brookes (2018). Outdoor programmes when they go wrong, feature in the press, as they often involve children or young adults. Participants in this research recognised that risk was inherent in the setting of the outdoors, the activities themselves and in the therapeutic approach. Participants voiced that as therapists in AT, they needed to be comfortable that these risks were managed.

The literature supports the findings from this research in expanding physical risk into two domains, actual risk and perceived risk (Newes & Bandoroff, 2004). Actual risk is an objective view of the combination of an outcome of an event and its likelihood. For example, rock climbing is low risk because of its safety mitigations such as ropes, belays, and backup safety systems. Perceived risk involves a subjective assessment of the potential for a negative impact from an activity. For example, a client feeling scared of falling and sustaining injury from rock climbing, regardless of the safety precautions (Davis-Berman & Berman, 2002). While participants in this current study did not refer directly to this split in definition it was implicitly understood in their conversations and by their references to comfort zone models that work with perceived risk.

Comfort zone models have three areas. The first is comfort, where clients feel at ease, the second is stretch, where clients learn from manageable challenges and the third is panic, where clients are overwhelmed (Brown, 2008). Perceived risk dictates a clients' comfort zone position, can be used for therapeutic effect, and is related to the therapy approach (Bandura, 1977; Gass et al., 2020). However, perceived risk must be managed to be appropriate to the client or client group (Davis-Berman & Berman, 2002).

Some participants in this research were at ease working with perceived risk to provide challenge and personal growth. In contrast, the comfort zone model has had some critique in the literature. Brown (2008) has suggested that there is little support for the comfort zone model.

A more appropriate approach was proposed that would recast the model as a metaphor and not a basis for activity programming. Brown's thinking has received support from others that have concerns about the use of risk in AT to drive change in clients. Pringle et al. (2021) suggested that the key to trauma informed approaches was to ensure that clients felt safe, emotionally, relationally and physically. They noted that past uses of perceived risk to challenge clients did not sit well with trauma informed approaches and proposed that ideas of empowerment and safety should underpin AT design.

The findings of this research also highlighted a need for trauma-informed approaches in AT. In addition, the findings indicated that careful use of the comfort zone model could sit alongside trauma informed approaches. This did not necessarily contradict Pringle et al. (2021) but advocated, in line with Carpenter and Pryor (2021), that psychological risk must be carefully managed to reflect that all clients may have potentially traumatic backgrounds. This study showed that there was a balance of wanting clients to be challenged just beyond their comfort zone, but not to the extent that trauma responses were triggered. Trauma informed approaches are at the forefront of development for AT purposes (Pringle et al., 2021). Pringle et al. have proposed a phased treatment approach that suggests AT experiences and experiential learning should have a focus on safety and stabilisation as primary. This can be done through achieving supportive group dynamics, using flow states, rhythmic activity and emotional regulation. Activities can be carried out with a particular focus on maintaining clients' arousal at low levels.

AT was linked to successfully working with adolescents on moderate to severe behavioural issues by research participants and this connection is supported by the literature base. Beck and Wong (2022) found that AT was promising as a justice system diversion programme. Hoag et al. (2014) found that behavioural issues were amongst the top two reasons for referral to AT in the United States. Mohan and White (2022) looked at AT's impact on violence, offending and reoffending and found that AT influenced positive outcomes. Mohan and White theorised that AT was effective on antisocial behaviour through challenge and,

development of self-worth and pro-social behaviour. These attributes were developed within group activities, separation from the clients' antisocial environment, and the therapeutic benefits of spending time in nature.

Participants in this research, expressed views of behavioural risk both in terms of actual physical risk, where non-compliance with instructions could put clients in danger, and psychological risk. Psychological risks could result in behaviour affecting the functioning or engagement of others in the group. In cases where behavioural risk could not be managed through therapy and relationships within the programme, the client would be returned home. The approach to behaviour management in Aotearoa NZ stands in contrast to the United States. There, physical restraint and seclusion to manage behaviour risk, is a regularly used technique in some AT or Outdoor Behavioural Healthcare programmes (Gass et al., 2020).

The findings underlined the necessity of a robust risk management process in AT programmes. The literature also reflects that risk management is a critical part of the AT framework (Gass et al., 2020). Reflected in this current study was the perception that psychologists were able to manage psychological risk but were not skilled in managing actual physical risk. Participants expressed a preference to partnering with a skilled outdoor organisation or instructor to manage actual physical risk. The wider literature supported this partnership approach although aspects such as confidentiality needed to be addressed (Harper et al., 2019).

Results in the study highlighting the increasing pressure on programmes and management systems to create safer physical and psychological environments, reflect ongoing ethical requirements to do no harm (New Zealand Psychologist's Board, 2002). However, findings showed that some health and safety rules could be detrimental to the programme. Findings that clients might be disadvantaged by over-protection are not unique to this research, although they have been more predominantly linked to parenting (Arslan et al., 2023). Brymer and Feletti (2020) have highlighted the multitude of benefits, physical, psychological and

spiritual of risk taking in adventure. In addition, risk continues to be seen as a general theoretical principle in AT that generates a psychological disequilibrium to enhance change (Richards, 2015).

AT and Psychologists

For some participants, motivation for wanting to be involved with AT stemmed from an independent relationship and passion with the outdoors that they had developed. For those that had not had the opportunity to develop this relationship, their experience of the positive aspects of AT generated support for the approach. Career paths into AT were seen as non-typical and required a motivation to be involved to navigate barriers. Skillsets in AT required further training for psychologists in outdoor instruction, which was seen as a rare combination. Alternatively, a collaborative model was highlighted, in which a psychologist co-facilitated experiences with an outdoor instructor. In this collaboration, the additional skillset development for a psychologist was focused on adaption of existing techniques rather than the accrual of new ones. The collaborative model was perceived by participants as being preferable to the multiskilled therapist concept.

The perception in this research that psychologists with a passion for the outdoors aligned with AT, is common with other AT practitioner profiles presented in the literature. Broader research on the attributes of AT therapists showed an alignment with the outdoors (Cooley, 2021; Revell & McLeod, 2017). Sharing a nature-based relationship with clients is seen to be an important part of AT. The sharing helps to create a deeper sense of self and a heightened sense of purpose (Charbonneau, 2016; Jordan, 2014). The research results showed that sharing a passion with clients aligned personal identity with professional identity. Charbonneau proposed that this enabled a more effective therapist and a deeper therapeutic relationship. The literature reflects that a therapist holding this relationship with nature is more comfortable in having nature involved in therapy as a co-therapist. Nature’s involvement can sponsor insights into relationships and can act as a pathway to therapy (Lane & Reed, 2023).

There are also benefits to the therapist themselves in working in the AT space. Benefits accrue as the work in the outdoor setting can be experienced as regulating and restorative (Charbonneau, 2016). These positive aspects might partially explain why those with a passion for the outdoors felt a motivation to keep practising or return to practising AT. This current research suggested that reasons for this incentive lay in several different areas. Firstly, some participants recognised the therapeutic power of outdoor activity through personal experience. Secondly, some participants personally enjoyed the activities encountered through AT. Thirdly, there was a recognition of the effectiveness of the modality and therefore satisfaction from achieving positive results.

However, the results showed that not all participants in this study had an active relationship with nature, yet they still saw value in AT. There is little in the literature that investigates this perspective. Still, it may be that this difference in relationship with nature accesses therapist motivation in an alternate way and results in a distinct but not less effective therapeutic alliance. In considering motivation through the self-determination theory, Ryan and Deci (2020) outlined that intrinsic motivation can be stimulated by interest, enjoyment and satisfaction. These can exist inside an AT practice through the therapy process alone and not necessarily requiring an interest or enjoyment of nature. Self-determination theory supports the notion that a therapist's motivation to practise AT does not require a passion for the outdoors.

The findings reflected that the therapeutic relationship between a client and therapist in the outdoors may be different to that traditionally experienced. The literature suggests that this different relationship has a more effective power sharing balance as the client can see the therapist as a real person. A higher level of power sharing takes place if both therapist and client experience the activity that is presented. Consequently the therapeutic relationship can achieve greater levels of collaboration (James et al., 2021). These changes in relationship were experienced by participants in this research and sometimes brought discomfort because traditional client, psychologist boundaries had moved. Schwenk (2019) validated this discomfort

and pointed out that the deepened intimacy needed to be managed with care so that an appropriate relationship with flexible boundaries could be maintained.

The findings showed that the participants in this study viewed AT as non-traditional by drawing out distinctions with typical therapy representations and career paths. The view expressed by participants of therapy in a four walled office compared to AT in the outdoors is one that has received attention in the literature. Typically, literature frames the tradition of conducting therapeutic conversations, as occurring indoors, although the likes of Charbonneau (2016) and Revell (2019) have challenged these assumptions. Both have promoted the benefits of outdoor work into the traditional therapy arena.

Perceptions of typical psychology career paths were at odds with career paths into AT. A typical path was described as, some time at a district health board (DHB) and then private practice. Private practice was seen as well-paying and a comfortable existence. In contrast, a career in AT was most likely as part of a non-governmental organisation (NGO). It was generally acknowledged by participants that NGO's, because of their funding models, could not compete in remuneration with either the DHBs or private practice. This difference made it hard for AT programmes to attract psychologists. The pay differential area is not covered in the Aotearoa NZ literature. Even so, findings from this research indicate that AT and the NGO organisations have turned to other allied health professionals to carry out therapy.

Participants reflected that time pressure and efficiency expectations, inherent in talk therapy, showed the practice of AT to be at odds with efficient time use drivers. Typical sessions of 50 minutes per client and five clients per day were juxtaposed with the relative inefficiency of going to and from the beach or, for a walk. These comparisons called to a 'McDonald's approach' to therapy where efficiency is prioritised over relationships (Strawbridge, 2003). Efficiency drivers act to limit opportunities to practice more holistic AT approaches where time is "operating at a different pace than the modern technological world" (Harper et al., 2019, p. 127).

The idea of expanding skillsets beyond therapy to include outdoor instruction type skills is commonly discussed in the literature (Gass et al., 2020; Jeffery & Hensey, 2022). The American Association of Experiential Education certifies Adventure Therapists and part of the skill base for this qualification includes both therapy and outdoor instruction skillsets (Association of Experiential Education, 2023). However, the results from this study have indicated that the combination of skillsets is rare. A preferred solution from participants saw the therapist and an outdoor instructor working together as an integrated team, an approach supported by Richards (2015). Participants reflected that in a collaboration, it was useful for therapists to still be involved with the adventure activities. Newman et al. (2023) suggested that this involvement would promote therapeutic relationship development during shared experiences.

Developing AT

The results of this study showed that participants had a perception that AT needed further development before it could be accepted as a mainstream treatment. AT was perceived as relatively unknown amongst psychologist circles. Competition for research dollars with the likes of CBT meant that it had not achieved the same profile. There was a feeling that in some respects all the right material existed to support AT but that it needed to be presented to showcase AT's scope and benefits to the therapeutic community.

The data also highlighted concepts that AT was in one facet, recreational and then in another facet associated with punishment. These representations work to reduce the validity of AT as a therapeutic approach. Participants reflected that improvements in documentation, empirical evidence and more involvement from psychologists would move the field of AT forward. Despite these needs for development, participants' impressions of AT painted an effective approach for clients, based on personal observation of success. Sitting behind this success was the ability of AT to create an intense therapeutic environment. The overall

impression of success and commitment from practitioners filtered through to a general view of a positive, growth-oriented future.

This research highlighted that AT suffers from a low profile in psychology circles. Wider evidence to support this perception, can be found from reviewing psychology training texts for Aotearoa NZ psychology students. For example, in Kaplan and Saddock's Synopsis of Psychiatry, or Prochaska and Norcross's Systems of Psychotherapy there is no mention of AT as a treatment (Prochaska & Norcross, 2018; Sadock et al., 2014). Internationally, AT has received high profile but negative attention as Wilderness Therapy has come under fire in the United States for unethical practice (White, 2011). The low profile of AT in Aotearoa NZ has been noted by other research (Jeffery & Hensey, 2022). Recommendations have resulted to develop the visibility of AT by strengthening the community of practice, enabling bi-culturalism and adopting trauma informed approaches.

There are parallels in the United States to the finding in this study that AT has struggled to gain research funding. Funding and creating a body of research to support AT has been a key focus of the Outdoor Behavioural Healthcare Council (OBHC; White 2011). The OBHC draws its membership from certified, operating AT programmes. OBHC sponsored research has been United States-centric and focused on membership programmes. It has become so successful in its research mission that there is the possibility it now has too much influence in the AT literature base. This influence has been raised as a concern given the OBHC's support for potentially unethical practice such as forced transport (Dobud, 2021; Magnuson et al., 2022).

The confusion of AT with outdoor recreation and punishment that this research has highlighted is problematic in that it works to devalue the approach. Recreation is often presented as sitting on a continuum with AT, so there are common elements (Itin, 1998; Jeffery & Hensey, 2022). There is also literature that shows simply being outside can increase positive affect (McMahan & Estes, 2015). This study showed the impact of when AT was confused with recreation and became framed as a reward. The framing was counterproductive when AT was

proposed in a correctional environment because of the perception that offenders were receiving rewards for poor behaviour.

Under the definition for AT adopted for this research, outdoor recreation, if it has a therapeutic intent, fits within the boundary of AT. The mixture of therapeutic and therapy terms further works against AT, serving to confuse the public and professionals. The definition of AT has long been debated (Itin, 1998) and there is no universally accepted description. The word therapy in AT remains contentious (Priest, 2022). It may be opportune to reconsider the practice in Aotearoa NZ and select a name and definition that more accurately reflects the practices and values important to clients and practitioners.

AT framed as a punishment also devalues the therapeutic approach. The term boot camp was referred to by some participants and was also referenced to the Aotearoa New Zealand political messaging where it has been brought up as an answer to youth crime from time to time (New Zealand National Party, 2022). The participants that discussed boot camps were aware that they were not therapeutically sound but by reference showed that there is a perception linking the two approaches. This linkage reflects that seen overseas, particularly in the United States, yet evidence in the literature shows that boot camps are ineffective (Russell, 2006).

Calls for improved documentation on AT delivery approaches highlighted by this research have been reflected in the international literature (Cavanaugh, 2020). However, it might be that AT's flexibility is an Achilles heel in this respect. Each programme is different and reflects clients, cultures, organisations, practitioners and even regional differences. Texts provide programming guidance but even the most basic of elements, that of the question "what is AT?" is confusing (Priest, 2022). It is likely that organisations might produce manuals of their own approaches according to commonly agreed principles but that are highly customised to their selection of therapeutic elements and their clients' needs (Carpenter & Pryor, 2021). While some participants in this study called for manuals describing AT methodology, the literature

promotes acceptance by therapists, of the myriad of approaches. Similarly to AT, talk therapy in the outdoors is seen as flexible and trying to define a certain approach would run counter to basic philosophies (Cooley, 2021).

Some participants expressed a sense of conflict regarding programme outcomes. While positive effects, such as self-confidence and social cohesion, were being observed, participants did not have the empirical evidence to prove that change was taking place. Positive support for therapy in the outdoors mixed with opinions on effectiveness measurement by therapists have been seen elsewhere in the literature (Cooley, 2021). These concerns have elicited similar calls for further research and framework development. Participants requests for research took two forms. The first was a focus on whether AT was effective as a therapy compared to other therapies. The second was a focus on whether a participant's individual programme was being effective.

In some areas of the literature base, there are recommendations for research to move away from benchmarking therapies (Miller et al., 2013). These calls propose adopting the Dodo bird principle which has come to mean that all therapies have comparable outcomes. These outcomes are influenced by common factors such as the therapeutic alliance (Rosenzweig, 1936; Wampold et al., 1997). The Dodo bird principle and related common factors theory, relieves researchers from trying to prove a therapy's comparable effectiveness and instead shifts research towards improving outcomes from each programme. Targeting outcome measurement is in line with the second focus of research that participants referenced. In alignment with this focus, Miller et al. have suggested that the measurement of outcomes be developed to improve therapist and programme performance. Improving the common factors in each programme through feedback informed treatment provides an opportunity to cater for the disparate makeup of programmes within the AT definition (Dobud, 2017). According to Dobud, feedback informed treatment gathers real time information on treatment outcomes and the

therapeutic alliance at each session. It is programme specific, drives continuous improvement and gives therapists clear measurements of programme performance.

Participants saw another area of development in promoting the increased involvement of psychologists in AT practice. There was a sense that psychologists had a specific set of skills that were relevant and value adding. This included theoretical knowledge, understanding of presentations, the creation of formulations, the application of evidence-based interventions and a rigour of approach. Cooley et al. (2020) suggested that assessment and formulation were important facets when taking therapy outdoors, to ensure client fit with the proposed approach. The addition of these clinical elements to the AT program is like that proposed by Fernee et al. (2017). Fernee et al. worked to extend the wilderness therapy model (Russell & Farnum, 2004) by adding a psychological component. This psychological element reflects findings by this research and was termed by Fernee at al. as, “an initial psychological assessment, including a diagnostic formulation, followed by the creation of an individual treatment plan with explicit treatment goals” (p. 124). Clinical elements supported by psychologists, promotes the AT theoretical framework as applicable into mental health clinical settings and in doing so bridges the theoretical gap between traditional psychotherapy and AT (Fernee et al., 2017).

Success stories in the data based on participant observation of client outcomes contributed to an overall positive impression of the therapeutic ability of AT. Part of the success of the therapy was attributed to the intensity of the therapeutic environment that had been created. This intensity allowed a greater impact to be achieved than that through the simple sum of therapy hours. Intensity is an element that is commonly identified in the literature. Somerville and Lambie (2009) found that intensity created an engagement into the therapeutic experience and that contributors were isolation, novelty, physicality and natural consequences. Intensity emphasised the immediate experience, paving the way for a generalisation into other contexts thus amplifying the therapeutic effect (Hattie et al., 1997). Intensity that drives a focus into the present moment was also commented on by Warner et al. (2020). While intensity in AT is not

defined, it appears related to two concepts. The first concept is achieving a flow state (Csikszentmihalyi, 1990). Flow occurs when a state of focused concentration is reached that completely absorbs a client into an activity. The second concept of intensity is related to the levels of contact, both time and depth, between client and therapist (Somervell & Lambie, 2009).

Associated with the general feeling of the success of AT within this study was a hope and a belief in the future growth of AT in Aotearoa NZ. While participants did not call on facts to justify this perception, there is some support from the literature base. Gass et al. (2020) conducted a survey in the United States that showed there was high agreement with observations of increasing numbers of adolescents being admitted to AT programmes across a range of presentations. In Aotearoa NZ, the research is consistent with these results referring to AT as “flourishing” (Jeffery, 2022, p. 17). As such, signals of AT growth are aligned with the growth in mental health concerns within Aotearoa NZ (Ministry of Health, 2022).

Implications From this Research

The Utility of AT

The research findings that reflected AT as a space where talk therapies can be done amongst a range of other therapeutic elements implies a flexible approach. Participants referenced a wide range of mental health presentations that AT could support. According to the literature this flexibility lies with employing a milieu of therapeutic elements. This mix allows a wide range of designs that can be applied depending on the context of the clients and of the therapist involved (Bowen, 2016). AT may be seen as providing therapy or being an adjunct with therapy (Carpenter & Pryor, 2021). As an adjunct, it can encompass other evidence-based therapies such as CBT within its approach (Tucker et al., 2022). Preferred collaborative models highlighted by this research, increase therapy and activity options. The literature reflects that applications of AT have spanned behaviour, substance use, depression, anxiety, family development, self-efficacy, esteem, through to physical health and spirituality (Cramer & Wanner, 2022).

The adoption of a collaborative model with a psychologist and an outdoor instructor working together to deliver AT might reduce difficulties of gathering outdoor skills in addition to therapy training (Jeffery & Hensey, 2022). Releasing the responsibility for outdoor activity facilitation to others might allow therapists to concentrate on the adaption of their therapy approach to best suit the AT platform. Participants noted that there was a skill in piecing this therapy approach together. Care was needed in the coordination of the AT workstreams but this coordination was already occurring in several of the programmes referenced during this research with no identified impact on outcomes. However, even in a collaborative therapy mode, therapists had to manage a redefined client boundary. Therapists, because of their participation in activities, operated more as a partner than in a traditional professional relationship.

AT is viewed as well positioned to address behavioural problems at the more moderate to serious level or where traditional therapy approaches have failed (Pringle et al., 2021). This was consistent with views expressed by participants where AT had been used with young people with offending behaviour. Consequently, this study suggests that AT is a potentially useful tool for government agencies such as Oranga Tamariki and Ara Poutama Aotearoa Corrections who work with communities engaged in offending behaviour. An Aotearoa New Zealand Government evidence brief supports the effectiveness of therapeutic outdoor programmes to reduce crime (New Zealand Government, 2017). The evidence brief notes that there was a zero dollar spend from the public sector on this approach. Despite this, $160k was budgeted by the Ministry of Social Development for clients with intellectual or physical difficulties to go on OB (Outward Bound). In addition, a private sponsor paid $100k per year for twenty Ara Poutama Corrections youth, at prison youth units, to do the Duke of Edinburgh Award. This award consists of individual programmes to “build skills, identity and self-esteem” (p. 5) having similarities to several AT elements. Given these low levels of expenditure there is room for further development in this area.

Some participants noted that in the political sphere, a solution touted for youth with criminal behaviour is proffered as the implementation of boot camps (New Zealand National Party, 2022). The evidence base indicates that boot camps are not effective (Ministry of Social Development, 2013) and are opposed by the psychological fraternity (New Zealand Psychological Society, 2022). Implementation of an AT programme in this space would move the rehabilitation approach away from a military punishment basis, towards a supportive psychotherapeutic basis with a more humane environment (Russell, 2006). While the two approaches may have some similar outward characteristics, Russell has proposed that they have fundamentally different programme theories. Some similar characteristics between boot camps and AT were mentioned by participants in this current research, for example physical activity and routine. However, ideas that stand AT apart from boot camps that were referenced by Russell and mirrored in this current study were therapy, care, facilitation, encouragement and support. The similarity of outward characteristics may offer a politically acceptable substitution that results in the more effective option of AT being used in this space.

The results from this study suggested that an AT therapist does not need to have a background or passion for outdoor activities. Other studies have suggested there are benefits in alignment, purpose, motivation and consequently effectiveness for therapists to have a connection with nature (Charbonneau, 2016; Jordan, 2014). The results from this current research suggest that: if a therapist can see the benefit of AT, is willing to participate alongside clients, and is willing to learn new skills, then they can deliver therapy within AT successfully. This potentially opens opportunities to access AT as a therapy approach to a wider pool of psychologists who themselves have not had a passion for nature but see benefit for clients in the therapeutic mix.

The Efficacy of AT

There is a considerable volume of literature that supports the effectiveness of AT across the mental health spectrum (Beck & Wong, 2022; Bettmann et al., 2016; Bowen & Neill, 2013).

All the participants in this study were able to relate stories of success they had witnessed. Yet, at times, half of the participants expressed doubts about the empirical proof of the effectiveness of AT and called for more research. There is a movement within the literature base that ascribes to the common factors theory (Rosenzweig, 1936) and has suggested that there is a need to move away from comparative treatment testing such as randomised controlled trials through to routine outcome research.

Routine outcome research has a focus on improving therapist performance, participant engagement and tailoring experiences through feedback of client needs (Dobud et al., 2020). Regular outcome monitoring as an approach to tracking therapeutic change has also been promoted in the Aotearoa NZ context by Blampied and Fitzgerald (2016). They have supported routine outcome monitoring because of a strong focus on the benefits of therapist development and knowledge of treatment performance. Dobud et al. have proposed a simple application of routine outcome monitoring to AT in the form of the outcome rating scale (ORS) and session rating scale (SRS; Duncan et al., 2003; Miller et al., 2003). Blampied and Fitzgerald supported the use of these scales because they are free, simple and quick. Using the ORS and SRS would progress towards resolving the AT effectiveness questions that participants expressed.

Barriers to the Use of AT

More stringent expectations towards physical safety risk management in recent years have been highlighted in this study. Ethical drivers under do no harm principles (New Zealand Psychologist's Board, 2002) focus practitioners to continually improve safety management in line with increased social expectations (Brookes, 2015). Participants reflected that the increase in safety requirements resulted in additional specialised staff or therapist training and more robust safety management systems. This view is mirrored in the literature and Gas et al. (2020) have summarised these areas of impact as: increased coverage of policies and checklists, more thorough management systems, increased training, increased information provision to clients and more comprehensive emergency response procedures. Impacts of changes in these

approaches were suggested by participants to be increased programme costs which could potentially affect the viability of providing AT.

The findings highlighted that the pressure in the mental health sphere for psychologists to practice traditional therapy is problematic for AT. Notions that depicted therapy approaches as being office based with strong efficiency and productivity drivers contrasted with out-of-office AT settings where time was secondary to holistic targets such as deeper relationships. An implication from this is that psychologists may require enhanced reasons for using AT. Some participants suggested in their conversations that this motivation might come from their passion for the outdoors. Horn (2021) also found that therapists were motivated by a connection with nature. Reflecting these findings, AT might be more likely used by those psychologists with a passion for the outdoors.

Another barrier was the lack of knowledge in two principal areas. The first was in the area of general knowledge of AT and that it was perceived to be unknown in psychology circles. The second was in practitioners understanding of the process of AT and how it should be delivered. Participants suggested that further development work might consist of general promotion of AT benefits and work to demystify the approach. For practitioners that wanted to engage in AT, participants discussed the development of programme manuals, including theory, process and training, which would build confidence in delivering therapy. Knowledge of process is seen as key in raising outdoor therapies to the level of being recognised as viable therapeutic treatments (Schwenk, 2019).

Finally, the difference between AT and recreation is not clearly delineated. Definitional issues around AT continue to be debated (Priest, 2022). Perceptions of AT as recreation, work against professions that use AT for therapeutic work. In an example mentioned by Earl where AT activities were mistaken as a reward that was being gifted to those that, because of their behavioural presentations, did not deserve them. AT in that case, was referred in a derogatory way as “goodies for baddies.” The term AT is not reflective of the process that takes place and

current definitions are so broad that confusion is understandable. Potentially the term AT, in its use as a generic umbrella has been cast so wide that it has limited use. Phillips et al. (2022) have noted that current definitions exclude two important components, the role of nature and holistic Māori perspectives. Together Phillip et al.'s observation combined with this research suggest that new terminology for AT with an Aotearoa NZ context will serve a better purpose.

Chapter 6: Conclusion

Chapter Introduction

The purpose of this chapter is to bring together the different elements of the research and conclude this study in a way that responds to the research question and objectives set out in Chapter 1: Introduction. The research question for this study is:

How do psychologists in Aotearoa NZ perceive the practice of adventure therapy (AT)?

Firstly, a summary of the research is provided followed by recommendations, strengths and limitations. It will also show areas for future research and conclude with a final reflection from the researcher.

Summary of Research

The rationale for this research was drawn from a landscape of increasing mental health concerns in Aotearoa NZ driving a need for innovative solutions (Paterson et al., 2018). AT, previously considered an alternative approach to psychotherapy, is known for its flexibility in addressing various issues, especially with complex adolescents (Conlon et al., 2018). Psychologists play a significant role in mental health services (Stewart et al., 2014), but their perspectives on AT have been overlooked in previous research. This study fills this gap by identifying psychologists' perceptions of AT, its utility, effectiveness, and barriers. The researcher, being both an outdoor instructor and psychology student, brings a unique perspective to understanding the interaction between these two areas within AT.

AT, defined as a field combining adventure and outdoor environments for therapeutic outcomes (Australian Association for Bush Adventure Therapy Inc., 2023), has a historical basis in the Scouting and Outward Bound (OB) movements. It has evolved with theoretical foundations such as experiential learning (Kolb, 1984), self-efficacy theory (Bandura, 1977), self-determination theory (Deci & Ryan, 2000), social cognitive theory (Bandura, 2006), and attention restoration theory (Kaplan, 1995). The history of AT in Aotearoa NZ traces back to OB

and international practices with adventure gaining an Aotearoa NZ national significance with Sir Edmund Hillary's mountaineering achievements.

The study employed semi-structured interviews and reflexive thematic analysis within a critical realism theoretical framework. Eight registered psychologists with experience in AT were interviewed. Four themes were interpreted from the data related to the therapeutic space, the presence of risk, the integration of psychologists with AT, and perceptions of AT as a developing practice.

The findings indicated that AT is viewed as a valid treatment strategy for mental healthcare and is particularly suited to complex behavioural issues and offending populations. Even so, many psychologists in Aotearoa NZ lack awareness of AT. For participants, there was a perception of AT's emerging nature, with a need for further development in documentation and research. AT's flexibility was seen as both an asset and a challenge, allowing for customisation but causing issues with definition, research evidence, and standardisation compared to traditional therapy approaches.

AT's flexibility enables it to address non-traditional therapeutic elements like connection with nature and cultural identity, aligning well with the growing focus on engaging with adolescents in mental health. Participants saw AT as a context for talk therapy, favouring a collaborative model between outdoor instructors and therapists. In addition, tensions exist between AT and traditional therapy, primarily due to time and efficiency pressures. While AT provides intense therapeutic change, it may struggle to compete with office-based therapies until a balance is achieved between efficiency and AT's comprehensive, integrative nature.

Recommendations

Recommendation 1: Oranga Tamariki, Ara Poutama Aotearoa and Te Whatu Ora should consider adopting AT as a therapeutic mechanism for both behavioural and other mental distress presentations. The natural partnership between those government entities, AT oriented NGOs and outdoor instruction providers should be explored to facilitate the development and

delivery of AT programmes. Psychologists from government entities or NGOs would be well placed to lead those discussions. Additionally, it is recommended that political boot camp discussions be redirected towards AT strategies to promote effectiveness and improved client outcomes.

Recommendation 2: This study indicated that there is confusion between the definition of AT and outdoor recreation. To establish a stronger, independent identity with an Aotearoa NZ context, a new term to cover AT is recommended. This term should be crafted to reflect bicultural approaches and work to accentuate that evidence-based therapy is a core element of the process, thus confirming AT as an effective therapy option. In addition, this study found that AT programme design should pay as much attention to transitions as to the programme itself. It is recommended that a new definition of AT accounts for this facet of treatment. Entities such as the Adventure Therapy Aotearoa organisation and AT researchers are well placed to consider these changes.

Recommendation 3: It is recommended that Aotearoa NZ Universities or Polytechnics consider expanding course offerings to cover AT topics for post graduate psychology courses or wider therapist training.

Recommendation 4: The Adventure Therapy Aotearoa association should consider targeting their bi-annual grant to raise the profile of AT. This could be done by advertising within graduate and postgraduate psychology circles to grow the body of academic research and consequently, further highlight AT as a valid therapy approach.

Strengths and Limitations

This qualitative study had several strengths. The research design combined the robust, systematic method of reflective thematic analysis with a critical realist lens. This combination allowed an analysis of participants perceptions but also contextualised those understandings against the participants backgrounds to gain a richer output (Braun & Clarke, 2022). Incorporating reflection and recognising the researcher's views and how they have shaped the

study improved the quality of outcomes (Braun & Clarke, 2023). Reflexivity has made this research more transparent and useful in the AT literature base.

The researcher was positioned as an insider in this study having a background in outdoor instruction and as a postgraduate student in psychology. This positioning enhanced the understanding of many of the experiences related during the interviews. An understanding position and encouraging approach allowed participants to express thoughts freely in a supportive environment and allowed a richer dataset to be produced.

The recruitment process was able to identify and recruit a participant group that were all registered psychologists. While this aspect of participants' backgrounds was homogenous, lending focus to the study, there were a wide range of other demographics. This range existed in age, ethnicity, experience in both psychology and AT, and geographical location within Aotearoa NZ. Diversity was added to the interview data, giving some confidence that consistent views were likely to be robust while in certain areas providing different perspectives that added nuance.

However, there were some limitations. There were a limited number of participants recruited for this study and therefore its generalisability is in question. Although the pool of participants in Aotearoa NZ is likely to be small, there was no way of categorically confirming that assumption. It is feasible that eight participants make up a reasonable proportion of psychologists in Aotearoa NZ that have experience with AT. In addition, the requirement that psychologists had experience with AT may have introduced bias to the study. The fact that they had used AT may have reflected a positive predisposition to the topic.

The interviews had brief time frames for the process of rapport building. The brevity of time may have had implications with participants not feeling comfortable in sharing their thoughts and experiences more deeply. A lack of rapport may have also been less effective at breaking down a potential power structure that can exist in the interview situation.

Consequently, participants might have anticipated what the researcher was looking for and supplied that data.

Further Research

The perceptions of psychologists presented in this study provide a valuable base for further research in Aotearoa NZ. Firstly, one group of psychologists that were excluded from this group were those that understood what the term AT meant but that had not had direct experience delivering AT. This perspective might yield useful views, would build a larger participant base, and might address any bias in the participant group recruited for this study.

This research has raised some questions about how AT fits with psychologists in their practice of therapy. Concerns regarding the tension between pressures for time efficiency in therapy and how that balanced with AT's more holistic approach remain unresolved (Fuentes, 2018). Community-based applications of AT were suggested by some participants to be one way of gaining efficiency. It is recommended that cost benefit analysis research is carried out to help resolve this perceived barrier and that this research aims to suggest an approach that meets efficiency and effectiveness goals.

The findings indicated that better outcome monitoring of programmes would give improved data on which to base effectiveness assertions. The literature showed that this is a necessary path for programme and practitioner improvement alike. Feedback informed treatment in AT is an area that is receiving current attention (Dobud, 2017; Dobud & Cavanaugh, 2023). Research on the effectiveness of feedback informed treatment would provide support to measuring and improving AT programmes.

This study reflected the perception of talk therapy as one element in the AT therapeutic mix. In Aotearoa NZ there are no comparisons of how therapy in a room compares to therapy in an AT context. CBT is an approach that blends well with AT overseas (Trundle & Hutchinson, 2021) and is also well known and understood. A study of this combination in Aotearoa NZ would support the ongoing development of AT with evidence-based treatments.

The use of culture as a therapeutic element in AT has been supported by this research. The application of this element was not present in all programmes described. Further research on a model of culture as a therapeutic approach in AT would benefit therapists that are seeking to develop this aspect in their programmes. One model that warrants investigation is the Te Whare Tapa Whā model of hauora (health).

Results showed that risk is integral in AT. All participants considered trauma informed care to be an important aspect of AT but there was little evidence of how this was operationalised in programmes. Given the interplay of risk with trauma, work on researching the application of international models of trauma informed approaches into Aotearoa NZ AT practice would give therapists guidance and confidence.

Final Reflection

I came into this study wondering why AT was not being used by psychologists as a regular therapy approach. Conversations showed that AT is relatively unknown. As I moved into the research and reflected on my knowledge and motivation, I started to see my thinking as two dimensional as the practicalities of delivering AT within a psychology practice were discussed with me by participants. Analysing the conversation data allowed me to gain an insight into a potential for AT that was greater than I had anticipated. At the same time the analysis revealed some of the sobering facts about mental health needs and the pressures that psychologists face to meet those needs.

Psychologists that were interviewed in this research were advocates overall for AT. Yet there remains a gap in knowledge for the rest of the psychology profession, that if not filled, simply holds AT's potential unrealised. As highlighted in this research, psychologists have a unique set of skills to bring to AT that would both help develop AT's potential and improve client outcomes. The challenge therefore, not only lies in explicating AT's untapped potential as a therapeutic approach but also in bridging an informational gap. By bridging this gap AT will be bought to the attention of the mental health community and their organisations.

The responsibility to carry out these actions can only sit with those who understand and support AT's effectiveness and flexibility. With further support and development, AT can realise a growing importance and contribution to Aotearoa NZ's therapeutic landscape. AT stands as an innovative approach to help improve, not only mental health, but overall wellbeing.

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Appendices

Appendix A: Facebook Advertisement Post

Appendix B: Invitation and Participant Information Sheet

Psychology Professionals' Perceptions of Adventure Therapy in Aotearoa New Zealand

INVITATION TO PARTICIPATE AND INFORMATION SHEET

Invitation and Researcher Introduction

Kia ora,

My name is Steve Nicholls, and I am excited to extend an invitation to you to participate in a research project that I am leading entitled, "*Psychology Professionals' Perceptions of Adventure Therapy in Aotearoa New Zealand*". Your involvement in this project would be greatly appreciated.

I am a post graduate student at Massey University and this research will be presented in partial fulfilment of the requirements for the Degree of Master of Arts in Psychology.

In addition, this project seeks to fill a gap in the research literature by investigating the perceptions of psychology professionals in Aotearoa New Zealand on the utility, barriers and effectiveness of Adventure Therapy practice. In doing so it is hoped that this research will support and grow the knowledge base of Adventure Therapy in the Aotearoa New Zealand context and to highlight it as a potentially valid treatment strategy to the wider psychology community.

Participant Requirements and Commitment

You are being invited to participate as a psychology professional with a postgraduate qualification in psychology, who has experience with Adventure Therapy and currently works in mental health, mental health research or Adventure Therapy.

Your commitment to this project will consist of one interview conducted either via an online medium or in-person if convenient. This will take between 60 and 90 minutes at your discretion.

I have attached further information for your review below. If you are interested in participating then please send an email to me at stephen.nicholls.4@uni.massey.ac.nz

I look forward to working with you.

Ngā mihi

Steve Nicholls

PARTICIPANT INFORMATION SHEET

Psychology Professionals' Perceptions of Adventure Therapy in Aotearoa New Zealand

Project Purpose and Description

Adventure Therapy has grown to be practiced around the world encompassing many formats and philosophies. However, this widespread use has had its downside as Adventure Therapy has struggled to get general acceptance in the mental health professions without a solid, consistent research base. The growing research looking at clinicians use and perceptions of Adventure Therapy tends to exclude psychologists as a cohort, particularly in Aotearoa New Zealand, where the need for research into current models of discipline-specific practice has been identified.

This proposed research project will adopt a critical realist epistemology to gather, thematically analyse and report on semi structured interview transcripts, gathered from Aotearoa New Zealand psychology professionals. The subject matter of the interviews will be the utility, barriers and effectiveness of Adventure Therapy practice in Aotearoa New Zealand. Some demographic data will also be recorded in order to contextualise the research.

Participant Identification and Recruitment

Recruitment methods will consist of purposeful sampling including, advertising through professional organisations, personal contacts, internet searches and snowballing.

A Psychology Professional is defined as someone who has a postgraduate qualification in psychology, has experience with Adventure Therapy and currently works in mental health, mental health research or Adventure Therapy.

In recognition of the time and knowledge that is being given to this project, a small gift of approximately $40 value will be exchanged with each participant.

Project Procedures

Participants will be involved in semi-structured interviews of 60 to 90 minutes duration. Some demographic information will also be collected at this time. Interviews will be recorded and may be online or if convenient, face-to-face. No preparation will be required. The opportunity to review and comment on the interview transcript will be given after transcription and accuracy checking is completed by the researcher.

Data Management

Information gathered during this project will only be used for this project and will be stored securely on Massey password protected servers. It will only be accessed by myself, and my supervisor. Data used for reporting will be anonymised. Information will be kept for 6-months following conferral of the degree for which the research report is to be submitted and will then be destroyed. When this project is finished, the results of the study may also be presented at conferences or published in journal articles. This will not include any identifying details.

Participant's Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study within one-week of your interview;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Project Contacts

Researcher: Steve Nicholls

Postgraduate Student, School of Psychology, Massey University

Email: stephen.nicholls.4@uni.massey.ac.nz

Supervisor: Julia Ioane

Associate Professor, School of Psychology, Massey University

Email: j.Ioane@massey.ac.nz

If you have any questions about the project, please contact the researcher and/or the supervisor.

Ethics Review

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher or supervisor, please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz.

Appendix C: Participant Consent Form

Psychology Professionals' Perceptions of Adventure Therapy in Aotearoa New Zealand

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I agree/do not agree to the interview being image recorded.
3. I wish/do not wish to have my recordings returned to me.
4. I agree to participate in this study under the conditions set out in the Information Sheet.

(Please cross out as appropriate)

Declaration by Participant:

I [print full name] _____ _____ hereby consent to take part in this study.

Appendix D: Semi Structured Interview Questions

Questions

Topic: Interviewee Credentials

1. Can you tell me about your current work in mental health?
2. What is your experience with Adventure Therapy?
3. How would you define Adventure Therapy?
4. How do you think Adventure Therapy works?

Topic: Utility

5. What were the outcomes of your Adventure therapy practice.
    a. Is there an example that sticks out in your mind.
6. What are your views on the advantages and disadvantages of using Adventure Therapy in the field of psychology?
    a. Why do you think that? Where have you found that to be the case?
    b. Are there areas where it might be more useful than others?
    c. In what areas do you think there is limited application.
    d. How else do you think it can be beneficial to clients?
    e. How do you think trauma informed practice sits with AT.
7. What are your thoughts on the role of adventure therapy in addressing mental health and/or wellbeing?
8. What are your views on the suitability or appropriateness of adventure therapy for different populations or client groups? Cultural Application
9. What are some of the ethical challenges that you have encountered or foresee in the use of adventure therapy?

Topic: Barriers & Effectiveness – Guiding Questions if gaps exist

- *What would be some of the main risks, problems or challenges in implementing adventure therapy in an Aotearoa New Zealand clinical or therapeutic setting?*
- *How do you perceive the effectiveness of adventure therapy in comparison to other traditional therapeutic approaches?*
    a. *What do you see as its unique strengths or limitations?*
    b. *What are some of the key factors that influence success or failure?*
- *What is the role of nature in adventure therapy?*

Topic: Future Focus

10. What do you believe are the future directions or potential developments in the field of adventure therapy in Aotearoa NZ?
    a. What are some areas that need further research or exploration to better understand its application?
11. That's pretty much all I had. Is there anything you think I might have missed in my questions about Adventure Therapy in Aotearoa New Zealand?
12. Did you have any final questions or comments for me about Adventure Therapy?

Topic: Demographics

Are you OK if I just collect a few demographic details.

Date of birth

Gender identification

Ethnicity

Psychology qualifications

Number of years practicing

Clinical focus or specialty area

Current geographic region