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ORIGINAL PAPER

Exploration of adventure therapy community and practice in Aotearoa New Zealand

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Abstract

This research explored the use of adventure therapy in Aotearoa New Zealand, how practitioners have learned their skills, and what they perceive the field needs to support its development. The mixed methods study used interpretive description methodology to analyse focus group and survey data. The field is diverse and includes practitioners from outdoor education, youth work, and therapy professions. They share common understanding of, and passion for adventure therapy practices. Formal learning opportunities are limited, and a Community of Practice model exists. Practitioners should use adventure therapy strategies within their discipline boundaries and practice with a trauma informed lens. The field would benefit from more education and training opportunities, from intentionally strengthening the Community of Practice model, and from Māori research to enhance appropriateness of practice for the unique cultural context of Aotearoa New Zealand.

Keywords Adventure therapy · New Zealand · Professional disciplines · Education · Community of practice

Introduction

Adventure Therapy (AT) is emerging internationally as a set of approaches or interventions in a range of social and health services for clients learning to manage or recover from behavioural, psychosocial, and mental health challenges. The field is diverse however there are generally accepted principles that people who use AT promote. These include a humanistic and strengths-based approach, the use of experiential learning theory, incorporation of adventure based or outdoor activities, and a connection with nature (Bowen & Neill, 2013). Practitioners in New Zealand (NZ) may include allied health professionals, educators, outdoor facilitators, and youth workers.

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AT has been evident in NZ for some decades. Initially informed by international research and practices, local practices are now emerging. Given this development and recent international literature promoting context situated understandings of what the field covers (Harper et al., 2014; Pryor et al., 2012), it is timely to explore AT practice in the NZ context. This research seeks to understand who AT practitioners are and how AT is used, how practitioners have learned their skills, and what they believe education or training needs might be. The aim is to better understand the field from a unique NZ perspective to support and inform its development.

Literature review

AT's long-standing debate around how the field is defined and described has resulted in acceptance that the field is rich with diversity (Harper et al., 2014; Itin & Mitten, 2009). This brings freedom for practitioners to adapt AT strategies to fit with their context, and difficulty defining exactly what the practice entails. Gillis and Ringer's statement that AT "*encompasses a myriad of approaches to the integration of adventure and therapy*" (1999 p.34) helpfully places a boundary around the practice however requires an understanding of what therapy is and who can do it, and what adventure is and who can facilitate it. The often-quoted Gass et al. (2012) definition states that "*AT is the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels"* and clearly situates the practice in the therapy world. Missing from this definition is the pragmatic challenge of providing adventurous activities which require knowledge and skill not developed in mainstream therapy education. Alvarez and Stauffer's (2001) broader definition: "*adventure therapy is any intentional, facilitated use of adventure tools and techniques to guide personal change toward desired therapeutic goals*" (p.87) places therapeutic intent central to practice and requires a shared understanding of what adventure tools and techniques are.

Rather than debating what AT "is", perhaps it is more useful to consider what legitimately fits "in" AT with context in mind. Contextual relevance is emphasised by Harper et al. (2018) who advocate taking care in ascertaining local culturally appropriate practices in the use of nature in wilderness therapy, with specific reference to growing awareness of indigenous ways of relating with nature. This is emphasised in the work of Carpenter and Pryor (2004) who illustrate the importance of culturally appropriate practices through their work with the perspectives of Australasian practitioners regarding the importance of integrating nature in AT. Chang et al. (2017) explored numerous aspects of culture as they applied Hofstede's five dimensions of cultural differences to adventure programming. Whilst framed at the education end of the spectrum, examining culture when planning therapy is equally important and a fundamental step towards cultural competency. Culture in terms of practice setting and client population (ethnicity aside) also influences how AT is framed. Some NZ research is emerging that indicates development of a NZ flavour to how the field is understood and practiced, evidenced in research into client outcomes illustrating the variety of settings where

selected elements of AT form bespoke services to fit the context. (See Burne, 1999; Wynn et al, 2012; Radford, 2013; Pretorius, 2020; and Lauchlan, 2018 for examples).

The diversity of organizations, individuals, and programs that self-identify with AT practice creates complexity (Norton et al., 2014; Ritchie et al., 2016). Pryor et al. (2012) identify difficulties associated with providing therapy in outdoor environments and using outdoor activities, not the usual skill set of therapists. They propose a model situating educational and therapy elements of the work within a framework that clarifies boundaries, and advocate for collaboration between education and therapy fields to enhance efficacy and safety. AT has been present in NZ for many years, and provided in disparate sectors throughout the country (Burne, 1999; Gilbert, 1998). Practitioners come from health professions, youth work, and outdoor education backgrounds. Some are "dual qualified" and have the skills to work as therapists and outdoor educators. The recent mental health and addictions review (Patterson et al., 2018), changes in corrections philosophy (Azuela, 2018), and focus on mental health in schools (Berger, 2019), are factors that can potentially enhance the growth of AT in mainstream services. Whilst this presents opportunities for AT, it highlights the importance of ensuring clarity around who is qualified and equipped to do what and with who.

The work of Jansen (2004) describes the use of adventure in work with NZ youth in various settings, helpfully summarises how adventure approaches can be useful, and articulates a need for NZ based research. This is now emerging as the field gains momentum. Mossman's (2005) work comprehensively reports on a service that provides AT with a therapy intent, exploring both the appropriateness of using adventure as therapy with youth, and associated challenges for therapists and services. AT is integrated into some mainstream mental health services. Radford (2013) explored an early intervention psychosis service finding the AT component was particularly useful for Māori and for males in terms of engagement. Applicability and efficacy of AT for Māori and for youth at risk was also emphasised by Pretorius's (2020) study on surf therapy. A fit between AT and occupational therapy has been identified by Levack (2003) and Jeffery and Wilson (2017) who propose that whilst different from occupational therapy, AT can legitimately be used by occupational therapists as an approach to their every-day practice. Additionally, adventure-based learning has a strong profile in youth development programmes (Jansen et al., 2010; Mercier et al., 2019). Some such programs such as the Spirit of Adventure Trust, Outward Bound, and Project K do not have therapy intent, however, are influential in youth development and have demonstrated therapeutic benefits (Arahanga-Doyle et al., 2019; Deane et al., 2019; Furness, 2017; Martin & Legg, 2002; Scarf et al., 2018).

For the purposes of this research, AT practitioners are people who use adventure-based tools and strategies and practice somewhere on the continuum between personal development and therapy as established by the intent of the program and the qualification of the practitioner (Fig. 1).

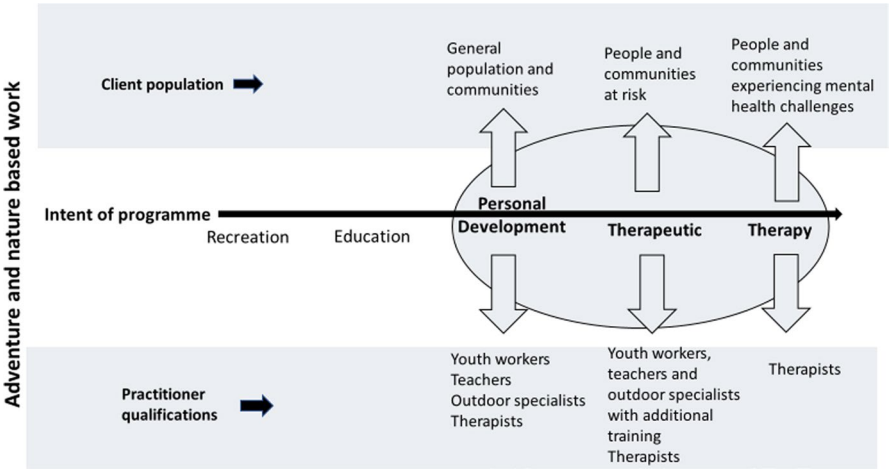

Fig. 1 Adventure Therapy Continuum

The research

This mixed methods research sought to ascertain the current practices of AT practitioners in NZ and their perception of what is needed for the field to develop. Ethics approval was granted by the academic institution's ethics committee. Participants who met the inclusion criteria of having used AT practices in their work as a therapist or educator/facilitator in New Zealand within the last 5 years were recruited through Adventure Therapy Aotearoa (ATA) via email communication. Snowballing was used to further recruit.

Interpretive description (Thorne, 2016) methodology structured the research design. Interpretive description (ID) uses a constructivist approach to generate knowledge pertinent to the health field of interest. Findings are sought that are relevant to the field, attends to practice based biases and commitments, and holds the context in mind. The intent is that findings are constructed through thoughtful linking to others' work in the field (Mitchell & Cody, 2002; Oliver, 2012; Thorne, 2016).

Qualitative data was gathered via one interview and three focus groups (two with 4 participants, and one with 3 participants). The interview and focus groups were semi-structured with guiding questions to maintain focus on what the participants are doing in AT, how they learned their practice, and what they believe is needed to help the field continue to develop. Identifying data was anonymized and pseudonyms allocated at the point of transcribing. Focus groups were mixed with participants who were therapists (3), youth worker (1), teachers and outdoor facilitators (4), and dual qualified therapists with outdoor qualifications (4). They came from diverse geographical locations and practice settings, including District Health Boards, schools, specific adventure therapy providers, and Non-Government Organisations.

The qualitative data was examined for patterns of content which were coded, and themes were identified and explored. Analysis of initial themes included checking for commonalities between data and for data that sat outside the identified themes. Preliminary themes were identified and explored separately by the primary researcher and a second researcher, then compared, discussed, and refined until consensus was reached. In line with Thorne (2016) analysis strategy of ensuring findings have pragmatic meaning for the field, preliminary findings were returned to participants for member checking and further comment was invited. Comments received were supportive and no additional data was forthcoming.

Descriptive and exploratory quantitative data was gathered via an anonymous survey using Qualtrics, distributed through the same networks. The intent of the survey was to gain a breadth of responses to the same research question and to gain a better understanding of the systems and funding structure practitioners are working in. Survey data questions were framed in 5 groups, with a total of 30 questions. Response styles included Likert scales, drop down menus, and ranking items, as well as a total of 7 short narrative response opportunities dispersed through the question groups. There were 29 valid responses, for context there are approximately 100 people in NZ who attend the annual conference and/or engage with Adventure Therapy Aotearoa (ATA). Survey data was analysed using SPSS (Statistical Package for the Social Sciences, version 27) software.

A basic tenant of ID is that the data remains amenable to re-evaluation through exposure to different contexts and frameworks for analysis (Thompson Burdine et al., 2021). To this end preliminary findings were presented at an ATA conference. Further analysis was conducted by the primary researcher and a research assistant following curiosity and questions from that presentation.

Findings – survey

Quantitative findings are presented as they relate to who AT practitioners are, the client base, what they do, how they learned and what they believe would help the field in NZ further develop.

Who we are

Despite the time and expense of maintaining currency in both health and outdoor fields, 11 of the 29 respondents reported having qualifications in both a health discipline and outdoor facilitation (Table 1).

Twenty-seven respondents identified as NZ European, 1 as Māori/NZ European, and 1 as Māori/Pasifika. Most provide services through either a non-government organisation (NGO), through a District Health Board (DHB), or Ministry of Social Development (MSD) (Table 2), with funding for their AT programs coming from government health and social services (Table 3).

Table 1 Practitioner Qualifications

Dual Qualified (11)	Outdoor only (5)	Therapist only (11)	Non-professional (2)
Counsellor/psychotherapist + education qualification (5)	Degree education (2)	Counsellor, psychotherapist (6)	Coach (1)
Counsellor/psychotherapist + specific instructing qualification (2)	Diploma outdoor education (3)	Occupational therapist (2)	Student (1)
Social Worker + specific instructing qualification (1)		Social Worker (2)	
Occupational therapist + specific instructing qual (3)		Nurse (1)	

Table 2 AT Services Providers

Service provider	NGO or charitable trust	DHB or MSD	School/ education	Adventure Therapy provider	Private practice or volunteer	Corrections, justice
% Who selected as > 50% of their work	20.7	27.6	17.2	13.8	6.9	0
% Times selected overall	37.9	37.9	31	20.7	20.7	10.3

Who we work with

A client cumulative age range of 6–65 years was reported. Of these, 50% reported taking clients over the age of 40, and 50% having clients between 8–26 years of age. Most reported they do not work with Māori or Pasifika clients. Five reported that 50–75% of the clients they worked with identified as Māori, and three had between 10–30% of their clients identify as Pasifika. Twenty-two reported over 70% of their clients were from an urban area, 5 had over 70% of their clients from rural areas. The psychosocial challenges clients presented were diverse and are represented on Fig. 2 depicting the top nine factors identified by respondents. Of note, factors were selected equally by therapists and educators.

What we do: Adventure Therapy and Mental Health Strategies

The most common AT and mental health intervention strategies evident in international literature were presented for survey respondents to select those they most often use. These are depicted as percentages in Figs. 3 and 4 respectively.

Most therapist respondents used a variety of MH strategies, outdoor educators used fewer and most often selected mindfulness and motivational interviewing techniques. Participants who selected "other" included positive psychology, dyadic developmental psychotherapy, and coaching. Respondents considered relationship skills, therapeutic group work, trauma informed practices, and the ability to use outdoor activities therapeutically as essential skills. Some identified generic outdoor skills (weather, risk management, first aid) and using a partnership model with co-facilitators if the therapist is not dual qualified as important, along with knowing the whakapapa of the land and having cultural and historical knowledge. Desirable attributes of practitioners included being self-aware, empathetic, compassionate, strengths and solution focused, and having a growth mindset.

Models of service provision

Models of service provision are presented in Fig. 5.

Respondents who selected "other" used walk and talk, field trips, and retreats. Multi-day journeys ranged between 2 and 10 days.

Table 3 Service funders

Funder	Fee for services	Govt through correction services	Govt through health and social services	Govt through education services	Grants, sponsorships, or donations	No funding
% Who selected as > 50% of their work	6.9	3.4	55.2	13.8	6.9	3.4
% Times selected overall	27.6	6.9	58.6	17.2	27.6	3.4

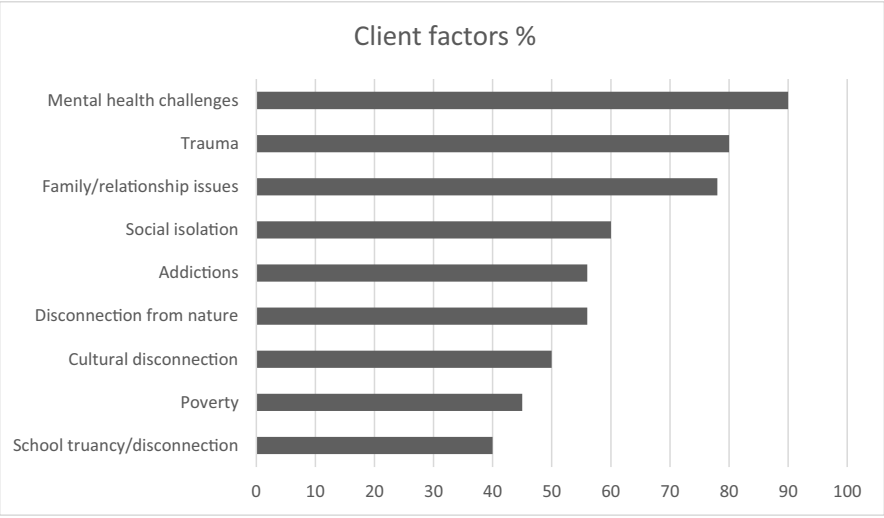

Fig. 2 Client Factors

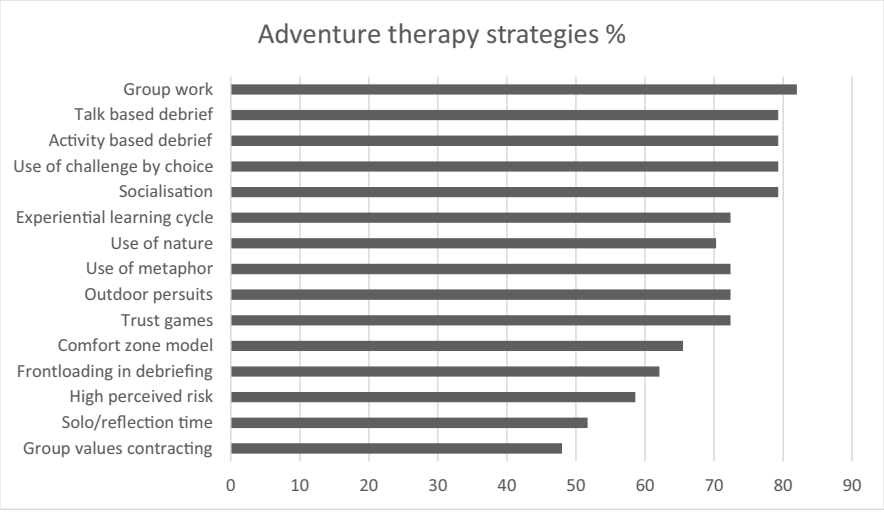

Fig. 3 Use of Adventure Therapy Strategies

Developing the field

The questions important for developing the field include concerns regarding AT practice which helps ascertain learning needs (Fig. 6) and ideas for development (Fig. 7).

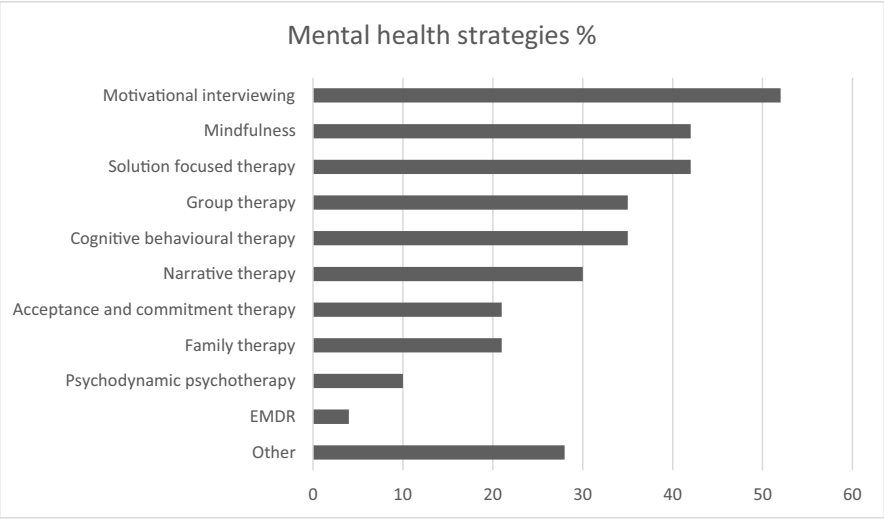

Fig. 4 Use of Mental Health Strategies

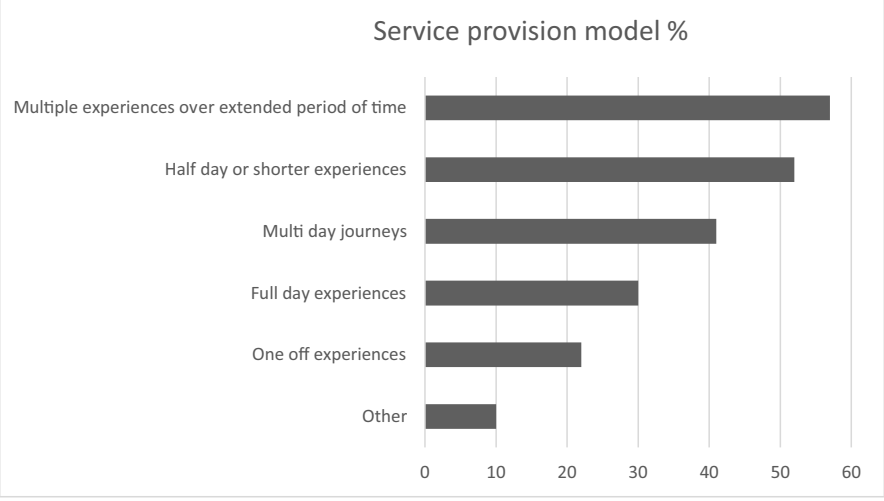

Fig. 5 Model of Service Provision

Twenty-four respondents agreed the field would benefit from further research, particularly regarding outcomes/benefits of intervention, cultural elements unique to NZ, and program structure and practices. Also suggested was research into AT in environments for people with high mental health needs, and in mainstream primary schools.

Interestingly, respondents selected formal education less often as their qualification became more substantive. This may be a reflection on the high number

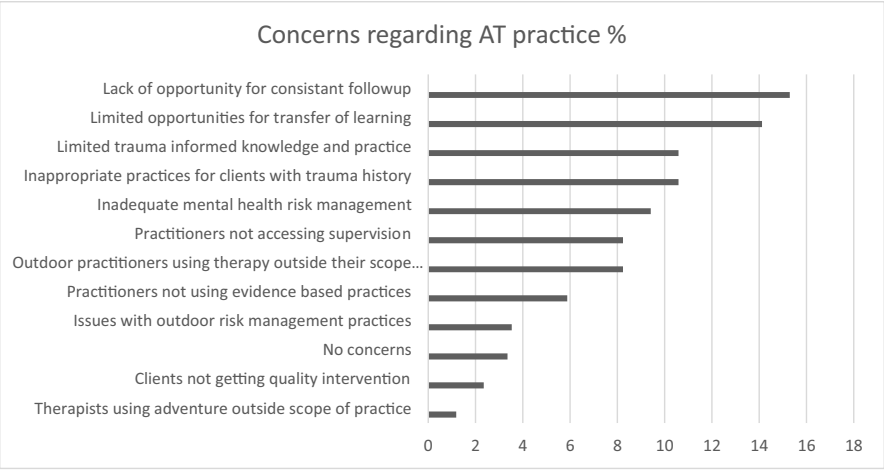

Fig. 6 Concerns regarding AT practice

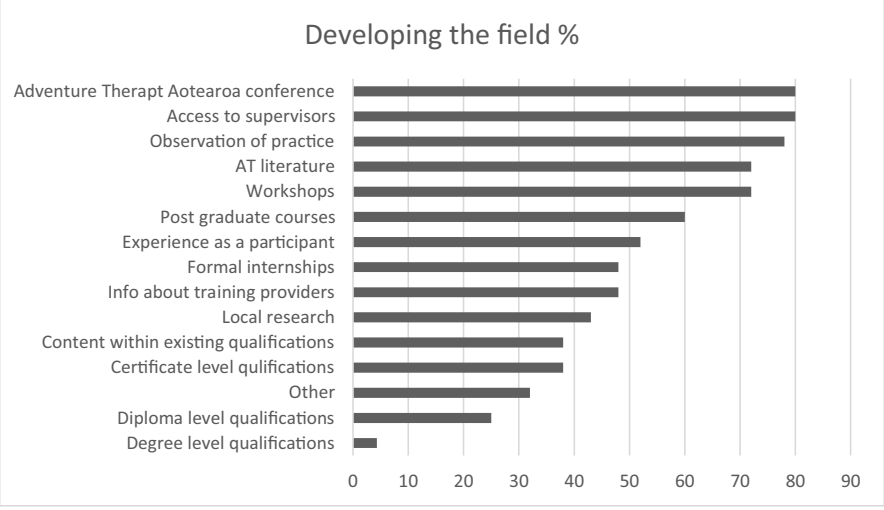

Fig. 7 Developing the Field

of survey respondents with an existing high-level qualification (83% degree or above). However, 60% did select postgraduate opportunities as desirable. In terms of developing the profile of AT, some respondents included the importance of integrating te ao Māori concepts into the way AT is understood in NZ, along with comprehensive understanding of working with te tiriti o Waitangi.

Qualitative findings

Who we are

"*…some of the beauties of adventure therapy in NZ is that it's not going down the exclusive clinical therapist end of the spectrum and only clinical therapists do a bunch of therapy. It is the kind of thing where anyone can pick up some of these tools and use them in lots of different settings."* (Hank).

NZ's stance of including practitioners from outdoor education, youth work, and therapy professions created discussion in the focus groups illustrating the value placed on the specific skills from each domain. Participants emphasised the importance of people knowing their role and working within their skill set and legitimate scope of practice. Some participants indicated that focusing on the intent of the experience helps maintain role clarity, illustrated by Cliff's comment:

> *"I say that our clients are going to have therapeutic experiences out there with us, but this is not a therapy program. I'm trying to create some sort of a separation between the intent of it being therapeutic and the outcomes of it …* [which] *could also be seen as therapeutic, but the intent itself is not that this is therapy."*

What we do

Focus group participants expressed passion for the potency of adventure-based learning strategies. Therapists also valued the expertise outdoor educators have in facilitating these experiences.

Integrating activity facilitation with a therapeutic process was considered the essence of AT, where therapeutic moments happen whilst engaged in the activity – this was also considered the most difficult feature of AT to learn and is where some participants drew a clear line between those who are educators or youth workers, and those who are therapists. Necessary skills for therapeutic use of activity were identified, including selecting, grading, and adapting activities to enable client learning as the activity process unfolds.

The potential AT has for developmental, therapeutic, and therapy outcomes were endorsed by participants. The notion of people maintaining professional boundaries through using AT as a part of their usual work was referred to by some. Speaking as a therapist, Bronnie talked about not seeing AT as *"a therapy in its own right. I think I see it as a context that enables other* [therapy] *techniques and strategies to be used more easily and more in the moment. … The counselling—that is the ability to facilitate and use the experience that they're having in the moment."* The concept of it being an approach or technique within therapy was identified by others, particularly the "in the moment" element, where clients can work on and work through what is happening, as opposed to talking in traditional therapy settings about "what happened" or what "might happen".

All participants valued AT's use of activity as the means for change, growth, or development. It was thought that the experiential nature of the practice provided clients a way to express themselves and understand themselves better. "… [the activity] *that's where those conversations happen… the inside comes out in a way. We try to let them share what they're thinking and what they're feeling*" Cliff. The experiences were thought to facilitate connections at a deeper level than conversation alone. Anita reported on client feedback that indicated "*the best part was just knowing that they weren't alone with what was going on and that kind of solidarity and support from each other helped."*

Participants identified the value of AT intervention is through engagement in the activity itself, and through facilitated reflection – "*…by getting them to reflect on the experiences they've shared and reflect on what strengths and qualities they see in each other as well. … I think it just helps them to recognize more consciously the part that they played in making things work…"* (Hank). Additionally, participants valued the place of nature in AT practice. Healing benefits of nature included promoting lifelong healthful habits of connection with, and time in nature and the way natural environments enhance elements of therapy. Although nature can be challenging because of terrain and weather, the participants identified that the challenge is with nature and not with other people and so it is less confronting: "*It creates a sense of belonging for people because … being in nature, it doesn't really talk back to you, or it doesn't judge you. So, sort of just a less confronting space to be in rather than in a clinical setting.*" (Deb). Some felt conversation happens easier in nature, and relationships are formed on a deeper level than in short group sessions in indoor environments. Highlighted was the connection to place that some people experience, and its importance for Māori in terms of whakapapa and stimulating connection with ancestral knowledge.

Important mental health strategies and skills in AT facilitation were identified and discussed. Therapeutic communication skills such as listening, the ability to create a safe and supportive space, being comfortable with and able to facilitate silence and work with and influence the mood of the group were considered crucial. Appreciating what is being communicated through language and behaviour was identified, as well as collaboration, group management and facilitation skills, and capacity to manage conflict in challenging environments. Knowledge of and language for understanding psychological processes/responses such as projection was considered important. Self-awareness of the practitioner and their capacity to be able to "*…be in the company of other people that are in their moments and not make it your moment."* (Cliff) was considered paramount. Overall, therapist participants spoke of using their usual therapy and integrating AT strategies. Non-therapist participants relied on referral to therapists e.g., school counsellors, when they felt "out of their depth".

The models of service provision included educator led and therapist led services, and a partnership between the two. Some stated that outdoor educators and youth workers have necessary skills for the activity facilitation, but not always in supporting youth with trauma histories and/or mental health challenges. When working at the therapy end of the continuum a partnership model, although expensive, was most endorsed—*"Given that we've got people in our field that are counselling trained,*

but aren't outdoor instructors or are outdoor instructors, but aren't therapeutically trained, there's a lot to be gained by those co-leadership opportunities." (Bronnie).

How we learned

"I've learned so much off my colleagues. A bit of my own reading, a bit of my own thinking. Lots of creativity… and then my experience in the outdoors tying into that. And then how I feel when I'm in the outdoors and how things are for me. And then doing it and seeing what works and seeing what doesn't and learning from it, getting feedback and being really flexible with what I do." (Carole).

With limited formal pathways, the most often stated learning strategy was experientially. Some participants felt that learning begins with their own experience of the healthful benefits of being in nature and engaging in outdoor pursuits. Others spoke of progressing from experiencing to teaching to wanting to use the approaches in a helping capacity. An underlying premise for many was a growth mindset in terms of their own personal development: *"If you don't come with a sense of reflection and self-growth and learning it's kind of hard…"*(Hank) and experience of being a member of a facilitated group as articulated by Bronnie: *" If we want to be really good at this, we kind of have to have had at least one experience of being in a group where stuff happens, where you have the experience of storming, where you have an experience of being disregarded, where you have to work through something to get on."*

Learning was enabled through connecting with others and in conjunction with mentoring and co-facilitation experiences. An apprenticeship mindset was evident, with participants acknowledging the power of learning through working alongside others and observing their practice. *"While we can go off and do training courses, I think that it's really hard to get everything you need from just that. You also need that kind of collaborative interaction with other practitioners… because so much of it is in the moment"* (Bronnie). Learning through experience facilitates learning about what happens when people come up against people, and importantly enables learning from the clients themselves. Therapists emphasised how crucial supervision is, and non-therapist participants identified it as a need not met in their field. Emphasis was placed on the importance of learning to be a therapist before doing therapy, for the sake of safety for the clients and because the knowledge and skills gained enabled therapeutic potential to be reached.

Therapists' ability to link AT with existing professional therapy skills and knowledge was considered important and sometimes difficult. Some mentioned the value of training they had received in adventure-based learning, project adventure workshops, and training offered by their workplaces as illustrated by Bronnie "*…around project adventure stuff and specific stuff I learned around facilitation was really helpful to help me understand how to get the best out of an activity, how to set up a group well so that they could get the best out of the experience they were going into.*"

Attendance at AT conferences (both NZ and international) was flagged as a highlight for intense learning opportunities. Connecting with like-minded people was key, evident in Deb's comment: "*…for me it's kind of about trying to get connected*

and networking with people who are working in the industry. …I've found those conferences have been so valuable to sort of really get the brain working and try and figure out how to link it all together."

Some specifically identified use of ancestral knowledge, and the importance of culturally relevant practice. Others identified applying knowledge gained through reading was helpful.

What we need

Ways to increase the profile included strengthening networks for people to connect and learn from each other: "*I think building on connections is actually taking advantage of meeting all these people who are passionate about what they do and make things happen… Just making that stuff happen if we are wanting to see the industry change and become more well known.*" (Fleur). Other strategies included advocating at a political level, developing a research base relevant to AT practice in NZ, disseminating literature and information about the approaches, and incorporating AT theory and skills in undergraduate health education. Also identified was continuing the annual Adventure Therapy Aotearoa conference and having a NZ presence in the international AT community.

Pete's reflection that "*witnessing the transformation or seeing something tangible rather than just* [hearing] *the stories is so valuable for learning*'' illustrates the power of learning experientially; and Cliff believed that "*… learning in practice and being able to bounce ideas off each other and collaborative delivery…this is kind of like the mentorship model, we need more of this*" Cliff.

The importance of culturally appropriate practices in relation to the indigenous Māori population was reiterated when participants spoke of education and training needs. Some mentioned a perceived fit of adventure therapy practices for Māori, and conversely the cultural activities of Māori that potentially fit with AT ethos. Weaving bicultural practices throughout the field was advocated. Some felt it important that the field intentionally grow the presence of Māori practitioners, others lauded work currently present in Kaupapa Māori initiatives. As articulated by Pete, "*…there are some fantastic things going on among Māori people that I think fit really well within the scope of what we see as adventure therapy… I think they have a huge amount to offer us*."

Another consideration is the diversity of practitioners and their training needs. Suggestions included short workshops, undergraduate and postgraduate formal education, and *"having more focus on facilitation in adventure courses''* (Pete) acknowledging that working with vulnerable people requires a skill set beyond that developed in outdoor education courses. The need for this group to have adequate training was emphasised to ensure emotional and psychological safety: *"… they don't have that kind of baseline training and then I feel like they're kind of aware of this comfort zone, extending comfort zone through challenge and may not be as in tune with the young person, and so I do sometimes feel worried about that…" (Anita)* and also to maximise the therapeutic moments that emerge within the experiences, as articulated by Cliff: "*with some counselling skills, you can take a moment*

of somebody expressing their truth and really go with them into it … If you don't, then it just leaves the whole as an unresolved or un-investigated sharing". Training in therapeutic communication and group work skills were considered essential, along with education to enable trauma informed practices. For the therapists, training in AT strategies was considered important to "*…understand how to get the best out of an activity, how to set up a group well so that they could get the best out of the experience they were going into.*" (Bronnie).

Discussion

An inductive process facilitated the use of existing theory to explore the findings, which are interpreted and discussed here with NZ context front of mind. They offer some insight into who is in the AT community, how they have learned their practice and their perceptions of how to further develop the field. These are discussed in relation to qualification status of AT practitioners and strategies for ensuring and maintaining safe practice.

The continuum

The diversity of who "belongs" in the AT community was evident in who volunteered to participate in this research and was valued by participants. This provides evidence that AT in NZ is emerging as a field where therapy and education meet, and where therapeutic outcomes are sought and celebrated whether or not the setting has a therapy intent. The continuum from personal development through therapeutic to therapy does not have sharp edges, however it assists practitioners situate themselves in terms of role and function (see Fig. 1). This is at odds with some international literature that situates AT clearly in the "therapy world "and is likely a reflection on cultural and system influences. Publicly funded health, education, and social services in NZ enables creativity in service provision models. Additionally, awareness of socio-cultural influences on health and wellbeing from western and indigenous perspectives nurtures potential for services to think outside the traditional "education" or "therapy" boxes. Support for this perspective is reflected in some AT literature. Pryor et al. (2005) describe a view of health and wellbeing that transcends pure educational or medical model ideals and encourage AT practitioners in Australasia to "*identify their own role within the spectrum of socio-ecological approaches*" and explore these approaches in terms of education, health promotion, therapeutic benefits to wellbeing, and intentional therapy programs. Ritchie et al. (2016) explored current AT practice in Canada and concluded that "*… AT in Canada is a broad inclusive field of practice, extending well beyond the words adventure and therapy to describe the people, organizations, literature, and institutional programs involved.*" (p. 14). Itin and Mitten (2009) discuss the restrictive position of situating North American AT in the clinical therapy domain, and propose a broader concept of adventure wellness, incorporating diverse practices and practitioners interested in enhancing and maintaining health and wellbeing from prophylactic work through to therapy. Indigenous perspectives, not well represented in dominant

Eurocentric views internationally, are appearing in NZ literature where the voice of Māori is emerging and the place of AT for Māori is considered (e.g. Arahanga-Doyle et al., 2019; Boyes, 2010; Jeffery, 2017; Pretorius, 2020; Radford, 2013).

Adventure and therapy

Our study found that the varied community of practitioners requires clear boundaries, an appreciation of where one's contribution to the AT community is situated, and awareness of elements of practice in terms of adventure and therapy. The term "adventure" is interpreted in different ways and facilitated for many reasons. Therapeutic use of adventure ranges from high to low actual and perceived risk, facilitating feelings from relaxed to challenged, can be novel or familiar to the client, and have different levels of structure and prescription (Carpenter & Pryor, 2020). Facilitation of many adventure activities in NZ require practitioners to have appropriate qualifications, not usually incorporated into therapy training programmes. Clear structures, systems and legislation exist to enable development of outdoor skills, acquire relevant qualifications, and monitor ongoing competence e.g., adventure activity operators in NZ are covered by the Health and Safety at Work (Adventure Activities) Regulations (2016). The resultant professionalism of qualified outdoor facilitators likely contributes to the respect and trust in their work expressed by therapist participants in our study. The concerns expressed about boundaries may indicate need for specific AT education incorporated into outdoor facilitator education.

Additionally, the term "therapy" is generally reserved for professionals who have education and training in specific therapies, and which outdoor educators and youth workers do not have. In NZ many therapists (including occupational therapists, nurses, psychologists, and psychotherapists) are required to register with the Health Practitioners Competency Assurance Act (2003) and work within a specific scope of practice. Social workers must register with the Social Workers Registration Board, and counsellors may voluntarily register with the New Zealand Association of Counsellors. Jeffery and Wilson's (2017) finding that occupational therapists can use AT as an approach to occupational therapy practice is likely compatible with other professions, enabling practitioners to use AT within their discipline parameters and scope of practice. Rather than being a constraint, we propose that maintaining these boundaries can be viewed as a strength for the field. NZ's social, health, justice, and education systems are well established and all employ professionals who could integrate AT strategies and principles into their everyday work, no matter where they stand on the continuum. We suggest that professing we "use adventure therapy strategies" rather than "we are adventure therapists" is an enabling viewpoint, and potentially enhances the profile and use of adventure therapy in both fringe and mainstream services.

Cultural lens

Accepting AT as the use of adventure strategies also enables development of practice to better meet the needs of specific cultural groups. Given that the highest population of youth at risk in NZ are Māori male (Ball et al., 2016) it is important

that effective interventions are accessible to that population. Literature exploring fit and dissonance between indigenous and Eurocentric views is emerging. Lugg (2004) helpfully explores social, educational, and environmental contexts in relation to adventure education. They challenge dominant patterns in the use of common adventure activities, asserting they are not necessarily appropriate for the geography of the place or culturally relevant, strengthening the argument for working in a way that best suits local context. Wratten-Stone (2016) reviewed literature on Kaupapa Māori models of psychological therapy and found that "*a main reason for the poor mental health of Māori is the lack of therapies and services that cater to cultural contexts that differ from the Western norm*" (p. 23). This issue is complicated by European health structures which are at odds with traditional Māori culture (Jeffery, 2005; Wratten-Stone, 2016).

In his work on developing NZ social worker education with an AT element Gilbert (1998) asserted that the *"…adventure approach connects almost completely with Māori traditional ways of working and learning*" (p. 7) citing groupwork, learning through doing, and knowledge belonging to and serving the people as examples of the fit. This fit is reinforced by Radford (2013) who suggested that AT resonates with Māori due to the activity base, natural environment, and emphasis on group involvement. His study found that being Māori and/or male was a predictor for attendance and engagement in the AT component of a mainstream mental health service. The work of Pretorius (2020) found that surf therapy had positive physical, psychosocial, and behavioural outcomes for an all-male group of youth at risk, with particularly strong outcomes for Māori. Both researchers attribute the positive outcome for Māori in part to the fit that can be enabled between te ao Māori and AT practice. However, this "fit" is not universal as evidenced in the work of Boyes' (2010) who explored Eurocentric views on engagement in adventurous activities with commodification of adventure, individualism in many pursuits, and the use of nature as a resource, in contrast with traditional ecocentric views in te ao Māori. In our research the number of Māori participants was limited, even so ancestral knowledge and Kaupapa Māori service development was identified as important by Māori and non-Māori participants. We suggest that the Kaupapa of existing Māori led practices that have a fit with AT philosophy have value in informing AT practices going forward.

Trauma lens

Our study found support for and wariness of intentional use of challenge and risk in AT. The comfort zone model requires that participants are in a situation at the edges of what is familiar, with elements of unfamiliarity and uncertainty introduced (Morris, 2020). Although often used, its' appropriateness is sometimes questioned. Alvarez and Stauffer (2001) assert that use of challenge and risk is a strategy rather than integral to AT, and that it may or may not be appropriate for the client or group. Davis-Berman and Berman (2002) challenge intentional use of risk, suggesting that effective change can better occur from a position of safety. This is supported by the work of Leberman and Martin (2002) who found that learning outcomes for many

were a result of elements of the program other than the activities with high perceived risk. Additionally, Reed and Smith (2021) explored use of risk and eliciting anxiety or fear and ask whether the "*risk + fear = growth hypothesis remains relevant within the complexities of the twenty-first-century sociocultural landscape*" (p. 11). Their work reinforces that of earlier researchers, indicating that peak learning does not happen if individuals are too far out of their comfort zone, therapeutic effect is often from adjunctive activities in a program, and perception of and tolerance for risk is very individual. Brown (2008) critiqued indiscriminate use of the comfort zone model, cautioning practitioners against using it to explain learning and justify incorporation of risk in practice.

One key concern expressed by participants in our study was the importance of a trauma informed approach to AT and how this is not always known or applied, particularly by outdoor educators. Neuroscience research into the impact of trauma on the developing brain is enhancing understanding of the individualised nature of responses to risk and experiences of anxiety. Impacts of childhood trauma may include lifelong difficulties with self-regulation and consequently the capacity to connect with others and cope with situations that trigger the stress response (Van der Kolk, 2015). Individuals who are living with these consequences are often involved in mental health, corrections, or social services, or are struggling in school or work. In NZ Māori experiences of trauma may present in distinct ways due to experiences of colonisation and subsequent racism, discrimination and dissociation from land and community (Pihama et al., 2017; Wirihana & Smith, 2019). Our research found that whilst "high adventure" activities continue to have a valuable place in AT services, activities that promote emotional regulation, connection with nature and retreat style experiences are also adventure therapy and considered more appropriate for many. A trauma informed approach is becoming integrated into mainstream services in NZ, including education (Berger, 2019), corrections (Dempster-Rivett, 2018), health and social services (Donaldson, 2018), with specific guidelines for Māori (McClintock et al., 2018). A phased approach to trauma intervention, evident in trauma literature from many disciplines, is emerging in AT literature (Pringle et al., 2021; Trundle & Hutchinson, 2021). Our research found concern regarding practitioners from outdoor education or youth work not always skilled to work safely with clients with a trauma history. Pryor et al. (2005) affirm the importance of AT practitioners having skills and knowledge in effective intervention with this group, and advocate for clear practitioner boundaries for the sake of safety. A trauma informed lens is important to enable safe AT across the continuum.

Activity lens

The prevalence of talk-based therapy for people experiencing mental health challenges influenced the early development of AT. Resultant emphasis on talk as a key element of the practice is evident in early literature e.g., Fletcher and Hinkle's (2002) work on adventure-based counselling. However, it is also argued that the experiential nature of the approach with less emphasis on talk as therapy makes it more acceptable and accessible for youth (Jeffery & Wilson, 2017; Pretorius, 2020). Our

findings support the view that the activity is as valuable as talk in AT facilitation. Activity based therapies include Occupational therapy, defined as a "*client-centred health profession concerned with promoting health and wellbeing through occupation* [activity]" (World Federation of Occupational Therapy, 2010) which has been found to be a good fit with AT (Crisp & O'Donnell, 1997; Jeffery & Wilson, 2017; Levack, 2003). Experiential therapies facilitate expression and processing using media other than words. Pimsler and McKenzie (2020) define experiential therapy as the "*umbrella term used for any action orientated, multi-level co-created therapeutic intervention*" (p.5) and include adventure therapy as an experiential therapy. They specify commonalities in practice including use of action/activity/doing something, working with the conscious and unconscious and use of bottom-up processing strategies. Hanna (2012) explores adventure-based psychotherapy, clearly situating AT within experiential therapy for some psychotherapists. Use of AT strategies in experience-based therapies supports the concept of AT as an approach to therapy rather than a therapy of itself.

Focus on talk-based therapies in AT literature risks placing outdoor educators and youth workers outside the AT community, or intimates they lack skills required to use AT strategies. Itin (2001) clarifies AT definition through exploring the level of client change (therapeutic or therapy), practitioner qualification and client population. Whilst this early work indicates AT practitioners require qualification in both therapy and outdoor facilitation, we argue that outdoor educators and youth workers can use AT strategies at the personal development end of the spectrum, or at the therapy end through supporting the work of a therapist. This co-facilitation model, endorsed by our research, is emerging in AT literature (Itin & Mitten, 2009; Richards, 2015; Wynn et al., 2012). Many AT strategies can be used in a variety of ways and so fit across the continuum. For example, conscious use of metaphor, often considered integral to AT, is simply a strategy that may be selected (Alvarez & Stauffer, 2004). Metaphor might be facilitator created (common in experiential education), co-created with client (by therapists or outdoor educators), emerge from the client through the experience (worked on within therapy, often using counselling skills), or emerge as a life metaphor becoming central to psychotherapy.

Some concerns emerged in our research from therapists regarding limited therapeutic knowledge and skills in outdoor educator and youth work sectors. To ameliorate related quality and safety issues we suggest these practitioners enhance their skills in therapeutic communication, maintain a strengths base, develop an understanding of presentation evident in people experiencing mental health challenges, learn about the effects of trauma, and learn mental health risk assessment and management (Gath, 2009; Jeffery, 2017). Importantly, the partnership model of therapists working alongside outdoor educators endorsed by some participants would enhance safe practice for those who are not dual qualified.

Community of Practice

Interestingly, links emerged in our findings between AT intervention, how using AT is learned, and what would nurture the field. Commonalities were use of

experiential learning, group membership and belonging, role of relationship, learning through observation, and use of role models. This is likely a reflection on both the benefits of learning in these ways and limited opportunities to learn AT practices more formally in NZ. Specific courses and qualifications are gradually emerging, for example a course on AT within the Bachelors in Sustainability and Outdoor Education (Te Pūkenga, 2022a), NZ Certificate in Youth Work Adventure Based (Adventure Works, n.d); Post Graduate Certificate in Applied Practice in Health – Adventure Therapy (Te Pūkenga, 2022b). In our research, networking opportunities were most identified as important for advancing the field in NZ, with formal qualifications at a degree level rating lower (see Fig. 6). The structure of AT in NZ is in line with Wenger's (2009) Community of Practice (CoP) model where a community of practice is "*a group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly*" (p. 1). CoPs benefit from intentional and organised planning to augment their often-organic evolution. Potential for learning through CoP is enhanced through opportunities for knowledge sharing across all levels of expertise where the interaction helps with assimilation and integration of knowledge. Knowledge translation (research into practice) is stimulated through incorporating academic discourse into practice descriptions. Importantly skills in boundary holding (where scopes of practice are maintained) and boundary crossing (enabling a shift in what practitioners are doing and how they are doing it within their scope) are strengthened. Reflection is triggered through the interactions, and a culture of questioning others about their reasoning and practice is encouraged. Relationships that form in CoPs have potential to lead to mentoring, practice observation opportunities, and supervision (Barry et al., 2017; Wenger et al., 2002).

Implications for practice

We advocate a two-pronged approach to enable the field to flourish – development of the profile of AT, and establishment of learning opportunities for practitioners to develop essential AT skills. We propose that:

- The CoP is intentionally strengthened
- Bicultural practice is enabled and Kaupapa Māori practice supported
- Trauma informed practice is everyday practice
- Practitioners have access to learning opportunities that strengthen their practice in relation to where they stand on the continuum
- Education about AT be incorporated into undergraduate health, education, youth work and outdoor programs
- Postgraduate AT education opportunities are expanded
- Learning about and access to supervision is facilitated
- Existing networking and sharing opportunities are strengthened
- Informal AT education and training opportunities are facilitated e.g., workshops

These actions would grow the profile and create space for integration of AT into mainstream services more effectively than creating a stand-alone new profession.

Limitations

This research follows Eurocentric research methodology, did not include Māori researchers, and had a limited number of Māori participants. AT in NZ would benefit from Kaupapa Māori research to influence the development of the field in a way that represents best practice for Māori.

This research provides a snapshot of the AT situation in NZ, further research into practice, outcomes and practitioner development is required for a deeper understanding.

Conclusion

Our findings suggest that rather than a profession of itself, AT in NZ is an approach to practice incorporating specific theory and strategies into practitioners' everyday work. Application of the strategies may enhance wellbeing and facilitate personal development, enable therapeutic moments or be therapy of itself. Practitioners include educators, youth workers, and therapists, reflecting inclusion of health and wellbeing agendas in educational, justice, social, and health services.

All practitioners need to ensure they work within their own professional boundary and have additional education and training regarding AT theory and practice to enable safe application of AT strategies compatible with their discipline.

All practitioners require knowledge and skills to enable trauma informed practice. Some, who are therapists, may use AT as an intervention to facilitate processing of trauma and amelioration of trauma symptoms. Others will use their understanding of the effects of trauma to ensure safe and healthful experiences for their clients.

AT strategies should be considered and selected for their appropriateness in terms of the client, the practitioner and NZ culture. Elements of Eurocentric AT definitions and practices do not fit with indigenous ways of viewing engagement in activity and relating with nature. There is NZ research to support and potential for Māori to shape and influence AT to form a good fit with te ao Māori.

Embracing the theory of Communities of Practice will ensure a strong AT community of diverse practitioners who can learn from each other, enhance safe practices, and influence the way AT develops in NZ.

Declarations

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