

**Just Another Approach:  
New Zealand Occupational Therapists' Use of Adventure Therapy**

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**Otago Polytechnic**

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## **Abstract**

Adventure therapy is an intervention increasingly used in facilities providing services for people wishing to make psychological changes, most commonly adolescents and young adults. This research explores New Zealand occupational therapists' use of adventure therapy to ascertain the fit between occupational therapy as a profession and adventure therapy as it is known in New Zealand

No literature was found that specifically explored occupational therapy's fit with adventure therapy, or how occupational therapists are using adventure therapy. However literature reviewed indicates that occupational therapists are well positioned to work as adventure therapists, provided they acquire additional training and develop skills in adventure activity facilitation and the specific additional theoretical bases of adventure therapy.

This was a qualitative descriptive study designed to capture the perspectives of New Zealand occupational therapists who utilise adventure therapy in their work. The practice and use of theory of seven therapists recruited through snowballing was explored through semi-structured interviews. Data analysis revealed therapists believe there are many features of adventure therapy theory and practice that are shared with occupational therapy as well as many differences. Occupational therapists can actively manage the differences between the two fields to ensure they are using adventure therapy appropriately in their occupational therapy work.

Adventure therapy's use of activity as a therapeutic intervention is different from occupational therapy's broader holistic view of the individual as an occupational being. Participants' observations and the literature reviewed describe adventure therapy using prescribed unfamiliar activities in novel environments to

provide challenge with an element of perceived risk. The intent is to allow the client to develop insight into their usual, possibly maladaptive, responses to challenge and try new ways of responding. Occupational therapy in contrast generally focuses on the client's everyday activities in familiar environments, has a more pragmatic approach and works on real life problems. In occupational therapy intervention, engagement in the activity may be viewed as therapy in itself, whereas in adventure therapy debriefing the activity is an essential component of the process. Adventure therapy is often directed at the group as a whole, whereas occupational therapy will have more of an emphasis on the individuals, even within settings where groups are facilitated.

Theoretical concepts and practice in the two fields are based on shared beliefs on the therapeutic use of activity and the influence of occupation and environment on health and wellbeing. Occupational therapists can use adventure therapy as an approach in similar ways that they use other approaches to occupational therapy intervention. Occupational therapists bring specialist knowledge and skills in activity analysis and adaptation, and in understanding the individuals overall environment which increases potential for transfer of learning.

Occupational therapists are well positioned to use adventure therapy as it is known and practiced in New Zealand. It is recommended that occupational therapists be explicit to employing facilities about the similarities and differences between the two fields, and claim the additional expertise that occupational therapists have in using adventure therapy as an approach. Occupational therapists can consider adventure therapy as a legitimate approach to intervention or tool that they can use enhanced by additional theoretical knowledge about experiential learning and either training in the adventure activity skills or partnership with qualified adventure activity instructors.

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Secondly I would like to thank my supervisors – Dr Jo Straker for her outdoor adventure expertise and being willing to read so much from another profession; and Dr Linda Wilson for her unfailing encouragement and her preparedness to put the experiential learning process into practice with me and my first research endeavour.

And finally my husband Ian, for his quiet support, willingness to help with the rest of life's chores through this process, and for not complaining too much at the diminished shared play time. Now we can fly together!

*I am learning to fly. I gather people around me who already fly. They teach me, watch me, guide me and provide support through the spooky bits. I enrol in a course and I go to the classes. I borrow the book – The Art of Paragliding and I take special notice of the weather forecast every day. I select my mentor, and I feel inspired. I browse the internet and I watch the DVDs and I lie on the grass and I watch the clouds form and move and dissipate. I watch them for ages. I wonder if I will ever feel them on my face...*

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# 1 Introduction

This study focuses on the field of adventure therapy, and seeks to understand the fit between adventure therapy and occupational therapy. Adventure therapy is explored and viewed through my eyes as an occupational therapist with considerable clinical experience (primarily in mental health, and at times using adventure therapy) and involvement in adventure based activities both as an instructor and recreationally.

## *1.1.1 What drew me to the study?*

Any research project generally begins with a general area of interest or curiosity, and consciously develops into academic exploration (Hart, 1998; Tolich & Davidson, 2003). I have had a lifelong involvement in outdoor pursuits from which I have gained pleasure, challenge and satisfaction, both personally and professionally. As well as recreational involvement in these pursuits, I have experience in teaching or instructing others in various adventure activities at club or association level, as an instructor at the Outward Bound School in New Zealand; and have incorporated adventure activity in mental health occupational therapy interventions. Whilst instructing at Outward Bound, I noticed parallels between the outward bound process and the occupational therapy process, and a consequent interest in and curiosity about adventure therapy developed. In the intervening years the number of occupational therapists working in adventure therapy has increased. This study is based on these observations and continuing interest in the overlaps, similarities and differences.

### *1.1.2 Research problem and rational for the study*

Through reading, discussion with colleagues, and working in the mental health field I have ascertained that adventure therapy is an intervention increasingly applied. It is internationally used with clinical populations in mental health, most commonly with adolescent and young adult populations. Adventure therapy as a term encompasses a wide range of concepts, practice models and underlying theories. The family of “adventure therapies” includes such terms identified in the literature as therapeutic adventure, adventure based counselling, adventure therapy, wilderness therapy, outdoor experiential therapy. The underlying theoretical bases for the various models of adventure therapy come originally from education; and education based literature has the most prevalent inclusion of relevant literature regarding adventure therapy. To a lesser extent adventure therapy literature is also found in health literature, particularly mental health. The education theoretical base is most commonly experiential education, health contributions to the theoretical base are primarily from counselling, psychology and psychotherapy bases.

An initial search of the literature in relation to adventure therapy and occupational therapy indicates that although adventure based therapies are utilized by occupational therapists and definitions of adventure therapy indicate occupational therapists are well equipped to work in the field, there is no evaluation of how occupational therapists are utilizing occupational therapy theory or practice in their adventure based work. As a result there is limited clarity around its appropriateness as an occupational therapy intervention or guidance for occupational therapists wanting to do adventure therapy.

### ***1.1.3 Clarifying terminology***

To provide clarity and consistency in this work specific terms used are defined here. For the purposes of establishing the parameters of this research I have defined adventure therapy *the use of adventure activities in groups for the purpose of facilitating a positive change in psychological or psychosocial function.* The term “*adventure therapy*” is used to encompass all of the related terms in the literature such as wilderness therapy and adventure based therapy, even though some authors differentiate between them. The term “*adventure therapist*” is used to encompass anyone who is doing or using adventure therapy, including occupational therapists who use adventure therapy. Even within the occupational therapy profession there are differences in how the terms occupation and activity are used. For this research, the definitions provided by Creek (2014) are used. Occupation is “*A group of activities that has personal and sociocultural meaning, is named within a culture, and supports participation within society. Occupations can be categorized as self-care, productivity and/or leisure.*” and activity is “*A structured series of actions or tasks that contribute to occupations.*”(p.35). The client population of interest is people who are seeking assistance on issues related to mental health or psychosocial function, and not people seeking leisure or recreational skills, or rehabilitation from physical injury or illness.

### ***1.1.4 Research question and purpose of the research***

A preliminary exploration of adventure therapy literature related to the field’s philosophical base, models of practice and how adventure therapy is used was conducted. Although a diverse range of theory and practice was evident there was consistency in the use of experiential learning theory, and its application alongside numerous mental health approaches. Relevant occupational therapy literature was reviewed in order to understand philosophy and theoretical bases that may or may not be compatible with

adventure therapy, and to ascertain the current understanding of adventure therapy within the occupational therapy profession. Internationally literature on adventure therapy and occupational therapy is very sparse, and only one article was found that considers adventure therapy's use by occupational therapists (Levack, 2003). As I have used adventure therapy in my own clinical practice, and I know of other occupational therapists in New Zealand who use it, I was confident that this is an area that warrants exploring. The literature review (see below) demonstrates there is a gap in the literature regarding the relationship between the two fields. What the fit is, or even if there is a fit, is not evident in the literature.

### ***1.1.5 Overview of the thesis and each chapter***

The literature reviewed was primarily from the field of adventure therapy; however some contemporary occupational therapy literature was included to make direct comparisons between the fields on a theoretical level. This is presented in *chapter two* in six discrete sections:

*Defining occupational therapy* provides a definition of the profession and a review of literature regarding contemporary occupational therapy theory including philosophical beliefs and a conceptual model commonly used (the model of human occupation). Concepts explored include occupation for health and wellbeing and the use of occupation as a therapeutic tool. These are the concepts that likely influence participants clinical reasoning most when considering their practice with adventure therapy.

*Defining adventure therapy* explores literature that helps with understanding its development as an intervention or profession and situates it in the New Zealand context. As well as philosophical beliefs concepts that are relevant to understanding adventure therapy in relation to occupational therapy are explored such as the therapeutic use of activity and environment.

*Experiential learning* is an educational philosophy that forms a base for adventure therapy. Experiential learning principles seem to provide the structure for applying activity in most adventure therapy processes; this literature enables comparison between this process and usual occupational therapy.

*Theoretical base of adventure therapy* explores theory developed within the field of adventure therapy, and theory used by adventure therapists derived from health theory bases (primarily psychology). This section enhances understanding of what informs adventure therapy practice, and enables comparisons with occupational therapy. Whilst the use of experiential learning principles is consistently present in adventure therapy literature, theory that informs other aspects of practice varies considerably. This variety contributes to lack of clarity about the definition of adventure therapy, who an adventure therapist is and how they work.

*The fit between adventure therapy and occupational therapy* is not immediately evident in the literature. This section of the literature review highlights the paucity of literature about occupational therapy's use of adventure therapy and explores features of both professions that may demonstrate a fit or not in terms of practice. Aspects covered are the client population adventure therapists work with, the skills adventure therapists require, and similarities and differences between the two fields in approaches and beliefs.

*Who is an adventure therapist and how are they trained?* This final section of the literature review addresses the debate around what an adventure therapist is. The qualifications of therapists most commonly working in adventure therapy are named, and contextual differences between the USA and New Zealand are explored to highlight potential reasons for occupational therapy literature having such a low profile in the field internationally. There is no one

pathway for training adventure therapists; implications of this for the field are identified.

By the end of the literature review I was able to identify my research question:

*“What is the fit between occupational therapy and adventure therapy as it is practiced in New Zealand?”*

Sub-questions (as follows) were then developed to provide a framework for the research and structure for the development of interview questions:

1. How do New Zealand occupational therapists familiar with adventure therapy define adventure therapy?
2. How do New Zealand occupational therapists use adventure therapy?
3. What are the theoretical bases used by New Zealand occupational therapists working in adventure therapy?
4. What are the links between underlying theoretical bases utilised by occupational therapists generally, and adventure therapists?
5. Are there knowledge, skills or attitudes that need to be developed by New Zealand trained occupational therapists in order for them to practice adventure therapy effectively?

These questions were developed in order to understand the fit between the two fields in New Zealand with a view to improving service provision of occupational therapists working in adventure therapy; and identifying knowledge and skill gaps in occupational therapists entering the adventure therapy field.

Once the research question was established the options regarding research methodology were considered, this process is covered in *chapter*

*three.* As I wanted to answer the question through understanding how occupational therapists in New Zealand are practicing adventure therapy, their perceptions of the fit or not, what theory they are drawing on and how they are using it, it was clear that a qualitative methodology was most appropriate. As similar research is not evident in the literature for this study to add to or compare with, it is appropriate to establish what is actually happening in the field, and so qualitative descriptive methodology was selected. Qualitative descriptive methodology provides a way of capturing and summarising what is happening in the field in order to gain a comprehensive understanding of the status quo. In order to gather participants' perspectives and insights semi structured interview research method was selected, and interview guide questions were developed.

Although this study is not specifically exploring aspects of Maori culture there is a possibility that data of significance to Maori would be gathered. I therefore consulted with Maori prior to ethics approval and secured a leading Maori occupational therapist to act as cultural supervisor should data significant to Maori be gathered.

From conversations with occupational therapists and a search of the New Zealand Adventure Therapy Association website it was established that there is likely to be very few occupational therapists in New Zealand who are working in adventure therapy. The inclusion criterion was therefore broad, and stipulated as:

“New Zealand occupational therapists who are working (or have worked within the past 10 years) using adventure therapy in New Zealand”

Snowballing and information from organisations that these therapists may be aligned with were used to identify participants; all who responded met the criterion and were selected and interviewed.

The work of Field and Morse (1996) was used to provide structure for the data analysis. They propose four discrete stages, the first named comprehending, or understanding what the data comprises of. The process followed in order to reach a state of comprehension started with reflection during the transcribing phase and went on to include identification of commonalities and differences, discrete concepts and eventually themes. The second stage, synthesis, refers to reorganising the data in a number of ways until a pattern emerges that can articulate the meaning of the data. The pattern that was eventually identified became the structure for the next chapter.

*Chapter four* presents the findings of the study three sections:

- a) **What is familiar to the participants** includes information on what is similar or shared between occupational therapy and adventure therapy.
- b) **What is unfamiliar to the participants**, includes information on what is different, conflicting or requiring knowledge and skills in adventure therapy that occupational therapists do not have
- c) **What participants do to “make it work”** – how they work with the differences to enable them to legitimately and safely use adventure therapy in their practice.

The data were analysed thematically, and it was clear that there were aspects of participants work in adventure therapy that they considered to be a good fit with occupational therapy. However there were also aspects of adventure therapy that participants identified as different from occupational therapy, and that had the potential to cause dissonance for the therapist. Participants employed a variety of strategies to address the differences.

The findings are discussed in *chapter five*, structured under the headings theory and practice. The theory section explores the findings and

relevant adventure therapy and occupational therapy literature to garner an understanding of the influence of philosophical beliefs on the participants' thinking and practice. The practice section explores how adventure therapy is used by occupational therapists and includes discussion related to skills, professional generic and specialist work, the fields' use of activity and environment and perspectives on how the individual is viewed in therapy.

*Chapter six* is the conclusion, and is presented in three sections. Conclusions that are drawn from the research are presented with an indication of the sector they are most likely of interest to. Limitations to the study are identified, and implications for further research are determined. My recommendations for occupational therapists, employers and managers of occupational therapists using adventure therapy, and education and training providers regarding use of adventure therapy in New Zealand are provided. I finish with a brief personal reflection on this research process.

The reference list is followed by appendices.

*Standing on my first high take off site I feel the stress response. Fight or flight they call it... The air is warm, the breeze is gentle and it comes and goes. So much of it is in the timing. Will I be safe if I go now? I choose flight and launch. Information is everywhere, clues and hints. I see clouds, shadows and sunny spots, the feel of the glider through the lines in my hands; hear the instructor talking to me on the radio. So much to think about – how steep to turn, what to watch, pitch control... I have launched not quite into the unknown because I can see where I am going and not quite unprepared because I have learned some useful skills, but nevertheless daunting because I have never been here before.*

## 2 Literature review

### 2.1 What is a literature review?

Literature review is defined by Hart (1998) as:

*“The selection of available documents (both published and unpublished) on the topic which contain information, ideas, data and evidence written from a particular standpoint to fulfill certain aims or express certain views on the nature of the topic and how it is to be investigated, and the effective evaluation of these documents in relation to the research being proposed.”* (p. 13).

A literature review is conducted for numerous reasons, including clarification of the problem or research topic, binding the research question to existing theory and research, demonstrating the researcher’s current knowledge of the topic, and placing the topic in context (Tolich & Davidson, 2003). Whilst I had identified the rationale for the research, the specific research question could not be discerned until literature was reviewed. I needed to ascertain existing uses of adventure therapy by occupational therapists, and current understandings of adventure therapy in the New Zealand context. Reviewing the literature assisted me to develop my understanding of theoretical bases underpinning adventure therapy, and identify that there are gaps in published research regarding occupational therapists’ use of adventure therapy.

Hart (1998) identifies the importance of doing the literature review early in the research process, in part to ensure the research-ability of the topic and to narrow the topic to a manageable scope. The literature review was initiated once the overall topic had been decided, so that it could be used to inform the formulation of the research question. An abbreviated version of

the literature review was submitted to the Otago Polytechnic ethics committee as part of the ethics approval application (see appendix 1).

## **2.2 Planning the literature search**

Planning the literature search well ensures that the time is spent productively in meeting the aims of the literature review. Hart (1998) identifies six stages in the literature search process involving defining the topic, considering the scope and outcomes of the topic, organization of the literature, planning the search and following the search plan. He also discusses the importance of using quality literature, with a focus on scientific research and published in peer reviewed journals.

### *2.2.1 Defining the topic*

The broad topic was narrowed and defined following reading of seminal works on adventure therapy, and generally “browsing” literature related to adventure therapy and its use by occupational therapists. A “mind map” was used through this process (see appendix 2), as were conversations with my supervisors (one from occupational therapy and one from outdoor education) and peers to assist in honing the parameters of the research. Tolich and Davidson (1998) identify the value in a small country such as New Zealand of networking and establishing “*who is the “guru” when it comes to researching this topic ...*” (p10). Two New Zealand academics were contacted and were prepared to talk with me about their research, their perception of adventure therapy in New Zealand, and to make recommendations regarding literature. These conversations helped me appreciate the limited extent of research regarding adventure therapy per se in New Zealand, and also confirmed that the reading initially embarked on was appropriate. The reading and the conversations helped me define the topic more specifically.

Notes on the key authors recommended were made, and terms associated with adventure therapy listed to assist with the search vocabulary.

### *2.2.2 The scope of the topic*

When considering the scope of the search, contextual and pragmatic factors were taken into account. I had access to The Robertson Library data base and through this access to other academic libraries, and so this is where the bulk of the search was conducted, augmented by using Google Scholar. The search was limited to literature in English, and initially limited to 10 years – this date was extended when the limited amount of relevant literature was ascertained. Search vocabulary, or a list of terms and phrases (Hart, 1998) was formulated and included various combinations of key words including occupational therapy, adventure therapy, outdoor education, experiential education, theory, training, definition.

### *2.2.3 Outcomes of the search*

The overall aim of the research (established when the topic was being defined) is to explore the theories utilised by occupational therapists in New Zealand who are working in adventure therapy. The purpose of this research is to ascertain the fit between occupational therapy as a profession and adventure therapy as it is known in New Zealand. The literature search outcomes are therefore to establish through the literature:

- What the current knowledge is regarding how adventure therapy is known in New Zealand.
- Occupational therapists use of adventure therapy in New Zealand (specifically theories utilised).
- Who the key theorists are, what studies have been done in the area of occupational therapy and adventure therapy in New Zealand?

- What methodologies have been used to frame research in this field to date?
- What is the extent of occupational therapy literature in adventure based therapies?

I also considered it important that I knew fundamental concepts related to adventure therapy prior to the research, such as the history of the development of adventure therapy internationally and in New Zealand, how adventure therapy is defined internationally and in New Zealand, and what theoretical bases are articulated in the literature that informs adventure therapy internationally and in New Zealand.

#### *2.2.4 Organisation of the search*

To ensure the search was well organised systems were established to ensure the search process was structured, and the search process and findings were recorded. A matrix was developed (see appendix 3) which guided selection of literature and ensured literature selected met the criteria of relevance and quality. A table was developed (see appendix 4) to record a brief summary of literature selected, and for journal articles the abstracts were printed, brief notes regarding their relevance written on the back, and filed in a folder. Literature sourced was also entered at this stage into Endnote (reference management software), and an electronic copy of the article linked to the reference.

#### *2.2.5 Plan sources to be searched*

The planned sources of literature focused on the identified search parameters and included how adventure therapy is defined, its use within occupational therapy and its theoretical underpinnings. Journals that were included in the search plan were peer reviewed occupational therapy journals, and journals that published work specific to adventure therapy

which included outdoor education journals, therapeutic recreation journals and experiential education journals. Searches were initially broad, then narrowed to the most appropriate data bases and journals once these were ascertained i.e. Cumulative Index of Nursing and Allied Health (CINAHL); Occupational Therapy Seeker (OT Seeker); ProQuest nursing and allied health, psychology and educational; and Education Resources Information Centre (ERIC).

### *2.2.6 The search*

The search was conducted utilizing the parameters developed (see appendix 5 for initial phase). Notes were made on relevant points either on the data sheets, or on the copies of the abstracts. Reference lists of relevant articles were used to identify other potential literature. A mind map was also used to capture themes and threads and to assist me further specify the research question. A large poster of a square (denoting a box) was used to assist in refining inclusion and exclusion of aspects of the topic – ideas or aspects of interest to me were written on post-it notes and placed in the box if considered relevant or out of the box if considered not relevant (see appendix 6).

### *2.2.7 Literature sourced*

The search identified a large number of research articles (qualitative, quantitative and mixed method) on the efficacy of adventure therapy in terms of clinical outcomes, and on the number and structure of adventure therapy programs offered (particularly in the USA). This falls outside the parameters of this research, although two articles were selected for the information they contained on theoretical underpinnings of the intervention.

Research articles on the use of adventure activities in leisure or recreation skill development, and the use of adventure therapy in

rehabilitation from physical injury also does not meet the requirements of this research, as this use of adventure in therapy differs from that used for this research.

All literature selected was from texts or peer reviewed journals, with the exception of one critically appraised topic which was from an open source website, not peer reviewed (Sullivan, 2011), an unpublished doctoral thesis (Newes, 2001) and a Winston Churchill Fellowship report (Crisp, 1996a). Four articles were qualitative research articles, and the remaining theoretical articles. Texts written and/or edited by Berman and Davis-Berman (1994), Gass (1993a), Gass, Gillis and Russell (2012), and Newes and Bandoroff (2004) were selected due to the authors' prominence in the field in their practice, research and academic writing. They are widely cited in research literature reviews, and their work includes a focus on both clinical and theoretical aspects of adventure therapy.

Prominent occupational therapy texts were reviewed to provide an overview of occupational therapy, and to ascertain if concepts relevant to adventure therapy are evident in the occupational therapy profession.

Data on the use of adventure therapy by occupational therapists was limited; there was no research in this area found, and no literature exploring the theoretical or skill fit between the two professions was found. Research on the theoretical underpinnings of adventure therapy was also limited; literature found in this area was restricted to aspects of reports on how programs were implemented.

The paucity of research regarding theoretical underpinnings of adventure therapy is surprising, given that many authors write about the importance of establishing consistent theoretical base and language as the adventure therapy field evolves into a "profession" in its own right (Itin, 2001). Sandra Newes has researched and written from the perspective of a

psychologist with an interest in adventure therapy on both theory and practice issues, and her work is included in this review. A recent book edited by Gass, Gillis and Russell (2012) includes work from a number of authors who write about adventure therapy theory from different perspectives and includes useful information on research and evidence in the field. Simon Crisp is an Australian clinical psychologist who is well respected for his work as a therapist, consultant and advisor in mental health services and education services. He is considered to be the pioneer of adventure therapy in Australia, and has explored the field from an Australasian and New Zealand perspective, which adds balance to the USA literature reviewed here. Of particular pertinence is his Winston Churchill Fellowship report which explores the use of adventure therapy in mental health services in UK, USA, NZ and Australia.

Adventure therapy literature is most prevalent from the USA. There are significant differences in health service provision between the USA and New Zealand, and also in the number of discrete “professions” providing services, including adventure therapy. Most literature selected was from peer reviewed journals, and were theoretical, opinion or research. Of the research articles selected, all were research regarding clinical effectiveness of adventure therapy (and were selected for their inclusion of underpinning theory), or the use of adventure based learning in education. No literature describing research into the use of adventure therapy in occupational therapy was found.

The literature sourced for review was initially chunked into six themes: defining occupational therapy, defining adventure therapy, theoretical bases of adventure therapy, the fit between adventure therapy and occupational therapy, and who is an adventure therapist and how they are trained. The following sections follow this structure.

## 2.3 Defining occupational therapy

Because this research is exploring the fit between adventure therapy and occupational therapy, it is useful to include literature that defines occupational therapy and briefly explains its place in mental health. Key texts for psychosocial or mental health occupational therapy were referred to, as well as the World Federation of Occupational Therapists (WFOT) website and the Occupational Therapy Board of New Zealand (OTBNZ) website.

WFOT defines occupational therapy as:

*“...a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.”(World Federation of Occupational Therapists Council, 2010)*

Occupational therapy’s paradigm is humanistic and holistic in nature. Wilcock (2005), Keilhofner (2009) and Molineux (2004) are three of many prominent theorists who advocate a return to fundamental or core beliefs articulated by the profession, particularly occupation as a determinant of health and a therapeutic agent for health. Growing understanding of the role occupation has to play in health and function, through for example the World Health Organisation’s definition of health and focus on occupation in the International Classification of Function, is considered an opportunity and a threat (Molineux, 2001). Occupational therapists focus on the occupations people need to engage with in their lives; often referred to as “occupation as end” and on the use of activities to help individuals maintain or enhance health and reach occupation goals, “occupation as means” (Trombly, 1995). In

this context, occupations are defined as *“the everyday, meaningful activities we engage in, related to our work, leisure and self-care.”* (Finlay, 2004, p. 40). Discrete activities, whilst on their own may have no specific meaning for the individual, combine to form meaningful occupations, and occupational therapists may use activity purposefully to effect a positive change in overall occupational engagement and participation (Creek, 2014; Finlay, 2004). Activity is specifically used to teach skills, to facilitate improved function in physical, cognitive or psychosocial domains and to establish adaptive habits that will enable successful achievement in life roles.

Occupational therapists use theoretical models that provide a *“means of identifying and rationalising what is being observed and a set of ideas within which to frame practice decision making.”* (Melton, Forsyth, & Freeth, 2009, p. 14). Conceptual models provide an overall way of framing and understanding the clinical data, and include tools for application of the theory; practice models provide more direction for actual intervention strategies (Melton et al., 2009). One conceptual model commonly used in New Zealand is the Model of Human Occupation (Kielhofner, 2008). MOHO is a generic or conceptual occupational therapy model which can be used in any clinical setting. The model utilises systems theory, and views the individual as an open system whereby information is received and interpreted by the person, and translated into a behaviour that influences the subsystems. The subsystems are labelled habituation, (patterns of occupation expressed as habits and roles), volition (preference for occupation influenced by interests and values) and performance (actions produced to enable occupation). The individual operates on and is influenced by the physical and social environment, which affords opportunities for occupation, and presses for behavioural responses (Kielhofner, 2008).

## 2.4 Defining adventure therapy

Literature addressing the debate over *what* constitutes adventure therapy and *how* it is defined was included to enable me to come to an understanding of differences in definition, language and practice of adventure therapy internationally, and begin to form an impression of how adventure therapy might be defined in New Zealand. Literature selected is from frequently cited texts edited by Gass, Gillis and Russell (2012), Gass (1993a) and Newes and Bandoroff (2006), and descriptive or theoretical journal articles including one literature review (Crisp, 1996b). The Winston Churchill Fellowship report from Crisp (1996a) was included for its relevance to the New Zealand and Australian context and its reference to occupational therapy in adventure therapy; and Mossman's (2005) thesis for its New Zealand focus. Autry's (2001) clinical qualitative research was selected for the theoretical implications in the findings.

Adventure therapy as an emerging profession has a multitude of definitions, and the processes vary by which adventure based activities form a therapeutic program (Gass, 1993b; Gillis, 1995; Mossman, 2005; Russell, 2001). The diversity of programs, facilities, staff qualifications and skills, populations served and research conducted all contribute to confusion and a lack of cohesion within the field (Alvarez & Stauffer, 2001; Autry, 2001; Mossman, 2005). Attempts have been made to define adventure therapy by examining the settings it is conducted in, the qualifications of the practitioners, the theoretical base and activities being used and the client population (Crisp, 1996b; Gillis, 1995; Itin, 2001; Russell, 2001).

Many definitions of adventure therapy incorporate opinions on the health qualifications of the provider and the psychological theory utilized in the program. In their text Newes and Bandoroff (2004) consider the use of adventure as a medium through which standard psychologically based

therapies can be utilized. They argue that adventure therapy holds more similarities with other forms of therapy utilized in mental health than has been acknowledged by adventure therapy practitioners. Clarifying and formalizing the shared knowledge and skill base as well as defining the specific adventure components will, they argue, help advance adventure therapy acceptance in mainstream mental health service provision.

A difference between adventure therapy and the therapeutic use of adventure is commonly articulated. Becker (2010) advocates distinguishing adventure therapy from therapeutic adventure in his discussion on the ethics of using adventure therapy in mental health services. He describes professionalism, safety and ethics as the main reason, with adventure therapy being conducted with clinical populations by qualified therapists. Itin (2001) also advocates distinguishing between the two, adventure therapy being directed at changes at the unconscious level or meta-processes and the therapeutic adventure facilitating changes in behavior, affect or cognition.

Itin (2001) explored literature that attempted to define both adventure and adventure based therapies and concluded that both the activity itself and the philosophy behind the activity were important ingredients. He ascertained that the activities in adventure therapy generally include initiative and trust activities, and higher adventurous outdoor activities; that they are generally conducted in the outdoors; and that they are presented in an atmosphere where active exploration of the unknown is encouraged. Challenges are seen as opportunities for change and the group is an integral component for change for the individual.

Many differentiate between adventure therapy and wilderness therapy e.g. Crisp (1996a), who defines adventure therapy as *“the use of contrived activities of an experiential, risk taking and challenging nature in the treatment of an individual or group”* (p. 9), separates wilderness therapy as therapy dependent

on the impact of exposure to an isolated natural environment. Ewert, McCormick, and Voight (2001) however acknowledge the usefulness of combining adventure therapy, and wilderness therapy under the term outdoor experiential therapy.

Most of the debate around definitions comes from USA literature and may be somewhat reflective of the user pays health system and a population base able to support the myriad of programs on offer (Crisp, 1996a). Crisp focused his exploration on the use of adventure therapy for mental health programs for adolescents in UK, USA, Australia and New Zealand. When discussing terminology and definitions, he states that "...authors should attempt to define their terms whenever entering the debate" (p20). To this end for the purposes of this research I have defined adventure therapy and associated terms (see p. 3).

## **2.5 Theoretical base of adventure therapy**

Literature regarding the theoretical underpinnings of adventure therapy was sought for me to gain a thorough understanding of current use of theory by adventure therapists, and in an attempt to understand how occupational therapists align their occupational therapy theoretical background with adventure therapy. No literature regarding the later was found. Relevant qualitative research into the theory bases used in adventure therapy was conducted by Russell (1999) and his doctoral thesis was included; other articles selected were primarily theoretical or descriptive. Many aspects of the theory bases of adventure therapy are shared with other types of therapy; however the purposeful use of experiential learning as an integral component of therapy is more specific to adventure therapy. It is

therefore helpful to explore adventure therapy theory in two sections – experiential learning and other therapy theory.

#### 2.5.1.1 Experiential learning

Adventure based therapies' literature predominantly acknowledges experiential learning as its primary underlying theoretical base (often described alongside theory from mental health therapy). Whilst specific components such as what constitutes adventure, the extent that risk and stress is included, the practice models of the program, and the health related theories utilized vary considerably, references to experiential learning theory are consistently included. For this reason, literature that focuses on how experiential education is defined is reviewed, with a particular emphasis on literature that informs the roots of experiential education, and literature that locates experiential education in the field of adventure therapy. The seminal works of Gass (1993a), Ewert (1989) and Newes and Bandoroff (2004) provide context to the use of experiential learning in therapy.

Experiential educational philosophy relates to beliefs that people learn best from experience and if there are multiple senses involved in the activity (Kraft & Sakofs, 1985; Newes & Bandoroff, 2004). Experiential education deliberately involves learners in activities or experiences that have real life consequences. The process involves active and conscious reflection following the experience in order to ensure the learning happens, and that meaning or knowledge is constructed from the experience (Kolb, 1984). The experiential educational philosophy is informed primarily by the work of Dewey, articulated in his *Experience in Education* published in 1938. Dewey's theory incorporates the concepts of continuity (each experience will have an impact on following experiences) and of interaction (the relationship between past experience and the current situation and experience).

Terminology in the experiential education field is often blurred with experiential learning; much of the literature uses the terms interchangeably. However Itin (2001) advocates clarity between the two. He describes experiential education as a construct whereby there is a transaction between teacher and student, and whereby the larger social, systemic and political aspects of the educational construct are considered and incorporated. Experiential learning is a separate construct involving the experience or work of the student and includes a process of experience, reflection and change as a result of the experience. From reading the literature my understanding is that adventure therapists use experiential learning.

Experiential learning is learning through reflection on doing; the emphasis is on the critical reflection and processing of the experience. As identified by Kraft and Sakofs (1985), several factors are inherent in the process of experiential learning:

1. The learner is a participant rather than a spectator in learning
2. The learning activities require personal motivation in the form of energy, involvement and responsibility.
3. The learning activity is real and meaningful in terms of natural consequences for the learner.
4. Reflection is a critical element in the learning process.
5. Learning must have present as well as future relevance for the learner and the society in which he/she is a member.

David Kolb is an influential recent theorist regarding the development of experiential learning, continuing on from the earlier work of theorists such as Freire and Mezeiro. Kolb stressed the processing and critical reflection of experience being the heart of learning (Kolb, 1984). Kolb defines learning as *“the process whereby knowledge is created through transformation of experience”*

(pg. 38), and emphasizes the learning that happens when content meets experience. Kolb utilized a learning cycle model to articulate his theory, with four stages in the process – concrete experience, reflective observation or critical reflection (where the learner asks questions about the experience based on past experiences), abstract conceptualization (where the learner seeks to find answers to the questions, makes generalizations, draws conclusions) and active experimentation (where the learner puts the new hypotheses or conclusions to test, leading to more experience).

Whilst Dewey influenced the movement of the use of experience in education in the USA, Kurt Hahn was equally influential in the UK. His development of programs including Outward Bound is universally considered to be the beginnings of the use of adventure in education and ultimately in therapy (Fletcher & Hinkle, 2002; Itin, 1999; Leberman & Martin, 2002; Newes & Bandoroff, 2004). Hahn is widely quoted as proposing that *“the foremost task of education is to ensure the survival of these qualities: an enterprising curiosity, an undefeatable spirit, tenacity in pursuit, readiness for sensible self-denial and above all compassion”* (HIOS 1990 p. 71, as cited in Itin, 1999). Hahn’s education style involved strengthening an individual physically and spiritually (Ewert, 1989), including contracting with students regarding the setting of individual goals, structuring the use of time, utilizing challenging activities with an element of risk and working together in small groups (Itin, 1999). Hahn’s model has been described as one better suited to psychological models of change than educational (Kimball & Bacon, 1993) and perhaps provides an explanation for the subsequent merge of education and health services in many areas providing adventure therapy today.

The facilitation style in Outward Bound schools has gradually developed, from initially utilizing experience itself to facilitate learning, through to utilizing group discussion and group-work techniques to facilitate

reflection and more recently the conscious use of metaphor (Bacon, 1987; Martin, 2002). Courses have gradually expanded to include specific groups with intended therapeutic applications (Levack, 2003; Newes & Bandoroff, 2004), and programs in addition to Outward Bound have developed utilizing experiential learning and various therapy theories to facilitate therapeutic change. Many of these programs utilize variations of the Outward Bound Model, developed in 1976 by Walsh and Golins. This provides a structure and process for the application of Hahn's principles in a variety of settings, including clinical. Walsh and Golins' model specifically includes the motivated learner being

*"...placed into a prescribed social and physical environment where he or she masters specific problem solving tasks. The course instructor acts as a guide to ensure the tasks are both authentic and manageable and provides the necessary feedback to aid mastery which in turn leads to participant development."*

(Sibthorp, 2003, p. 81)

Experiential learning as a concept and theory is familiar to occupational therapists in New Zealand, and utilized in therapist education and in professional development. This theory, particularly the reflective component of it is advocated by the occupational therapy board to facilitate ongoing professional development (Occupational Therapy Board of New Zealand, 2010). However no literature was found on its clinical use in occupational therapy practice.

#### 2.5.1.2 Other adventure therapy theory

Alvarez and Stauffer (2001) helpfully frame the theoretical concepts of what is unique to adventure therapy as tools or techniques the adventure therapist may choose to select and use. This simplifies the discussion on what constitutes adventure therapy theory, and allows proponents of the various

techniques to use them as and when appropriate within their adventure therapy. These techniques include:

- Use of an unfamiliar environment
- The positive use of stress (eustress)
- Solution focused approach
- Small group work
- Active and facilitative role of therapist
- Use of perceived risk
- Metaphoric connection
- Natural consequences

(Adams & Sveen, 2000; Alvarez & Stauffer, 2001; Berman & Davis-Berman, 2005; Gillis, 1995).

Although the environment most commonly used is the outdoor environment, it is the contrast with the client's day to day environment that is important; (Gass, 1993b; Gass & Gillis, 1995; Gillis, 1995). Most of the literature reviewed identifies that the activities participants are involved in are novel, usually involve elements of perceived risk, demand group problem solving, and provide for opportunities for competence/mastery of the task and the development of more adaptive coping strategies. If perceived risk is high but actual risk is low, then the subjective experience of both stress and adventure is enhanced. If the activity is shared with others then the process also allows for the development of relationships with peers and facilitators and the rapid development of trust and group identity (Gass et al 2012, (Adams & Sveen, 2000). The combination of a novel environment and involvement in activities with a high level of perceived risk creates the level of dissonance and disequilibrium required for individuals to be forced into a

process of adaptation. This adaptation and the associated feelings of success can be very powerful, and if used in conjunction with conscious use of metaphors can enhance an individual's ability to relate the experience to home life (Adams & Sveen, 2000; Newes & Bandoroff, 2004). This process (commonly termed the adventure therapy process) is summed up by Nadler (1993) as:

*"The client experiences a state of disequilibrium by being placed in a novel setting and a cooperative environment while being presented with unique problem solving situations that lead to feelings of accomplishment which are augmented by processing the experience which promotes generalisation and transfer to future endeavours."* (p.60).

The theories, knowledge and skills utilized by adventure therapists and shared with other mental health professionals are varied, and depend on the facility and the therapist involved. Most of the literature reviewed acknowledged the comprehensive use of group developmental theories and the importance of group facilitation and management skills (Adams & Sveen, 2000; Berman & Davis-Berman, 2005; Gillis, 1995). There is some discussion on the use of psychotherapy based skills being integral to adventure therapy; Newes and Bandoroff (2004) propose that activity based psychotherapy is a more appropriate term as adventure is not necessary but an activity is. Theories commonly applied include cognitive behavioral therapy, humanistic theory, the positive psychological theories (e.g. solution focused therapy, brief therapy, person centered therapy) theories of change (Gass & Gillis, 1995; Prochaska & Velicer, 1997) and systems theory (Adams & Sveen, 2000; Becker, 2010; Berman & Davis-Berman, 2005; Hill, 2007; Newes & Bandoroff, 2004). Stich and Senior (1984) identify the facility processes as being crucial e.g. needs of the individual assessed and goals set, and adventure therapy utilised as part of a comprehensive program. They also stressed the

interpersonal skills and processing skills of the therapist as being most important. Crisp (1996b) proposes a framework (Experiential Reconstruction Theory) based on personality development, citing literature advocating that developmental issues and gains are fundamental to the therapeutic benefits of individuals successfully experiencing adventure therapy. Adams and Sveen (2000) reiterate the importance of theories of lifespan development in adventure therapy.

In a recent text on adventure therapy published in the United States Wasserburger (2012) clearly identifies adventure therapy as the use of experiential learning and adventure processes (as described above) by qualified mental health professionals. Here adventure therapy is described as a psychotherapeutic approach. Theory and approaches from psychology underpin the therapeutic aspect of the field, and theory from experiential and adventure based learning provide structure for the practice.

Theories and therapies utilised in adventure therapy are consistent with those used in other mental health interventions, and include many of the approaches used by occupational therapists in New Zealand.

## **2.6 The fit between adventure therapy and occupational therapy**

A general search seeking research into or literature supporting a match or otherwise between adventure therapy and occupational therapy was conducted. Only two theoretical articles and a critically appraised topic were found that directly explored the fit between occupational therapy and adventure therapy. Levack (2003) proposes that the use of adventure therapy, whilst not directly utilizing activities that can be considered daily occupations, has the potential to have a positive effect in an individual's spiritual domain. She also advocates that therapy through doing is legitimate

occupational therapy, and emphasizes the use of activity to facilitate positive change aspect of adventure therapy. This is reinforced by Frances (2006) who, although exploring the use of adventurous activities in recreation rather than adventure therapy summarizes literature evidencing the physical, psychological and emotional benefits of engagement in these activities. She identifies recreation as a legitimate daily occupation. Sullivan (2011) appraised literature from adventure therapy (in the absence of occupational therapy research in this area) and surmised that occupational therapy's use of task analysis, group development and leadership, motivational interviewing, stages of change, strengths base, engagement and learning through doing and therapeutic use of self all situate the profession well to work in adventure therapy.

Populations most commonly worked with in adventure therapy are the same as those that occupational therapists work with in mental health settings, as are the desired outcomes/goals that the service users are working towards. These commonly include facilitating positive changes in behavior, increasing self-efficacy, self-concept, sense of wellbeing, and developing coping skills (Crisp, 1996a; Fletcher & Hinkle, 2002; Gillen & Balkin, 2006; Levack, 2003).

The fundamental clinical skills utilized in adventure therapy (often referred to as "soft skills") are skills integral to all mental health professions, including occupational therapy e.g. micro-counselling skills, development of therapeutic relationship, group management and facilitation skills. Of particular note to occupational therapy however is the emphasis in adventure therapy that it is activity based, and this action approach is utilized to augment talking therapies (Gillen & Balkin, 2006; Hill, 2007). These authors argue that skills that help define adventure therapy include skills in selection of appropriate activity, sequencing and grading activity, analyzing and

adapting activity and utilizing activity with individuals and groups to facilitate change. Crisp (1996a) argues that this emphasis on the therapeutic use of activity of adventure therapy places occupational therapy as an ideal profession to work in this field.

As well as the use of activity, the adventure therapy approach of goal directedness and client centeredness, and the focus on success and mastery of skills as articulated by Hill (2007) and Gillen and Balkin (2006) complements occupational therapy approaches. Crisp (1996a) describes a mix of holism and reductionism being useful within adventure therapy approaches. The use of a bio-psycho-social paradigm including theoretical foundations in body systems, psychological processes, sensory processing, systems theories and analysis skills re both systems and activities are considered crucial in adventure therapy. On the more reductionist side he advocates adherence to processes of assessment and diagnosis, understanding the impact of diagnosis or problems on function and participation in activity, treatment planning and goal setting. It can be argued these are all essential elements of occupational therapy as well.

Much of the literature reviewed focuses on the soft skills of adventure therapy as being crucial, with less emphasis on the “hard” or technical skills of adventure activities. This is probably because of the move from adventure based education to adventure therapy, whereby facilitators came to the profession with skills in education and effective use of adventure activities, but without a health qualification or training. Crisp (1996a) sees therapeutic skills as the most important, rather than hard skills and suggests training in one or two adventure activities is sufficient. However others emphasize a number of areas of skill and knowledge essential in adventure therapy that fall outside traditional health profession trainings. These include the use of experiential education cycle, processing skills with the use of metaphor and

paradox, specific facilitation styles including concepts such as front loading and back loading (Fletcher & Hinkle, 2002). The literature generally agrees that generic skills needed when working with adventure activities include good personal fitness, knowledge of weather systems, specific competencies in teaching adventure activities, outdoor risk assessment and management and first aid training. Most of these areas of skill and knowledge fall outside traditional occupational therapy education.

## **2.7 Who is an adventure therapist and how are they trained?**

The final area explored was literature describing who adventure therapists are, exploring their training and qualifications, background and skill set. This was in order to establish a fit or otherwise between adventure therapists and occupational therapists in knowledge, skills and attitudes; and gave me an understanding of the diversity and dilemmas within the adventure therapy field regarding its' use.

There is no one academic or training course for adventure therapists and whether or not it is defined as a profession in its own right is debated in the literature. Generally the literature reviewed identified the importance of adequate and appropriate therapy skills, combined with safe and effective adventure activity facilitation. This set of expertise in both "soft" and "hard" skills is what defines an "adventure therapist". The difficulties in terms of the time it takes to get these qualifications and the expenses incurred, were highlighted, and the fact that many facilities utilize staff from both areas working together to cover the needs was identified as a possible alternative to specialist staff (Crisp, 1996a; Fletcher & Hinkle, 2002; Gillen & Balkin, 2006).

The professions most common in adventure therapy are those from psychotherapy and counselling backgrounds, social work, and recreational

therapy. Occupational therapy was mentioned only in articles from New Zealand, Canada and Australia (Crisp, 1996a; Levack, 2003; Reed, 2003). This is probably due to the fact that most adventure therapy literature is from USA, where therapeutic recreation seems to have parallels with occupational therapy in mental health in other countries. Itin (2001) asserted the importance of quality training i.e. degree training, and describes the current status of adventure therapy as multidisciplinary. He identifies that in USA adventure therapy meets the criteria for a profession in its own right, other than the fact there is no one training pathway, and describes how additional training in the use of adventure activities is at times tagged on to other programs. Norton and Tucker (2010) describe the use of adventure based activities in social work training, and advocate its inclusion in courses due to the high number of social workers involved in adventure therapy in the USA.

Papadopoulos (2000) identifies the lack of consistent training and certification in Canada as an issue for the profession there, stating there is no formal training at an undergraduate or post graduate level. She identifies a set of 38 competencies under five separate components – personal, adventure, programming, therapy, and operational. She advocates the use of these competencies in the design of training curriculum and in the selection of adventure therapy staff.

The literature reviewed focused on the importance of training and qualification of the therapy or soft skill side of the needs of adventure therapy practitioners. How the hard skills are learnt was not identified, although technical, instructional, risk management and group management skills are identified as equally important (Fletcher & Hinkle, 2002; Gillis, 1995; Papadopoulos, 2000; Reed, 2003).

Although formal qualifications are clearly a priority for the field of adventure therapy to identify and work towards, the characteristics of

individuals working as adventure therapists are relevant to their effectiveness. Taniguchi, Widmer, Duerden, and Draper (2009) extracted the most desirable qualities or attributes in an adventure therapist from a piece of qualitative research conducted in the field, identifying eight key attributes. Effective adventure therapists were identified as being ambitious, service orientated, hard-working, possessing identified personal goals, interested in others, generous with their time, fun loving and were perceived to have a sense of freedom and ability to do whatever they wanted to do.

## **2.8 Summary**

From the literature reviewed it is clear there is debate internationally regarding how adventure therapy is defined. Much of the debate is from USA where adventure therapy is most used, and is influenced by health and education contextual factors (e.g. funding systems) and diversity in adventure therapy service provision. How adventure therapy is defined in New Zealand is also unclear, so this research will explore how participants define adventure therapy.

Experiential education is consistently referred to and its use advocated in adventure therapy literature. Reference to many other theories is made, primarily from educational and psychotherapy arenas. No literature from adventure therapy sources referred to occupational therapy theory, and very limited reference to adventure therapy was found in occupational therapy literature. Use of theory informs practice, and so knowing what theory occupational therapists are drawing from in their adventure therapy work will help ascertain a fit or otherwise between the two fields.

Exactly what knowledge, skills and training a person requires in order to practice adventure therapy is also under debate, particularly in the USA,

with literature discussing adventure therapy qualifications and the development of its status as a profession. From the literature reviewed it would seem that occupational therapists are well positioned to work as adventure therapists, however this is not explicit. Understanding what knowledge, skills and attitudes therapists require to use adventure therapy that they do not already have as occupational therapists will help establish the fit or otherwise between the two.

Because many aspects of what is considered occupational therapy in New Zealand are covered in the USA by disciplines that do not currently exist in New Zealand e.g. Therapeutic Recreation; and for pragmatic reasons (limited time and resources) I decided to place the research within the New Zealand context. The research question and sub-questions developed as a result of this literature review and my experience of adventure therapy in New Zealand are presented in the introduction (p. 6).

The following chapter, methodology, describes the rationale behind the methodology and method selected for the research, and the process that was followed throughout the research.

*My first cross-country flight. Now I will launch with a goal but without knowing exactly how or even if I will get there. The conditions are good, the sun has warmed the slopes and the thermals are strong. There are ridges to the left and right of me as I launch; if I get high enough to cross the valley there will be even more options to choose from. Goodness, which way to go? There is so much to look at, think about; to reach my goal I need a flight strategy. There is a prevailing breeze; it is climbing up the valley where my goal is. And so I climb with each thermal I find and choose to fly with the wind. I am still not sure where I will end up, but given the conditions I know I have chosen the most appropriate route.*

### 3 Methodology

Research involves a systematic approach to finding things out, to developing theory, understanding situations or environments, or to answering questions. The research process generally begins with the area of interest and the development of a specific focus, followed by the formation of a specific research question to identify what needs to be discovered or answered; or what assumption or hypothesis needs to be challenged or explored (Hancock, Ockleford, & Windridge, 2009).

Methodologies in research are selected based on the research question and the aims of the research. Some questions lend themselves to experimental or statistical analysis, require a deductive approach and suit a quantitative methodology. Others rely more on the development of an understanding of the experience of the population of interest, are inductive in nature and suit qualitative approaches. Flick, von Kardorf, and Steinke (2004) describe qualitative research as claiming to:

*“...describe “life worlds” from the inside out, from the point of view of the people who participate. By doing so it seeks to contribute to a better understanding of social realities and to draw attention to processes, meaning patterns and structural features.” (p. 18).*

This study explores aspects of the practice of occupational therapists using adventure therapy. It seeks to describe the theoretical bases they use in their work, how they define adventure therapy and what they perceive as the similarities and differences between occupational therapy and adventure therapy. As ascertained in the literature review the field of adventure therapy has limited literature that specifically supports occupational therapists. Because of this gap the clinical reasoning and day to day practice of occupational therapists involved is of interest so that their clinical reasoning

and practice can be described. In essence, the perceptions and points of view of the occupational therapists regarding their work is explored to gain an understanding of occupational therapists' practice alignment with adventure therapy concepts and practice. A qualitative paradigm is therefore appropriate for this research.

### **3.1 Research design**

The basic design structure for research considers the needs generated by the research question, the research population and the resources available to the researcher (Flick et al., 2004). This research project aims to establish current perceptions of New Zealand occupational therapists with expertise in adventure therapy; it is appropriate to consider both comparative and snapshot as study design features. Comparative studies refer to the gathering of data from a number of experts in the field, compared or contrasted with each other. Snapshot, defined by Flick et al. (2004, p. 148) as "*analysis of state and process at the time of the investigation*" acknowledges the degree to which qualitative data may represent the here and now, and the value of and challenge in identifying what data is chosen to be represented and compared or contrasted. Data regarding how key players in the profession of occupational therapy presently view adventure therapy is captured, analysed and compared with each other, and findings present the current situation regarding fit (or not) between occupational therapy and adventure therapy

Qualitative descriptive methodology provides a way of capturing the facts as they are, in everyday language, in order to understand the current status and to provide a comprehensive summary of the events (Sandelowski, 2000). Rather than developing theory, or interpreting meanings, qualitative descriptive methodology seeks to describe participants' experiences by staying as close as possible to the original data, and using the original language and meaning as intended by the participants (Neergaard, 2009).

Neergaard also proposes that qualitative descriptive is useful in structuring interview questions related to specific and focused areas of expertise not well known in the field, and in presenting the findings as they are without interpretation – both of these features suit the intention of this research project. Qualitative description is therefore consistent with the aims of the study and was selected as the research method.

### **3.2 Methods**

Methods in research can be described as the tools or techniques for the gathering of data. In qualitative research data gathering techniques include observations within the environment of interest; interviewing; gathering or collecting documents, records or artefacts; or exploration of feelings/sensations (Yin, 2011). Data are the elements or collection of information that result from the data gathering process (Yin, 2011). Selection of the method depends on the specifics of the data of interest, size of the sample or research participant group, the resources available to the researcher, and the planned analysis process of the data (Flick et al., 2004).

This research seeks an understanding of fit (or not) between occupational therapy and adventure therapy as it is practiced in New Zealand through exploring the practice of New Zealand occupational therapists involved in adventure therapy. When data sought are the perceptions, opinions and understanding of participants involved in the field of interest, interviewing is deemed the most appropriate data gathering method (Louise Barriball & While, 1994). Interviews fall into three fundamental forms – in depth interviews, structured interviews or semi-structured interviews (Britten, 1995; Yin, 2011). Generally structured interviews have set procedures and use closed-ended questions, whereas semi-structured have set open

ended questions that define the area of interest and allow for additional clarifying and probing questions (Britten, 1995). Semi structured interviews can be more conversational in nature, and allow for both the interviewee and interviewer to discuss the topic or point in more detail (Hancock et al., 2009)

This research has clearly defined questions and the area of interest is specified, however the nature of the question requires the researcher to be able to be responsive to new or unexpected information. Hancock et al. (2009) discusses the benefits of using semi-structured interviews for this reason, and for situations where interview time is limited.

Lazarsfeld (as cited in Louise Barriball & While, 1994) identifies the benefits of using semi structured interview pertinent to this research project. These include wanting an enhanced response rate over non-interviewing methods, the ability to explore in detail the specifics of participants' views through the use of probing questions (specificity), the ability to phrase and sequence questions to best effect (division), and the ability to identify and check the meaning of seemingly obvious words or phrases to ensure a common understanding (tacit assumption). Qualitative descriptive research focuses on existing knowledge and the experience of those in the clinical field, and calls for structure in the interview guide to ensure focus on the specialty are (Neergaard, 2009). The usual methods of data collection for qualitative descriptive research method is semi-structured interviews, either individual or in focus groups (Neergaard, 2009; Sandelowski, 2000).

Semi-structured interview was selected as the data gathering method for this research project. Questions were developed to be asked in a sequence that began with a broad overview of participants' general work, which was considered to be easily answered by participants, and then became more specific and theoretical in nature requiring more reflection and thought to answer. Questions were designed to provide structure to the conversation, to

ensure consistency in the data gathered between participants, and to provide a basis for in depth exploration of the information offered. The number of developed questions was limited to ensure responses could be explored and clarified without having the interview exceed the planned timeframe of 45-60 minutes.

The questions developed were:

1. Can you please tell me a little about the facility or organisation you work for, and about your job?
2. Do you consider yourself to be working as an occupational therapist, or an adventure therapist, or a bit of both?
3. What are the kinds of things you do in your day to day work?
4. How would you define adventure therapy?
5. What do you think are the differences between adventure therapy and occupational therapy (if any)?
6. What do you see as the similarities or way in which the therapies complement one another?
7. What contradictions do you feel exist between the two either philosophically or practically?
8. Is there a specific model or framework you use to guide your work? What is it?
9. When you think about the theory you use in your work, do you think it comes from occupational therapy, or adventure therapy, or from counselling/psychotherapy? Or from somewhere else?
10. Can you talk to me about the theories you use or draw from in your work? What do you consider to be the main theory or theories you use?

11. Think back to when you first graduated as an occupational therapist. What knowledge and skills would you have needed then in order to use adventure therapy that you weren't introduced to in your occupational therapy training?

12. Is there anything you would like to add?

Britten (1995) describes potential pitfalls for novice research interviewers, and encourages interviewers to carefully monitor their interviewing technique, even if already experienced as clinical interviewers. Specifically interviewers need to attend to their level of directedness in interviews, whether they are asking leading questions, the amount of time that participants are being given to answer, and whether or not cues or areas for potential data are being picked up on or not. These points are reiterated by Yin (2011), who adds the importance of the researcher speaking in modest amounts, remaining neutral and maintaining rapport.

In order to both check the quality and appropriateness of the questions developed, and my interview style, the interview was piloted twice. Pilot participants were selected from year three occupational therapy students who had an interest in and some knowledge and experience with adventure therapy. Being students, they did not fit the criteria to be actual research participants, and allowed all potential respondents to be used in the actual research. Pilot interviews were recorded and critically listened to by myself, and by my supervisor. Feedback was given to me between the pilot interviews regarding the questions and the interviewing technique. The sequence of two of the questions was changed to improve the flow of the interview, otherwise the questions were deemed appropriate for gathering the data sought, and were not changed. Minor changes were made to the interviewing technique, for example related to me being cognisant of a tendency to respond to some comments in a way that might indicate either

approval (e.g. yes, yes) or evaluating respondents' comment (e.g. "yup, that makes sense").

### **3.3 The research process**

#### ***3.3.1 Ethics***

Ethics in research has a fundamental function of safeguarding the information gleaned from participants, and generally encompasses core principles of doing no harm, voluntary participation, informed consent, avoiding deceit and confidentiality or anonymity (Tolich & Davidson, 1998). Ethics approval for this research was gained by following the guidelines produced by the ethics committee of Otago Polytechnic, and gaining approval from that committee (see appendix 7).

#### ***3.3.2 Treaty of Waitangi obligations***

Researchers in New Zealand are required under the treaty of Waitangi to ensure the concepts of partnership, participation and protection are adhered to. Although this research does not specifically explore concepts or practices specific to Maori culture, adventure therapy as a treatment modality is likely offered in New Zealand to clinical populations where Maori are highly represented. Adventure therapy is used in a variety of settings, but is most commonly utilized when working with youth at risk, or youth who are experiencing challenges to their emotional or mental health. Settings include district health board programs, non-government organizations and private organizations. Service users of these facilities include people who identify as Maori (Baxter, 2008). The proportion of youth at risk of anxiety or depressive disorders, hospitalization via intentional self-harm and health related issues related to regular binge drinking and cannabis use is higher for Maori than

non-Maori (Craig et al., 2013). Of the Maori population in New Zealand, a greater proportion (%) is youth; youth mental health service provision is of interest to Maori.

It is likely that participants would be working with Maori in their clinical populations, and too that participants may identify as Maori themselves. Therefore research outcomes may be of interest to Maori. So it was important that the research design met the needs of this group, and Maori had an opportunity to be involved at the design stage.

A document answering specific questions provided by the Otago Polytechnic ethics application form related to consultation with Maori was forwarded to Otago Polytechnic Kaitohutohu office, and feedback was received by return email. On their recommendation Te Ara Kika (Hudson, Milne, Reynolds, Russell, & Smith, 2013) was utilised to structure aspects of the process examining the research project against the institutional Maori Strategic Framework, and was ultimately chosen to guide the written ethics committee application. This framework arranged material under the headings of Whakapapa (Relationships), Tika (Research design), Manaakitanga (Cultural and social responsibility) and Mana (Justice and equity).

Using this framework assisted me to incorporate feedback from the Kaitohutohu office, including evidence of documenting practical steps of meeting Treaty of Waitangi obligations, inclusion of the notion of kaupapa Maori epistemology and how this would be worked with, and providing detail on the approach to research in relation to Maori participants.

Reflecting on this feedback, I also decided at this point to seek an academic supervisor (in addition to existing primary and secondary supervisors) for supervision regarding working with data and concepts of particular relevance to Maori. A well respected Maori occupational therapist

was approached who agreed to act in this role as required. A copy of the ethics application document, which included the consultation with Maori process was forwarded to her for comment, and received favourable feedback. Also at this stage I specifically decided to ask each participant at the interview stage if they identified as Maori themselves, and if they worked with Maori population in their occupational therapy/adventure therapy work.

The revised document was again forwarded to the Kaitohutohu office for approval, before being incorporated into the full ethics application document for Otago Polytechnic ethics committee.

### *3.3.3 Do no harm*

This principle means that participants, or the people they are talking about, should not be harmed physically or psychologically by the research process (Snook, 2003). In this research there was considered to be minimal risk to participants beyond any emotional response to the questions asked and the information disclosed, because they are health professionals and dealing with professional rather than personal information. Strategies for managing these risks revolved around my experience in helping people manage difficult emotions, and in me reminding participants of the need for confidentiality if discussing clients or information pertaining to the organisation that may be deemed commercially sensitive.

### *3.3.4 Voluntary participation*

Participation in research must be voluntary, and researchers should be aware of any aspects of the project that may influence a person's decision to participate (Tolich & Davidson, 1998). For this project potential participants made the initial contact with me, and were invited into the research process only when it was clear they met the inclusion criteria. They were aware of

their ability to withdraw at any stage without the need to give a reason, or to withdraw their contribution up until member checking was complete.

The concept of informed consent relates to adequate information being conveyed to the participant prior to their consent being given, so they are aware of as much detail of the research and expectations on them as they choose. In their discussion on utilising semi or unstructured interview, Tolich and Davidson (1998) identify a potential issue regarding the possibility the interview may explore information that neither researcher nor participant anticipated at the outset. In this project participants were given detailed information sheets via post or email prior to their participation (see appendix 8), and were invited to discuss the research function and process with me by phone if they wished, and prior to giving consent to participate. Once they were prepared to consent, they were asked to sign and return a consent form (see appendix 9). They were also aware that they were able to review their information once collected, and to either remove some of the data or to have it withdrawn from the study totally at this point.

### *3.3.5 Avoid deceit*

Deliberate deceit of participants in qualitative research is unethical (Tolich & Davidson, 1998) however can either purposefully or inadvertently occur in some study designs, for example where the process may include observation of participants. This research design (semi-structured interviews with opportunity for member checking) minimises the chance of unintentional deceit.

Through the process of informed consent and provision of opportunity for participants to ask questions, which were answered truthfully and honestly, participants were not intentionally deceived. There was nothing

about the research design or purpose that required withholding of information from participants.

### *3.3.6 Anonymity and confidentiality*

Anonymity refers to the researcher not knowing who the participant is, or not being able to link the participant to specific data gathered (Tolich & Davidson, 1998). In the case of this research, where participant numbers are low (7) and where the data gathering method is interview, anonymity with the researcher is not possible. Despite the fact participant names are not transcribed it is likely I will remember aspects of interviews and be able to match who said with what.

Confidentiality refers to the researcher not making known to others details that link data to specific individuals, and often includes not disclosing the names or other identifying information of participants. For this research confidentiality is protected through the use of pseudonyms for each participant, and through ensuring potentially identifying data such as participants' workplace are not included in research writing.

Snook (2003) identifies that research usually involves a community of people who share assumptions and values. In this instance, the community of occupational therapists involved in adventure therapy is small, and it is likely know each other or know of each other. As snowballing was a participant identification technique, some participants were recommended by other participants. Despite me maintaining confidentiality regarding who was being interviewed, it is probable some participants are aware of the names of others. Possible linking by others of specific data to individuals is minimised by me maintaining confidentiality by not identifying participants' names to others, by not transcribing participants' workplaces, or any other information that would make them easily identifiable to others, and by allocating gender

neutral pseudonyms once I had identified there was no significant gender specific data.

Participants were made aware of processes to ensure confidentiality via the information sent to them prior them giving consent to participate (see appendix 8). This information included ways in which the confidentiality of their clients would also be maintained, should they inadvertently disclose confidential or identifying client data in their interview.

### **3.4 Participants**

#### ***3.4.1 Inclusion criteria***

Yin (2011) identifies two important considerations in selecting participants in qualitative research – selecting “*those that will yield the most relevant and plentiful data*” (p. 88), and those that can offer the broadest range of information related to the topic or question. Identifying participants deliberately is known as purposive sampling, and is common in qualitative methodologies (Flick et al., 2004; Yin, 2011).

Because this study is exploring the fit between occupational therapy and adventure therapy in New Zealand participants needed to be occupational therapists who have worked in adventure therapy in New Zealand. Inclusion criteria for participants were:

*New Zealand occupational therapists who are working (or have worked within the past 10 years) using adventure therapy in New Zealand.*

New Zealand occupational therapists were defined as people who are or have been registered as occupational therapists in New Zealand, and who have used adventure therapy in New Zealand. The number of occupational therapists working in adventure therapy is small, so a broad 10 year timespan was allocated to include those who have worked in this field in the past, but

are not currently doing so. This enabled the number of potential participants to be increased whilst keeping a focus on relatively current practice.

### ***3.4.2 Participant recruitment***

There is no specific formal professional governing body or organisation encompassing this group of professionals in New Zealand. Whilst purposive sampling was identified as the most appropriate sampling technique, snowballing was utilized within the community of occupational therapists and adventure therapists to enable identification of individuals. Given the limited population of occupational therapists working in adventure therapy, individuals tend to know of each other, and to work in a limited number of discrete organisations. This technique was therefore effective in identifying potential participants. Of the eight identified, seven were interviewed, which indicates an accurate representation of the population was included.

Initial participants were sourced through adventure therapy and occupational therapy networks, including Adventure Development, Project Adventure New Zealand, New Zealand Association of Occupational Therapists and the Occupational Therapy Board of New Zealand. Contact was made with each of these organisations outlining the research and inviting eligible occupational therapists to participate. Participants who volunteered were also asked to suggest other potential participants. An additional three participants were recruited from this snowballing process.

After the initial contact, potential participants emailed me expressing their interest, and an information form and consent form was emailed or mailed out to them (see appendices 7 & 8). Participants were given the opportunity to talk with me if they required further information, and to return their consent form by email or in a stamped addressed envelope to me.

### 3.4.3 *The participants*

Eight occupational therapists who met the criteria were identified and all consented to participate. This was considered to be a manageable number for this research, and all were included. Of these, seven (four female and three male) were interviewed with one not responding to multiple offers of inclusion at the interview stage.

Although this study is not specifically exploring the use of occupational therapy and adventure therapy with Maori, many of the client groups that adventure therapy techniques are effective with are groups that Maori in some New Zealand communities are over-represented in e.g. alcohol and drug addiction services, probation services, youth at risk services (Craig et al., 2013). Data that includes concepts, beliefs and practices of Maori culture may become evident and may have an impact on the theoretical base utilised by participants. For this reason, participants were asked if they identify as Maori, and if their client population was predominantly Maori. Of the seven participants, one identified as Maori, and all worked with a mix of Maori and non-Maori populations.

Participants were from a wide range of geographical locations; all worked for separate facilities, three were currently utilising adventure therapy in their work and four had done so within the last five years. Gender and ethnicity of therapists or clients did not emerge in the data analysis and are not referred to again.

## 3.5 Data collection

### 3.5.1 *The interviews*

Participant interviews were conducted by me over an eight week period. Six interviews were by phone or Skype, and one was face to face due to geographical location. Interviews took between 45 and 60 minutes, and were recorded using both computer recording software (audacity) and as a back-up a separate electronic recorder (iPad with Pro-Recording application installed). Recordings were saved as files on a password protected computer and backed up on an external hard drive.

Each interview was preceded with a few minutes conversation with the participant prior to the recorder being switched on. This was in order to develop rapport, and to answer any questions that the participant might still have regarding the interview or the research project. Interviews followed the interview guide questions (see appendix 10) and were conducted in a conversational style. Participants responses facilitated the content of subsequent questions; this required improvisation in a *“thoughtful and theorized way”* (Wengraf, 2001, p. 5) on the part of myself to ensure the interview remained focused and untainted by researcher input (Wengraf, 2001). Validity was enhanced in the interview process by me formulating questions that purposefully challenged my own perception or opinion. For example, I have a belief that adventure therapy is as effective with adults as with adolescents, despite the fact it is most commonly used with adolescent populations. I asked of one participant:

*“Do you think that adventure therapy is as valuable with adults, or do you think that its strength is really with adolescents?”* (Interview 1, lines 187-189).

All interviews were transcribed verbatim by me, utilizing computer software to minimize the time required (Express Dictate). Copies of the

transcripts were emailed to participants for member checking, which ensures credibility. Participants were asked to respond within 5 days if they wanted changes to be made. One participant responded with ideas for more data; however this was outside the scope of the research and so not incorporated. All participants agreed the transcript was an accurate representation of what they had said.

### ***3.5.2 Transcribing***

*“A transcript is the written version of the interview”* (Wengraf, 2001, p. 212) and decisions regarding who should do the transcribing and exactly what should be transcribed influence the research process.

Transcribing was completed by me, to enable the time and space to listen to and reflect on the interview as the transcribing process was conducted, with the primary purpose of identifying any aspect of the interviews needing additional clarification at this stage of the research process. Tolich and Davidson (1998) identify other advantages of researchers transcribing their own interviews, including self-evaluation of interviewing skills. Interviews were therefore transcribed as they were conducted, rather than at the end of the interviewing process.

Transcribing was also completed as soon as possible after the interview so that information regarding e.g. tone, apparent attitude, hesitancy etc. could be remembered and noted against the appropriate sections of the transcription. Transcriptions were almost verbatim, the only exclusions being verbal pauses that were repeated or lengthy. This was in order to ensure the subtle nuances of communicating state of mind or associated feelings were captured as accurately as possible (Wengraf, 2001).

### 3.6 Data analysis

Data analysis is the process of drawing from the data patterns and insights, and describing and applying them to the question. It is about making sense of the data (Bradley, Curry, & Devers, 2007; Davidson & Tolich, 2003). In qualitative research it is usually an inductive process where ideas or theory is generated from the data (Morse, 2012; Thorne, 2000). Whilst there is no one prescriptive way of analyzing data from qualitative research, it is acknowledged that there are discrete phases common to most processes, that have been described in a variety of ways (Davidson & Tolich, 2003; Field & Morse, 1996; Yin, 2011). The analysis process fundamentally involves reducing the data to manageable themes or categories, organizing the data around new themes and interpreting the data in a way that is meaningful and relates to the original research question.

Field and Morse (Field & Morse, 1996) describe four cognitive processes that they consider integral to all qualitative methods. The first, *comprehending*, refers to understanding what is in the data to the point where rich description of the data is possible. Here patterns and themes are identified, data is analyzed comprehensively (generally constant comparisons between interview transcripts), and literature is used only as a guide for comparison. The second phase, *synthesizing or decontextualizing*, refers to the phase where the researcher is able to understand the norms and averages of the data, is aware of categories and themes and can see variations from the norms. This is facilitated by analysis of both the transcripts, and of the categories and themes identified. *Theorizing* follows, which involves both linking data to established theory and working out ways of organizing data to show what is significant. Here ideas around what has been found and how it fits with what is known, are explored. The final stage is *re-contextualizing* where established theory provides the context and the research links new

findings to the literature. This is where the usefulness and implications of the findings are stated, and facilitates generalizability of the findings.

These four stages have been used to base the data analysis process on for this work, with the first two phases (comprehending and synthesizing) covered in the findings chapter, and theorizing and re-contextualizing providing structure for the discussion chapter.

### ***3.6.1 Comprehending***

Comprehending, or understanding what the data is comprised of, begins with compiling the data, or *“putting them in some order”* (Yin, 2011, p. 178)

The first stage of data analysis occurred during the transcribing phase, when I chose to transcribe all the interviews myself in order to listen critically to the data (rather than just read it), to identify if any areas required immediate clarification with the participant, and to identify immediate aspects of interest or surprise that might influence subsequent interviews.

Transcripts were then printed (2 copies of each) with each line numbered, double spaced and with wide margins to allow room for highlighting and comments (see appendix 11). Interviews were numbered and any names of individuals or specific workplaces used in interviews were removed at this stage for confidentiality reasons.

As the transcribing was happening at the stage of interviewing, I was able to reflect on the content of each transcript to help me identify areas in the following interview I may want to explore in more detail. Notes were made in the margins related to data that seemed immediately relevant, or that drew my attention to a concept I could explore in future interviews. Notes were also made regarding areas not covered comprehensively, or opportunities for richer data were missed (see appendix 11). This process, referred to as

positive and negative coding by Davidson and Tolich (2003), helped me refine interviews as I went.

Once all interviews and transcripts were completed, I went through a process described by Yin (2011) as disassembling, where data is broken down into fragments or elements, considered and reconsidered with the aim of gaining deeper insight into ideas and meanings within the data. Firstly each transcript was read and elements or ideas listed as they arose. Transcripts were numbered 1-7, and the number assigned to the transcript entered against the element. A total of 98 elements were identified, those that were consistent were clearly evident by the number of transcripts they featured in (see appendix 12).

From this seventeen themes or concepts were identified, and a paragraph written about each concept including numerous quotes to illustrate them. Once the paragraphs were completed, I was confident that the data was comprehensively extracted from the transcripts. To double check, the transcripts were all re-read by me, and also by my supervisor with a view to identifying material in the transcripts not captured in the paragraphs. A further two concepts were identified at this stage.

The paragraphs were then printed, cut into separate sections and their content considered in terms of relevance to the research question, the level of overlap within the content, and whether or not any could be combined into one theme.

From this 7 key themes were identified around the elements that were common to the participants. These themes were theory (models and bases), therapy, use of activity (what, how and why), unique to adventure therapy, unique to occupational therapy, points of conflict, the fit between the two. These themes are closely related to the interview questions. Next transcripts were read more critically, this time with a focus on what was familiar to me

from the literature and my prior knowledge, and what was surprising or unfamiliar to me. My emotional responses were also noted at this stage, to help me be aware of biases, feelings and attitudes that may influence my interpretation of the data (see appendix 13).

### *3.6.2 Synthesising*

Yin (2011) describes the next stage as reassembling, where elements are grouped or sequenced in a variety of ways until a pattern is found that can be used to articulate the meaning of the data. This is the synthesizing stage, where norms and anomalies become clear, and the data is very familiar to the researcher. At this stage data were chunked together a number of times in a number of ways as I thought about their relevance to the research question, their relationship to each other in the context of the interview, and as I identified patterns that were emerging. This was done with the use of electronic concept mapping using C-Map Tools software, and five separate concept maps were drafted (see appendix 14 for an example). The map that was considered to best be able to capture the findings in a useful way was selected, and the structure for the findings chapter established.

### *3.6.3 Theorising*

The theorizing stage, which Yin (2011) describes as a reassembling procedure, involves arranging and rearranging the data as links are made with the literature, to ascertain an effective way of presenting what is significant in the data. What has been found in the research is linked with existing knowledge. At this stage I again used C-Mapping (as described above) and identified a number of possible options (see appendix 15 for an example). Part of this process was to link theory to the findings and so I read further as I tried to make sense of the data in terms of what is known in the literature. I listed key concepts in a table that clearly depicted what was

similar and what was different between occupational therapy and adventure therapy (see appendix 16), using both findings and literature. I wrote an initial draft of paragraphs (following the format in appendix 15), linking findings to theory, and discussing implications. As I identified concepts I had not previously thought of I read more in order to make sense of them in terms of what I already knew.

#### ***3.6.4 Re-contextualising***

This phase of the research is about arranging the material in a way that enables the researcher to make fresh interpretations, and may necessitate the material to be disassembled and reassembled in different ways. It is at this stage that interpretations become clearer and that conclusions can start to be drawn (Yin, 2011).

I printed the draft, and worked with arranging and rearranging the paragraphs in different ways to find a way that better enabled me to interpret and present the material. Eventually I chose the headings and arrangement of material as it is in the discussion chapter. Through this process of arranging and rearranging, and receiving feedback from my supervisor regarding how the material appeared to the reader I was able to further refine my ideas, interpretations and writing. During this process I also developed the diagram which linked aspects of findings into the flow chart now included in page 158. The final stage Yin (2011) describes is concluding, which “...calls for drawing the conclusions from your entire study.” (p. 179). At this stage I noted material from each section of the discussion chapter that either was or alluded to a conclusion I had made, and drafted conclusion paragraphs which would form the basis of the conclusion chapter. Again I used a table to clearly depict my conclusions and also formulate implications for further research. Here is where the usefulness of the research for the profession is

established, and where recommendations are made that potentially facilitates generalization of the research.

### **3.7 Rigour**

Overall rigour of this research has been demonstrated throughout the research process. I selected a research methodology and method appropriate to the research question, and have been transparent in each step of the process as demonstrated in the writing and supported by inclusion of appendices. I have made my own interest and experience in the topic evident, and in the writing I have made it clear when I am giving my own insight or opinion as opposed to the participants or from the literature by using phrases such as “I conclude” or “I surmise”. I checked the interview guide was appropriate for the length of interview and the relevance of data by conducting two pilot interviews, and having these listened to by a supervisor. All participant interview transcripts were returned to participants for member checking, and submitted to my supervisor after findings were identified to ensure I had not misrepresented participants’ responses or missed identifying themes. I have used supervisors from occupational therapy and outdoor education/adventure fields intentionally to ensure the findings and resultant discussion are considered from both perspectives. Triangulation has occurred through using these supervisors, adventure therapy literature and literature from the field of therapeutic recreation in the USA (which parallels occupational therapy in New Zealand in terms of positioning in the field of adventure therapy). I have ensured the findings are presented through rich, thick description with insights and numerous quotes from participants in the findings section.

Other measures taken related to rigour are covered in the next two sections where validity and reflexivity are addressed.

### **3.7.1 Validity**

*“A Valid study is one that has properly collected and interpreted its data, so that the conclusions accurately reflect and represent the real world (or laboratory) that was studied.” (Yin, 2011, p. 78).*

Validity in this study was initially considered in participant selection through clear identification of the specific population of interest, and broad snowballing participant identification techniques.

Maxwell (2009), as cited in Yin (2011) identifies seven strategies for addressing potential challenges to validity in qualitative research. Of these, three have been specifically utilised in this study.

The first, respondent validation is assured by interviews being recorded and transcribed, then returned to participants for checking regarding their accuracy. Participants had an opportunity to check that what they had said was accurately documented, and were also invited to make further comments if they wished.

The second, termed “rich” data was facilitated through the choice of semi-structured interview as the method. This allowed for the same base questions to be asked of each participant, with clarifying and probing questions to add to and enhance the data gathered. The conversational style of the interviews allowed participants to expand on answers and to explore concepts to some extent. This enhances validity by ensuring participants have the opportunity to give detail and be specific in their answers, expanding on and developing answers as they go and ultimately having the opportunity to fully articulate their view of the field of interest. The final interview question asked if participants had anything they would like to add, which gave them

an opportunity to either expand further, or to include information they felt was important but not specifically asked for in the interview. This ensured that perceptions and opinions of all participants were comprehensively sought.

The third is the process of testing rival or competing explanations. This was attended to in the interview process, where I ensured that not only was my own opinion not evident, but that questions that challenged that opinion were asked. Participants were also asked to define terminology to ensure I was not making assumptions on the meaning of terms used, particularly regarding adventure therapy terminology not usual in occupational therapy language. Pre-interview confidentiality agreements and an interview style that consciously facilitated development of rapport, and consequently safety for participants to answer questions candidly, was utilised. Questions to clarify participants' answers were asked throughout the interview, e.g.

*"...you said a little bit earlier that in adventure therapy you think that you let the activity talk for itself....can you talk a wee bit more about that. What do you mean by letting it talk for itself?" (Interview 6, lines 134-136).*

Contradictory information was challenged in order to solidify participant's opinions and allowed me to check on assumptions and understandings gleaned from the interview. An example of this is in interview 3 where the participant had been talking about how adventure therapy activities are not every-day activities, whereas occupational therapy focus is on the day to day activities in life. The participant then went on to talk about the cooking component of the adventure therapy work he was involved in, which I consider to be an every-day activity. The challenge question asked was:

*"So when you think theoretically about your understanding of adventure therapy and you think about the times that you're spending for example cooking with*

*the young people is that adventure therapy or is that occupational therapy?"*  
(Interview 3, line 206-208).

### 3.7.2 Reflexivity

Reflexivity is described by Yin (2011) as acknowledging and describing the effects of the interaction between researcher and participant, and is important to consider through all stages of the research process. Particularly in the qualitative research paradigm, the views and understandings of the topic held by the researcher is acknowledged to have an impact on their ultimate understanding of participants' contribution. Qualitative research studies social worlds, and social researchers cannot remove themselves from the social world they are studying. Social researchers are an integral part of both the research process and of the product of the research (Dowling, 2006); and cannot separate prior experience, knowledge and belief from influencing their interpretation of the data gathered. *"We cannot escape from our insider's knowledge about the experiences we are trying to understand."* (Tolich & Davidson, 1998, p. 37)

Given that researchers are unable to remove themselves from their effect on the research; the effects must be recognised and made explicit. This requires the researcher to be aware of their responses and what is influencing those responses, of their relationship to the topic and of their relationship with the participants. Dowling (2006) identifies two resultant principles of reflexivity – personal (or awareness of self via reflection) and epistemological (awareness of own assumptions about the world and knowledge made during the research).

Reflexivity is illustrated in this research by my critical reading of transcripts and submitting transcripts to my supervisor to double check to ensure I was identifying all themes in the data. I have personal experience

and hold my own opinions regarding adventure therapy, and so was aware of potential bias when developing questions and during interviews. I consciously included questions that would challenge or confirm my assumptions. For example I am of the opinion that participants using adventure therapy should still be working as occupational therapists, and so I asked *“Do you consider yourself to be working as an occupational therapist, or an adventure therapist, or a bit of both?”* I have past experience working in the same facility as one participant, and so was careful to start that interview by disclosing that and talking briefly about how the facility operates now. This enabled me to understand what is the same and what is different from when I was there, and reduced likelihood of making incorrect assumptions regarding the facility processes and environment.

### **3.8 Summary**

This qualitative research explores the fit between adventure therapy and occupational therapy. Due to lack of previous research or literature exploring occupational therapy and adventure therapy qualitative descriptive methodology was selected. Seven New Zealand occupational therapists who have experience in adventure therapy were interviewed following a semi-structured format. Data was analysed thematically, following a process of comprehending, synthesising, theorising and re-contextualising. Measures taken to ensure rigour are described. The findings from the data that emerged following this analysis phase is described in the next chapter.

*I need to keep the big picture in mind. I must watch for clouds spilling over the mountains to the west as I know bad weather will come from there. I must watch the lake for whitecaps that will tell me the wind is too strong, and I must keep focused on my goal. I am in sink, it is very turbulent here; I am terrified. I need to fly closer to the terrain to find lift but it will be rougher. If I fly out into smooth air I will sink. My heart is pounding and my mouth is dry. My tummy churns and I feel overwhelmed. I focus on the detail that will help me so much. I can feel the warmth of thermic air on my face, it comes and goes as I lift and sink. I frantically look for circling hawks, dark hot cliffs, rustling trees and swaying grasses, and for dandelion seeds floating up – anything that will help me find rising air and keep me progressing. I visualise the invisible.*

## **4 Findings**

### **4.1 Introduction**

The process followed to establish the structure for this chapter was described in the data analysis section synthesising. The data are presented in three sections; what is familiar to the participants, what is unfamiliar to the participants and what the participants do to “make it work” for them.

Elements related to the theory, the therapy and the therapist are presented for each of those sections.

### **4.2 This is familiar to me**

The participants’ stance regarding fit between occupational therapy and adventure therapy was established by exploring their perceptions of the similarities and differences between the two “therapies”, how they defined adventure therapy and justified using adventure therapy (when most were employed as occupational therapists when involved in adventure), and specific statements that gave a clear opinion.

All participants identified factors that indicated they were using adventure based activities as an integral part of occupational therapy, or that adventure therapy fitted well with occupational therapy, and were able to talk about how they use adventure therapy within their occupational therapy practice with relative ease. There was consistency in how adventure therapy is defined, with most participants summing it up as the therapeutic use of adventure based activities. That there is no specific profession of adventure therapy in New Zealand was identified by some, and all participants described using adventure therapy as a part of their work but not as all of

their work. Themes that emerged that illustrate how they apply adventure therapy in their work include therapeutic use of activity, compatibility between adventure therapy and occupational therapy philosophy and principles, and the use of theory that is either shared with other adventure therapy practitioners or enables adventure therapy to be incorporated into occupational therapy. This section explores the fit between adventure therapy and occupational therapy through examining factors related to theory, therapy and the therapist.

#### *4.2.1 The theory*

Participants were able to identify that some of the generic therapeutic approaches traditionally used by other disciplines using adventure therapy, and described in adventure therapy literature, are known and used by occupational therapists. As well as these approaches, participants were also able to identify and describe how they use some occupational therapy specific theory in their adventure work, and described how the use of this theory enhanced their adventure based therapy.

##### 4.2.1.1 Psychology theories

All participants described using approaches to their intervention that comes from psychological theory. There was consistency across all participants in their use of the psychology constructs, and in the specific therapy approaches they used. Four of the participants spoke of using cognitive behavioural therapy (CBT) and/or dialectical behavioural therapy (DBT). Kelly worked alongside a psychologist in joint sessions with the client, and then in individual sessions reinforcing the behavioural component of the therapy whilst the psychologist worked on the cognitive component. This pragmatic way of using CBT was reinforced by Morgan, who spoke of the

value of keeping the psychotherapy aspect in perspective and focusing on the practical and behavioural elements with the adolescent population.

Four participants identified motivational interviewing as an approach regularly used. The stages of change theory that motivational interviewing has developed from was identified as being helpful for clinical reasoning (identifying the stage of change the person is at when planning therapy) and for client centred practice (moving at the pace of the client, and in the direction the client is indicating). Use of interactive drawing therapy techniques were also identified by four participants. Five of the participants specifically identified counselling skills as important in their work, and talked about counselling when identifying theory they draw from. Most said that counselling was used by everyone on the team; some linked the term counselling to specific therapies or approaches such as solution focused therapy or narrative therapy. Others use the term to cover specific micro-counselling skills expected of health workers. Whilst it was acknowledged that counselling skills are valuable, most participants qualified its use either directly or at other places in the interview with statements supporting the use of activity as therapy alongside or instead of talking therapy. This was nicely illustrated by Pat:

*Rather than say counselling in a clinical room, it's going out and doing stuff, using the activity to do the therapy, letting the adventure stuff do the teaching. The counselling just kind of sits in the background, supporting the real therapy... (Interview 7; line 104).*

#### 4.2.1.2 MOHO

Six of the participants identified the Model of Human Occupation (MOHO) as the model they most used in their work. The MOHO encourages a holistic view of the person, their occupations and their environment. This

was acknowledged by participants who talked about considering the everyday environment and activities of the person influencing the direction of the planning for the adventure therapy component of the programme. Participants used the MOHO language as a way to articulate these concepts. Whilst describing how they used the MOHO, they gave information on these aspects of the client's life and were using the model to provide a framework for their clinical reasoning.

#### 4.2.1.3 Experiential learning

Four of the participants specifically talked about experiential learning theory and practice in adventure therapy. This is in line with the literature reviewed, where experiential learning theory was consistently used to inform adventure therapy techniques and explain the effectiveness of the approach. Pat specifically identified experiential learning as the underpinning theory:

*... the whole experiential education thing is pretty much what adventure therapy seems to be grounded in. You know, experiential learning cycle – most of the stuff I've read about adventure therapy is in the experiential education journal. (Interview 7; line 186-188)*

Three of those participants specifically identified experiential learning and reflection as theory familiar to occupational therapists both in their practice and in their own professional development through professional supervision and continuing competence processes. This is illustrated by Jamie who linked this theory to professional development as an occupational therapist:

*I know that Kolb...I don't know who he is but they use his theory a lot with OT and with the reflective cycle and in supervision so I know that it's certainly used a lot in OT as well, the need to reflect in order to learn and understand, you know, you need to challenge yourself in order to grow as a person, you*

*need to reflect in order to learn from you know life I guess...* (Interview 4; 297-300)

#### **4.2.2 The therapy**

This section explores concepts related to the philosophical and practical fit between occupational therapy and adventure therapy.

##### 4.2.2.1 Definitions

Occupational therapy is defined and described in the literature review, and in summary is “...a client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life” (World Federation of Occupational Therapists Council, 2010).

The debate about how adventure therapy is defined is discussed in the literature review, where variances in definitions are identified and the paucity of literature regarding adventure therapy and occupational therapy is stated. Participants were asked how they define adventure therapy in order to ascertain consistency in definition between participants, and links to how it is defined by others in the field. There was consistency between participants’ perceptions of adventure therapy and the summary provided by Itin (2001) in terms of both the activity and the underlying philosophy. Most participants talked about adventure therapy involving the therapeutic use of adventure based activities. Dale’s description of “...using the medium of adventure to bring about therapeutic change in someone” (Interview 5; 95-96) sums up the definitions of most participants, with adventure activity being a medium for change the most common theme.

There was a high level of consistency between participants regarding what specific activities were used. The most common activities identified were kayaking, tramping and camping, climbing, abseiling, mountain bike

riding, high and low ropes courses. The use of trust and initiative or problem solving games was also discussed by some. All participants identified aspects of the way the activities were used that was specific to adventure therapy, alluding to the philosophical approach aspect of the activity. Participants identified the therapeutic component as facilitating self-disclosure and talking through engagement in activity (the activity sometimes shared with the therapist), facilitating increased insight and self-awareness into usual coping styles and strengths through engagement in the activity itself and from others involved, and opportunities for clients to develop and practice different more adaptive coping strategies.

When defining adventure therapy none of the participants spoke of it being a profession in its own right or a discrete therapy, but rather described it as the use of adventure activities in a therapeutic way. Most participants made clear links to the occupational therapy practice of using activities therapeutically. Some indicated that when involved in adventure therapy they believed they were doing occupational therapy, and that they were using adventure based activities in the same or similar ways to how they would use other activities within occupational therapy. Chris perhaps articulated this most clearly when asked what the differences were by replying:

*Well OT is a whole profession....I see adventure therapy as a kind of a legitimate part of OT really because like it is using therapeutic...using meaningful activity as a therapeutic media... (Interview 1; 114-116)*

#### 4.2.2.2 Philosophical fit.

Participants identified that the underlying philosophical belief that the activities individuals engage in have an impact on their health is shared between the two fields. Participants described using activity to facilitate talk

and emphasised the importance of meaningful activity and motivation for or facilitated by activity. These concepts were considered to be shared by adventure therapy and occupational therapy philosophy. This therapeutic use of activity in adventure therapy was described as similar to the therapeutic use of activity in occupational therapy, although participants acknowledged the actual activities and how they are facilitated are in some ways different from what is usual in occupational therapy.

One of the ways participants identified that the two fields were philosophically aligned was by considering the emphasis on the therapeutic power of activity. All participants talked about activity or occupation being the therapy for both occupational therapy and adventure therapy.

Jamie illustrated this when by saying:

*Yeah, it just seems they naturally fit. It's almost very difficult to explain sometimes but the whole programme that we were in was very very OT because the whole thing was occupation based. It was all working towards being able to achieve occupations in the young people's lives, so yeah OT was very... tied in really well with adventure therapy... (Interview 4; 219-223)*

Dale also spoke how integral activity is to both fields:

*They are both activity focused at the core of them I think. From what I understand of adventure therapy... they're using activity as a therapeutic medium....um I think and from what I understand adventure therapy is again... activity is used throughout the whole therapeutic process like OT. (Interview 5; 193-196)*

The two fields were also identified as sharing the philosophy that what people do influences their health and wellbeing. This was talked about both in terms of the maladaptive behaviours clients engaged in that had negative health consequences, and the health giving benefits of being removed from

the environment that supported those behaviours; and being provided with opportunity to engage in alternative behaviours that were potentially adaptive. As stated by Pat, “...they both share an understanding that what people are actually doing in their lives has an impact on their health and wellbeing...” (Interview 7; 107-108).

Occupational therapy was generally described as broader and more holistic than adventure therapy, and more grounded in the realities of daily life for the clients than adventure therapy. Participants identified factors that indicated a belief that adventure therapy could fit within their occupational therapy practice but not be the whole of their occupational therapy practice. The usual planned outcomes for clients of adventure therapy services enhance individuals’ abilities in terms of reaching occupational therapy goals. Adventure therapy is considered by participants as a legitimate tool or approach for occupational therapists to use in their occupational therapy. Pat talked about this most directly when asked if there was any conflict between the two fields:

*...no, I don't think there is. So long as the desired outcome is OT in nature so looking at occupational performance and participation in communities and roles and habits and stuff, then it's [adventure therapy] just another way of getting there. (Interview 7, 152-154)*

Chris compared adventure therapy use by occupational therapists with other occupational therapy practice:

*...and I really do believe in the media and I really do believe that as fringe as people make it out to be its actually not that different to a lot of occupational therapy practice. I think it fits really well with OT ethos.” (Interview 1; 379-381)*

#### 4.2.2.3 Practical fit

Adventure therapy is most commonly used with youth who are deemed to be “at risk”, or who have mental health or substance misuse issues. The term “at risk” relates to the population of adolescents who engage in “risky behaviours” e.g. violence and crime, substance misuse, truancy and are consequently at risk of poor education and outcomes, unemployment, social isolation, habitual involvement in crime and violence, and mental health disorders such as conduct disorder, anxiety and depression. This has been attributed by some authors to an increase in family structure breakdown, families moving regularly, domestic violence, adolescent pregnancies, poverty and lack of adult supervision and support (Autry, 2001; Hill, 2007; Mossman, 2005). All of the participants were working or had worked with youth when using adventure therapy and most were working in facilities that specialised in youth mental health or substance misuse interventions. This is a population that occupational therapists often work with in both inpatient/residential settings, and in community based services.

As well as the client population being common to both fields, participants described planned outcomes of adventure therapy likely similar to or the same as those identified in settings that cater for this population but do not use adventure therapy, including settings that occupational therapists work in. Outcomes expected for adventure therapy included increased insight into strengths and abilities, changing behaviours or thoughts, learning skills, building capacity for change, and motivation for change. Morgan highlighted this by saying:

*...adventure therapy and OT, there's a huge emphasis on building capacity and in this setting we're not using physical aids and that stuff but it is about developing capacity in a communication style, in how we talk to ourselves of*

*treat ourselves or our bodies, or how we treat other people and so that kind of fits nicely..." (Interview 3; 242-246)*

Jamie also spoke of the complementary way the two fields worked on client change:

*"[adventure therapy] seems to be able to address some of the stuff in the moment that kids are struggling with ...it can kind of unlock the door to being able to achieve what they want to achieve in their lives...that's what I've found...so I guess that's a way it compliments OT..." (Interview 4; 207-212)*

#### 4.2.2.4 Room to talk

Involvement in activity was identified as a stimulus for disclosure and sharing on the part of the client. The value of activity itself and the value in having the therapist involved in the activity alongside the client were both identified as important factors in enhancing therapeutic relationship and creating a safe environment for the client to talk. Participants spoke of how young people don't necessarily talk openly in an interview room, but that involvement in activity gave them the wherewithal to share more freely about difficulties or issues for them. Participants described using a variety of activities in relation to this feature of therapy, including adventure and non-adventure activities, indicating its presence in both adventure therapy and occupational therapy.

The information shared was considered to be at a deeper level than in a clinical interview situation, due to both involvement in the activity and the depth of the relationship established as a result of the therapist being involved in the activity as well. Morgan illustrated this well:

*I think when we are doing something with someone we get richer info than asking someone questions in a sterile room...do you know what I mean? Especially young people um it makes people human, the humanness of it, I*

*think of memories from on the journey of doing meal prep chopping up onions together, you know very humanising.” (Interview 3; 270-273)*

This concept was reiterated by Pat who also highlighted the enhanced relationship through shared activity, saying that:

*I think because we are doing things with people we are able to establish that relationship easier and quicker and kind of deeper. So both OT and adventure stuff – it’s the sharing the experience that makes it easier to get that rapport established and the relationship firmed up. (Interview 7; 115-118)*

That activity can facilitate therapeutic change in itself is a concept occupational therapists identify with. Jamie linked this to young people often developing self-awareness when confronted with their behavioural responses in adventurous activity, with talk in the form of debriefing enhancing the benefit:

*...teenagers in particular don’t want to talk about things all the time necessarily but when they are experiencing things in the moment there’s this kind of light bulb moment for them, when they can see what’s going on, they can start to see patterns of behaviour, and its debriefed in the moment they can’t actually deny that.” (Interview 4; 224-228)*

#### 4.2.2.5 Meaning in activity

Occupational therapy has an underlying premise of using activity or occupation that is meaningful to the individual. Two of the participants talked about the concept of meaningfulness from different perspectives. Pat spoke of activities in adventure therapy being prescribed rather than selected by the client; and justified this process by identifying that clients of adventure therapy services often have limited experience of variety in activity participation in their lives. Meaningfulness was attributed to the client’s potential for continuing with these activities in their future life. Chris spoke

of the meaningfulness of the activity becoming apparent as clients learned from the activities and applied the learning to their everyday life. Meaning for the clients was attributed by Chris to the enjoyment they experienced, to the adventurous nature of the activities being relevant for the adolescent age group, and to the immediacy of the activities:

*...it has more meaning because it is here and now, they are getting kind of some of their um automatic reinforcement or ....and the activities are kind of quite relevant to them...I mean they talk about adolescents having a need for risk taking and adventure and fun and all that kind of stuff, so I think that the activities we do kind of fit that bill..."* (Interview 1; 171-176)

#### 4.2.2.6 Motivation through activity

When participants talked about their use of the MOHO (as discussed earlier) they emphasised the relevance of the volitional component of the model, and the importance of motivation for engagement in activity. This link to motivation featured in many interviews, with participants identifying both the motivating nature of adventure, and the need for motivation to participate in adventure. Some participants spoke of the importance of engagement in the adventure activity for the process to be effective, and the role adventurous activity has in facilitating motivation for action. Others considered the importance of facilitating motivation with this group to ensure engagement, and discussed ways that this occurred – selection of interesting/exciting activities, use of physical activity that produced endorphins, modification of the activities to facilitate success, and grading activities to provide opportunity for people's expectations to be exceeded. Alex alluded to the natural fit between the adolescent life stage and adventure, and linked meaning to motivation – *"they were meaningful because they wanted to do them"* (Interview 6; 221).

#### 4.2.2.7 Habits and roles

As discussed earlier participants used the MOHO to make sense of and articulate aspects of the therapy. The habituation subsystem of the MOHO was specifically talked about by four participants, who identified that adventure therapy enables people to try different roles, gain insight into existing patterns of communication and behaviour, change existing maladaptive behaviours and find ways of engaging more effectively in current real life roles.

Both social roles in the group e.g. leadership and task roles e.g. being the photographer were described as at times emerging as a natural part of the process or being consciously allocated, as Morgan explained:

*Um I think about MOHO and I think about habits and roles...throughout the journey we're always trying to place someone in a role. So if someone's not biking for whatever reason then they're the photographer...um so they are included. (Interview 3; 232-236)*

Kelly talked about the challenge aspect of adventure therapy helping people identify roles they take on, and maladaptive patterns of behaviour.

*...within a few days for the young people...and you would start to see the same patterns of behaviour that were maintaining and quite often precipitating the drug or alcohol use...or whatever; (Interview 2; 87-90)*

and went on to describe the value of helping people identify with and take on adaptive roles and supporting habits:

*I guess a big focus of what I did was how to build up the other things you can participate in and do and hopefully in the process you are gradually reducing the drug and alcohol use...thinking about what other things you can do to have a good time with your friends...or participate more in school... (Interview 2; 357-361)*

The value in comparing roles they take in the group to roles they take in groups in their usual environment was identified by Alex: *"...and then the role that they took upon themselves within the group, sometimes you could see that that was probably roles that they took on outside in their real life..."* (Interview 6; 278-280).

Chris described how adventure therapy helps people develop skills to engage in expected roles in their usual environment:

*...and trying to aid these young people to um, to do things to improve their function and improve their ability to manage their lives and to kind of do the normal occupational roles of being a school member, a family member, a friend um all or those sorts of things are the legitimate kind of roles for people at this age group that I work with and I think adventure therapy aids improvement in those roles...* (Interview 1; 117-121)

Morgan emphasised the opportunity when with people in a novel environment to try out different daily routines:

*It's trying to think about that stuff, in that roles and habits are important for people, um trying to set up really good habit kind of like we get up in the morning, we have a shower every-day, and that sort of stuff."* (Interview 3; 236-238)

Chris also talked about opportunity for clients to try different roles when involved in adventure therapy, specifically regarding trying out more adult roles than they may have had opportunity to do at home –

*There's a transition in developmental stage and kind of exploring adult roles so you can sort of put those things into the activity experience...through taking leadership roles...taking on more empathy roles...allowing people to step back and allowing others to take leadership roles, that kind of thing. The adult learning that's actually kind of important as they move on and work*

*with others and people...there's certainly an expectation of personal responsibility the adolescents don't get much of as children. (Interview 1; 176-183).*

#### **4.2.3 The therapist**

Adventure therapy is not a recognised profession in New Zealand and is in the emerging phase in some other countries. There is no internationally recognised definition of who an adventure therapist is or of a specific qualification for adventure therapists.

Participants were all working or had worked in facilities that provided adventure therapy alongside or within other therapies. None of the participants identified themselves as adventure therapists, and some were very clear that they were working as occupational therapists and used adventure therapy as a tool or approach. The professional backgrounds of participants' colleagues included social workers, nurses, psychologists, and counsellors. Some of the facilities contracted in adventure activity instructors to cover hard skills deficits amongst the therapy staff. Therapeutic intervention was commonly managed at these times by therapists' informing instructors of client issues and planned outcomes, and therapists conducting the debriefing sessions. For some of the participants the adventure therapy component of their work was separate from the rest of their clinical work, for others it was merged.

Although participants were all able to identify skill deficits they had when they first started working in adventure therapy, the fundamental philosophical and practical elements of using adventure therapy seem to be present in qualified occupational therapists. Dale examined personal level of preparedness for using adventure therapy and concluded that:

*"...in my mind they um do overlap a lot. I haven't sort of done anything at [workplaces] where I've thought "oh gosh this feels really different..." There was far more that was perhaps contradictory or wasn't so much in our training when we were getting into the talking therapy side of it....that was you know where I thought I don't know if I'm really trained for this stuff....just learning it on the fly....but the adventure stuff just seemed to totally make sense, and I think that was because of the [OT] training that I had. (Interview 5; 214-221)*

Most participants identified aspects of occupational therapy that enhanced their ability to use adventure based activities therapeutically. Chris identified the ability to *"really look at the needs of the young people and to grade and adapt the activity to meet the needs of the group and the needs of the individual..."* (Interview 1; 137-138) as something that occupational therapists are able to do to a greater extent than others using adventure therapy. This was also identified by Dale when talking about the strengths of an occupational therapist working in adventure therapy:

*I think um the way that we're trained to dissect activities and reconfigure it to suit the client, where the clients at, reconfigure it to suit assessment as opposed to therapy and the process of evaluation...um it was a massive advantage. (Interview 5; 226-229)*

Occupational therapists tend to focus on the essential skills necessary for adaptive living, and as Chris said *"relating it to the function that they require to have more normal lives..."* Chris went on to say that:

*Adventure therapy is probably more at that "OK we just want these guys to have a great experience and learn something" ....we kind of think a little more about kind of the really basic levels of what these young people need to actually go out into the real world sort of thing.... (Interview 1; 273-277).*

#### **4.2.4 Summary**

Participants talked with ease about how they use adventure therapy as a part of their occupational therapy practice. Shared philosophical beliefs about the therapeutic power of activity and the influence of occupation on health and well-being provide a base for participants comfort in their use of adventure therapy. This is enhanced by shared concepts of activity engagement facilitating therapeutic talk, meaningfulness in activity and motivation for activity. Some participants saw adventure therapy as the same as occupational therapy when considering how activity is used. Others indicated that they were aware that there were some differences in how activity is used in adventure therapy compared with occupational therapy, but were able to justify its legitimate use in occupational therapy. This is covered in more detail in the “This is how I make it work” section. The theory drawn from psychology is shared between the fields, and the use of the MOHO enabled participants a structure for their clinical reasoning that enabled the use of adventure therapy approach within occupational therapy practice. The confidence with which most participants were able to talk about their use of adventure therapy within their occupational therapy programmes indicates a clear fit between the two fields. Differences between the two fields, some potential conflicts and areas participants felt poorly equipped to perform competently in when starting out in adventure therapy will be covered in the next section – “This is different for me”.

### **4.3 This is different for me**

Participants identified a number of features of adventure therapy that were different from occupational therapy, and had the potential to cause some conflict. These differences are presented here as they relate to the

theory that informs adventure therapy compared with occupational therapy, the specific approach to therapy in adventure therapy and differences in the individual therapists' areas of skill and knowledge.

#### *4.3.1 The theory*

Adventure therapy involves the use of adventurous activities to facilitate a positive change at a psychological or psychosocial level. The therapy purposefully uses challenge by selecting unfamiliar and difficult activities that are novel for the clients, and that are conducted in an unfamiliar environment (usually the outdoors). This process is different from usual occupational therapy practice, where clients are engaging in everyday activities of their own choice.

##### 4.3.1.1 Unfamiliar environment

Occupational therapy is usually conducted in the individual's everyday environment, or with an emphasis on function in their everyday environment. That an integral component of adventure therapy is the purposeful use of unfamiliar physical and social environments featured heavily in participants' descriptions of their work. Six participants identified valuable aspects of clients being away from the usual environment. These included gaining perspective, having a "clean slate" on which to make behavioural decisions, understanding that there are options other than their usual environment in which to operate, structuring the environment to make it conducive to learning, and the therapeutic value of being in nature and of being in a challenging environment.

Three participants specifically identified the concepts of challenge and risk when talking about the physical environment, both in terms of the therapeutic benefit, and the difficulties associated with working in risky

environments. Alex talked about groups developing in adventure environments more intensely than in usual occupational therapy settings:

*I guess because you're out of ...or in an unfamiliar environment, so a lot of the time you've got a whole group and so the whole group has to work together a lot more maybe than in the education skills development sort of groups that I would run... (Interview 5; 157-160)*

Morgan specifically described the social environment that developed within the adventure therapy and described talking with clients about the difference between that and their usual social environment.

*...we do a lot of reflection around the journey group and how it becomes family like and supportive, so we kind of...so in MOHO that's talking about the social environment and so actually thinking about so who are people at home that might be important for you achieving your goals, and being able to think about that away from home. (Interview 3; 246-251).*

#### 4.3.1.2 Unfamiliar activity

As well as the use novel environments, adventure therapy purposefully uses unfamiliar activity. Six participants spoke of adventure therapy involving activities that are novel or unfamiliar to the individual, as opposed to occupational therapy on the whole utilising familiar or every-day activities. The value of using novel activities in adventure therapy was attributed to the ability to incorporate challenge and risk, and the motivating element this brings for young people with the risk taking and adventure seeking element of the adolescent life stage.

#### 4.3.1.3 Challenge

Adventure therapy's purposeful use of challenge is in contrast to occupational therapy's usual approach of working with people within their comfort zone and keeping the level of challenge optimal for effective

learning. Although participants identified this as a clear difference between the two fields, they were able to speak of the value of the use of challenge in adventure therapy and justified its use in a variety of ways.

Jamie illustrated the use of challenge and the value of having people engage in activity that put them outside their comfort zone with the implication that this would enhance feelings of achievement once the activity was completed:

*So before caving we'd talk about personal goals in the group before we left and some of the challenges, so we'd set a personal challenge and say if it was um going to the high ropes they might just actually say all I can do is go half way up the ladder actually, or all I'm going to do is um just maybe enter the cave to a certain point, or even just being there is a big challenge for me so they'll be able to support people in their various level of challenge and... (Interview 4; 126-132).*

Jamie also spoke of the value of challenge and risk in the way it

*...pushes people out of their comfort zone basically...it raises levels of expectation and anxiety in people and also excitement because um you know it's an activity they wouldn't normally do or it's something that they find is motivating just by the fact that it's novel. (Interview 4; 162-165)*

Kelly identified this sense of achievement as an important feature of adventure therapy when saying:

*...um so there was a bit of unknown challenge involved and it gave people a chance usually...often to exceed their expectations of themselves about what they would be able to achieve... (Interview 2; 142-144)*

Pat spoke of the activities being purposefully challenging in order to facilitate learning about managing challenge in every-day life,

*Yes, that and the challenge, the activities are challenging for them. Not just because they are new, but because they might be hard or scary as well, or difficult to learn... So they get to do these things that are not usual or easy, and they learn things that make a difference to how they then cope with or behave in their real world. (Interview 7; 54-58)*

Chris spoke of the value of working with the individual in the moment when challenged and experiencing high levels of emotion, describing it as “real time work”. Real time work involves

*Encouraging them to look at what is actually going for them rather than getting into panic mode...calming them down...look at what's actually going on, the thoughts that are happening for them...their physical reactions trying to slow their physical reactions down and allowing them to overcome those too so that they achieve a lot more than what they thought they could. ...it's about helping them to manage that in a different way to how they would normally manage it, so it's kind of real time, it's happening now. (Interview 1; 75-86)*

Kelly talked about the use of challenging activities in helping clients demonstrate and/or identify usual coping styles when in challenging situations, and therefore consciously practice making changes:

*...creating the challenge that was in a different setting so not their usual challenges that they faced when they were at home...and usually there was some the challenges did present themselves...eventually...within a few days for the young people...and you would start to see the same patterns of behaviour that were maintaining and quite often precipitating the drug or alcohol use...or whatever it was...or mental health difficulties...and yeah so it provided a useful vehicle for reflection and yeah...creating awareness of this... (Interview 2; 84-91)*

#### 4.3.1.4 Risk and metaphor

The level of challenge is often linked to risk. Adventure therapy uses the concept of perceived risk and actual risk, with staff work on providing activities that have a high level of perceived risk, with actual risk being acceptable and managed. This purposeful and somewhat contrived use of risk is also different from occupational therapy practice, where consideration of risk is more usually around managing risk factors related to the individual and their usual environment. Participants spoke of how they used risk in adventure therapy in a number of ways.

Pat talked specifically about a difference between challenge and use of risk in occupational therapy and adventure therapy, saying that

*...in OT even if the activity is new for people we try and make it like easy or relaxed, so they are confident they can manage and achieve from the beginning. But in adventure therapy it is often about providing challenges that seem almost insurmountable, like really challenging to the individual and that's why it has such a dramatic affect – they succeed and it's like wow, I did that!!! So we use risk in a purposeful way, we make the activities seem really risky – high perceived risk, but actually we have managed a lot of the risk so it is pretty safe really – that's low actual risk.(Interview 7; 80-86)*

Dale considered risk an integral part of the concept of adventure and what defines adventure therapy – “so it's my understanding that adventure is unknown outcome and there has to be some level of risk but I think there doesn't have to be any real risk, but at least ideally far more perceived risk than real risk, for it to be used therapeutically.” (Interview 5; 127-131).

The therapeutic value of purposefully facilitating activities with risk was nicely described by Dale, who said that

*I think adventure activities are some of the most powerful mediums I've ever used as an OT because it's very real, um it's got real risk ...well, at least perceived risk...so it has an element of risk and that puts people in a very real place, a very honest place, with themselves and with each other um and I think it gives people a really good....because of that realness and that kind of this is real feeling and like there's real risk here...you know, there's um unknown ...all those things, out people in a place where they have to be their real selves and therefore they realise things about themselves they might not have done otherwise that they um that are great about themselves or that they might want to change about themselves..." (Interview 5; 112-121)*

Adventure therapy theory incorporates conscious use of metaphor, with the metaphor being either specifically included in the briefing, or an unspoken but integral part of the therapeutic process (Russell, Hendee, & Phillips-Miller, 1999). Use of metaphor consciously is an adventure therapy technique that was mentioned by three participants. Pat and Kelly both spoke of it as a facilitation technique, and Morgan gave an example of an activity suitable for use of metaphor:

*...like caving is a really nice activity to finish on as well because you can use the metaphor you're going into a cave on a journey sort of thing, it's kind of like when you kind of overcoming things in the cave and you're coming out in a different place, and what's next sort of thing. (Interview 3; 120-123)*

#### **4.3.2 The therapy**

Participants all indicated that they were doing adventure therapy within their occupational therapy roles, and they felt comfortable using adventure therapy techniques as they defined them in their work. However they did identify differences between the two fields in how the therapy is conducted.

As identified above, adventure therapy theory is based on the use of unfamiliar environments (usually outdoors), the use of prescribed unfamiliar activities, and the purposeful use of challenge and risk. The therapy is conducted outside of the clients' usual social and environmental systems. Adventure therapy is generally conducted in groups and the group is an integral component of the therapy. It may be conducted within a specific session or over a number of days, is generally but not always in the outdoors and is often a one off experience (Russell, 1999). All of these features are different from usual occupational therapy practice.

Occupational therapy was considered to be broader than adventure therapy, and participants talked of how the adventure therapy component of their work was somewhat restrictive. Chris summed this concept up by saying:

*OT looks more at the real life picture and is looking at developing skills for occupations more specifically whereas adventure therapy is 'OK we have done something now what have we learned about that? (Interview 1; 217)*

Pat spoke of the same concept, but made a direct comparison:

*They [other adventure therapists] might do an activity and then debrief it and help the person figure out what they learned and then maybe get them to talk about what they will do different in the future and that's it. But I will get the person to be specific about what habits at home they will change, and what roles that will help them take on, and what skills they need for them; all that stuff. Just a bigger and more practical view of the client's world. But that's OT really isn't it – a big practical view of the clients whole world! (Interview 7; 216-221)*

Two participants did acknowledge that there was likely more to adventure therapy than they were aware of. Dale talked about not having a

clear definition of adventure therapy and that talking with others about what it is had not helped clarify what it is:

*And while I'm saying what I think adventure therapy is, I know that it's a lot more than that. But I just don't know what that is... I don't think that it is just a medium that OTs use, I think it's something a lot more than that, um but I'm not sure what that is, and I would be surprised if there was a massive difference between that and OT, that's my sense. (Interview 5; 359-367)*

Kelly spoke of being able to quickly understand and use adventure therapy because of occupational therapy training, but did allude to there being something more to adventure therapy:

*...I think that OT and adventure therapy go well together...I do think that as an OT it was um I wouldn't say easy but relatively...um ...at least comfortable I think when working in a facility that is using adventure therapy as one of the treatment modalities...I was quite quickly able to see the benefit of it, a bit like just another activity but there were other things involved... (Interview 2; 433-437)*

Participants also identified adventure therapy activities to be traditionally restricted to outdoor activities with an adventurous nature to them. Specific activities most commonly identified included kayaking, rock climbing, high and low ropes courses, mountain biking, caving and tramping/camping. Pat identified this as different from occupational therapy, where the potential selection of activity was much broader, in essence *"in OT it could be anything at all the client wants or needs to do, or agrees that might be beneficial for the"* (Interview 7; 235-236).

As the activities are prescribed, there is potential for clients to never do the activities again in the future, and for them to not find them meaningful or satisfying when engaged in them – this is at odds with occupational therapists' usual use of activity.

Participants spoke of adventure therapy considering the whole group as the “client”, and identified that activities and debriefing sessions often focussed entirely on the group as a discrete entity, rather than the individuals within the group. This was identified as a difference between adventure therapy and occupational therapy where even in group work the emphasis is on the individuals within the group, as explained by Dale:

*Yeah, so it's almost like I go through the therapeutic process, but it's not just with individuals, it's as much if not more for the whole group...assessing where the group...at what stage is the group at, what activities um are needed to make the assessment of where the group's at, and then once you've finished that, what activities are needed to - you know for the therapy to develop this group....we don't have the ability to do one on one activities with people to go on the side or this person could do with more kayaking, or this person could do more rock climbing....so um so that's probably the difference, thinking more at a group level. But still having quite a good understanding of where the individual is at. (Interview 5; 78-83)*

Alex also talked clearly about adventure therapy focusing more on the group than individuals –

*Um, I probably more aware of the process with the group rather than- I usually worked individually in...Well I didn't actually, I did groups and individual...um I guess the process is more of the whole group rather than individuals. (Interview 5; 99-102)*

Alex went on to say that this changed the dynamics of the group as activities in adventure therapy are set up to be completed as a group –

*So I guess you have to all be more aware of each other and where everyone's at. Which is quite different for a lot of people kind of thinking outside of themselves... (Interview 5; 164-166)*

Pat also talked about adventure therapy's focus on the whole group, saying that

*In adventure therapy a lot of the stuff happens in groups, especially when you're away for a trip, like as an OT you're looking at the whole group not just the individuals in it. I think in a hospital or even community based OT group you'd still be looking at individuals within the group..."* (Interview 7; 93-96)

### **4.3.3 The therapist**

Whilst participants generally considered themselves to be legitimately able to use adventure therapy techniques or approaches in their occupational therapy work, they also identified perceived gaps in their level of knowledge and/or skill between their occupational therapy training and their work in adventure therapy. This gap was explored to identify potential differences or conflict between the two fields in terms of the therapist – a large gap between skills and knowledge on graduation and skills and knowledge required for the job may indicate a poor fit between occupational therapy and adventure therapy.

Most participants mentioned that occupational therapy training did not equip them with any of the hard skills needed, for example kayaking or rock climbing, and also acknowledged that this would be unrealistic to incorporate into occupational therapy training. Some participants talked about their facility engaging instructors for the hard skills, and using therapy staff to co-facilitate and to engage in the debriefing and therapy aspect of the experience. Others had gained the necessary hard skills through engagement in the activities in their leisure time, and through additional training, and were able to do all aspects of the role.

Six of the participants identified group process and group facilitation as an area they felt they had inadequate skill level on graduation from

occupational therapy training. Whilst they acknowledged it was covered in the curriculum, and that occupational therapists do facilitate groups, it seems that in adventure therapy the work is done with the whole group to a much greater extent than in typical occupational therapy settings. Dale and Alex both directly identified group facilitation skills as a skill they lacked –

*“Um I think perhaps facilitation skills was probably the biggest thing.”*  
(Interview 5; 345).

*“Um, and then my facilitation skills would have needed to be improved a lot I guess to be able to run more adventure therapy programmes”* (Interview 5; 324-325).

Dale talked about how much of the intervention focused on the group as a whole, illustrating the importance of being able to effectively facilitate groups and to consider the therapeutic process in terms of the group as an entity in itself –

*Yeah, so it's almost like I go through the therapeutic process, but it's not just with individuals, it's as much if not more for the whole group...assessing where the group...at what stage is the group at, what activities um are needed to make the assessment of where the group's at, and then once you've finished that, what activities are needed to - you know for the therapy to develop this group....* (Interview 5; 78-83)

Dale also spoke of the potential for occupational therapists to use facilitation as a discrete therapeutic tool, intimating it was not presented in this way in undergraduate occupational therapy training –

*When I look back at my training....just the facilitation is one side that I feel wasn't covered that much at OT school. The group facilitation there was a lot of “here's how you do groups” but then it's more ....what I took from polytech anyway was...you know the activity with a group but then you work with the*

*individual...you know, you discuss with the individual how it's going to work in their real lives...but I don't see why facilitation couldn't actually be a really powerful OT skill. (Interview 5; 232-239)*

Chris specified group process as an area of weakness on graduation:

*Um probably more work on group process and how to manage group process issues when things go slightly pear shaped. How to get the best ... (Interview 1; 326-327)*

Participants also identified specific therapeutic approaches or techniques that they were introduced to in occupational therapy training but not to the extent that they felt equipped to use them comfortably. Whilst four participants talked about using motivational interviewing as a therapeutic approach, two of them specifically mentioned use of motivational interviewing as a skill gap on graduation. Pat said:

*I remember learning about what solution focused therapy was like, but never how to actually do it. The same with motivational interviewing, it was just words. We were made aware of them and maybe had a bit of theory, but not how to do them... (Interview 7; 258-260)*

Kelly also spoke of this gap:

*Um I think probably when I graduated my knowledge of things like motivational interviewing was you know like a 1 hour tutorial um but hadn't ever done...yeah so that was obviously a big part... (Interview 2; 376-378)*

Counselling skills was also mentioned by Pat when talking about areas of weakness on graduation –

*We did the counselling skills quite superficially I think, and kind of learned about things rather than how to do things. We did practice basic counselling skills you know reflecting back and stuff...but... (Interview 7; 255-258)*

Experiential learning was identified by Jamie as something not covered in training but picked up through working:

*...and I never learnt that whole experiential learning type of learning ABL theories within my training at all. And so I didn't know anything about you know...well we did some group-work, and in fact our programme was all group-work so it would have been really good to have learned about experiential learning, and to have experienced it for myself um in my training, and I didn't do that. (Interview 4; 355-360)*

Dale also identified a lack of knowledge regarding use of experiential learning, and linked it to lack of confidence initially in group facilitation:

*...um I think perhaps facilitation skills was probably the biggest thing. You know the experiential learning cycle is inherent in OT but I just needed to get my head around that stuff as well. (Interview 5; 344-347)*

As much of adventure therapy is based on using risk therapeutically and selecting activities for their level of high perceived risk, it is not surprising that risk assessment and management was identified by participants as an area they felt under-equipped in when beginning in adventure therapy. Dale summed this theme up by saying:

*Risk assessment...um was definitely a gap that needed to be filled. Although in saying that I think that our ability to kind of...we did learn a lot about um the inherent safety risks in activity so it wasn't too much of a jump but I think just kind of big picture like you know when your baking bread with someone you don't have to come up with a massive RAMS (risk assessment and management system) form around how you would carry out that activity, so kind of big picture and more complex risk assessments, rather than just really focused what is the risk inherent in this particular activity. (Interview 5; 336-344)*

Morgan reinforced the importance of risk management in adventure activities:

*There's also knowledge around risk management. So in OT school we'd think about um not burning yourself when you're cooking scones or whatever...but there's some issues in risk management in the outdoors - it's just a mine field.*  
(Interview 3; 481-483)

Pat spoke of how important risk management is in the adventure therapy field, but acknowledged it is present in other occupational therapy settings as well, such as forensic services:

*Risk management is big in this field, as the activities have so much potential for accidents or problems. Although I can think of other settings where risk is potentially high like the mental health prison places...what are they...forensic services. Yeah. I'm surprised looking back that we didn't learn just one way of identifying risk and doing a management plan that would suit any setting...it's pretty important really...* (Interview 7; 251-255)

Risk is also inherent when working with groups of people who likely have high levels of expressed emotion, or difficulty managing strong emotions such as anger. Conflict management and the process of de-escalating situations was identified by Chris when talking about group management skills:

*Um probably more work on group process and how to manage group process issues when things go slightly pear shaped. How to get the best ...." and later "... more around the group facilitation, getting the best from the group and being really aware that just because you plan the group it doesn't always go that way, and that you need back up plans, plan B...* (Interview 1; 236-340)

Morgan also specified conflict resolution as an important skill under-emphasised in occupational therapy training:

*Conflict resolution...I don't know if that's possible...but on every journey something goes down between something and someone and actually you've either got to grab it and deal with it in the moment and work with it in some way, or it won't go away... (Interview 3; 500-504)*

Using activity consciously in order to facilitate change is clearly an integral part of the philosophy of both occupational therapy and adventure therapy. Whilst all participants spoke of this, two of them also identified aspects of using activity in adventure therapy that they felt initially ill-equipped to do in the beginning. Morgan spoke of not having a variety of often used group activities on tap initially, and skill in making them relevant on the spot:

*So for example all the silly wee name games, energisers, ice breakers, but really being clear about this is what we are trying to achieve by doing this activity, so being able to shape or develop a programme, you know? (Interview 3; 512-515)*

Jamie linked an initial skill or knowledge deficit to the potential activities have in group work:

*But I did not grasp the concept of the power of activities for learning in my OT training. And I didn't get a lot of mental health placements anyway, therefore it didn't get reinforced, I might have experienced it if I had of had an inpatient or group-work kind of placement but yeah that was completely new to me when I learnt it way down the track... (Interview 4; 361-366)*

Many of the identified gaps were around knowledge or skills the participants acknowledge were covered in their occupational therapy training. As some of the participants were novice practitioners when they used adventure therapy they are likely to have had to refresh their knowledge and hone their skills once practicing. Many of the challenges they

identified are likely shared with occupational therapy practitioners starting out in any mental health setting.

#### **4.3.4 Summary**

Participants identified differences between adventure therapy and occupational therapy at a theoretical level. These related to adventure therapy's use of unfamiliar environments and activities, purposeful use of challenge and risk, conscious use of metaphor, and a specific therapeutic process based on experiential learning theory. Differences in how the therapy is conducted include an emphasis on the group and group process, use of briefing and debriefing to facilitate learning, adventure therapy's prescription of activity and restriction on what activity is selected and what environment is utilised. Participants identified a number of skills they felt they did not have adequately when first working in adventure therapy. These included the hard or technical skills of adventure based activities, risk assessment and management skills, and skills in group facilitation and the use of activities in a purposeful but contrived way to facilitate learning. Participants did acknowledge that most of the concepts were introduced in their occupational therapy training, but not practiced enough to enable full skill development. This is likely in part a reflection of still being in the consolidation stage of their careers when first starting to use adventure therapy.

#### **4.4 This is how I make it work**

Participants are clearly able to apply adventure therapy to their work as occupational therapists, and identified features that illustrate compatibility between the two fields. There are however some differences between adventure therapy and occupational therapy that have the potential to create conflict.

This section explores the ways that participants managed the dissonance caused by the differences between the two, and demonstrated an ability to legitimately utilise adventure therapy techniques in their occupational therapy practice. Again, the concepts of theory, therapy and the therapist are covered.

#### *4.4.1 Theory*

Participants all defined adventure therapy in a similar way, on the whole talking about concepts such as therapeutic use of activity and adventurous activity being a medium for therapeutic change. None of the participants identified it as a separate therapy, although two did talk about there being more to adventure therapy than they knew. The way that participants defined the term adventure therapy is compatible with occupational therapy's use of any activity, which likely positively influences their comfort of using adventure therapy in their practice. The fact that participants did not identify it as a profession in its own right, and were all employed as occupational therapists at the time they were using adventure therapeutically indicates their perception of some fit between the two fields in New Zealand.

Participants talked about their familiarity with adventure therapy theory and also about how they used occupational therapy theory to inform their work. The occupational therapy model most used is the MOHO, and its use seems to have enabled participants to maintain their occupational therapy focus. This is enhanced by an apparent perception that adventure therapy is an approach or way of working that occupational therapists can legitimately select.

#### 4.4.1.1 Model

Six participants talked about using the MOHO as their primary model of practice, and indicated that they used it in ways that enabled them to consider their adventure based work in occupational therapy terms. The MOHO helped them articulate what they were doing in occupational therapy terms, and reportedly guided clinical reasoning processes.

Participants acknowledged that they did not use the MOHO language in their documentation or in their communication with colleagues; this could be attributed to their colleagues not being occupational therapists, and generic facility guidelines regarding documentation. Morgan thought it was because his colleagues were aligned philosophically with occupational therapy practice, but used the MOHO language more intentionally when with occupational therapy students:

*No, I mean I use it [MOHO language] with OT students I have, I pressure them into making links but actually um I think in another setting it might be more overt but these guys are...what I really like about these guys is that they all get this stuff. They've all I think....because they've developed the company they've learnt some stuff that I think ...some OT knowledge I think along the way..." (Interview 3; 316-320)*

Morgan also described having the MOHO as a basis during the assessment phase and as a result having a broader view of the person than just utilising the facility assessment guide. The impact of a shift in one of the subsystems during adventure therapy activities was explained, along with the potential impact on the everyday function of the person, illustrating the holistic nature of the MOHO:

*I guess the idea of MOHO that I understand is that if you can do an intervention in one of those boxes then there's a shift...there's a shift and a*

*reshuffle...and ideally you can change behaviour through that.” (Interview 3; 251-254)*

Jamie identified that the MOHO structured thinking (but not documentation or talking with colleagues) and helped to ensure the “big picture” was considered and not just the context of the intervention,

*What we did as a whole because it wasn't just about adventure work, it was about the whole thing, so you know we were working towards restoring the function and restoring the skills addressing those sort of areas of life like the school, vocation, that kind of stuff....work, play rest...making sure people had enough rest, all that kind of thing, and structuring the environment so that it was going to be conducive to learning, and working with the parents in the home environment was basically reinforcing what we were trying to change, you know the boundaries and all that sort of thing...and communication that we were working on within the programme... so yeah, I think it was just a natural framework for the programme, the MOHO kind of model.” (Interview 4; 322-337)*

#### 4.4.1.2 Approach

Participants described psychology approaches they use in their work that are shared among adventure therapy colleagues, and that are also used by other occupational therapists working in mental health. The way that some participants described using adventure therapy is similar to how they described using other approaches within their occupational therapy practice, indicating that adventure therapy for them could be considered just another approach to select from. This concept was most clearly identified by Pat when discussing facilitation techniques specific to adventure therapy – use of metaphor, team exercises and debriefing. Occupational therapists using

adventure therapy as an approach was justified in the way that occupational therapists might use cognitive behavioural therapy:

*I think it's just an approach we use... like CBT or biomechanical or whatever, it's an approach or model. It just seems a wee bit different cos we don't learn about it in OT school, but then you can't learn everything you're ever going to use or need in OT school! (Interview 7; 144-148)*

#### **4.4.2 Therapy**

The adventure therapy process utilises experiential learning cycle with prescribed and at times contrived activities (for example having the group work together to get all members over a 10' wall without the use of assistive equipment) to facilitate change. This differs from the occupational therapy process, which is in essence a client centred problem real life solving process with a focus on achievement of occupation based goals. Participants described different ways of perceiving and managing this difference.

##### 4.4.2.1 Activity as therapy

One theme was occupational therapy's belief in the value of engagement in activity in its own right. Morgan talked about this, describing occupational therapy's emphasis on participation or engagement in the activity as opposed to adventure therapy's focus on the debriefing to facilitate learning:

*I think often as OTs we see the benefit in the activity itself as being inherently beneficial to be participating in that activity itself... whereas I think sometimes other clinicians think that you've all got to debrief it in the way that they do....I think that's a difference, in that sometimes I think yes that's great we have someone engaged, that's good, they're doing alright or well, and I think sometimes I might see the value in that whereas another clinician whose not an*

*OT might say well we're only half way there, we've got to debrief this in a really meaningful way. (Interview 3; 466-476)*

Jamie spoke about the power of the activities in themselves in terms of learning and growth for the clients, and acknowledged potential enhancement of learning through good facilitation skills in the briefing and debriefing phases:

*But I could see how amazingly therapeutic it actually was, even without someone debriefing it, um using therapeutic adventure activities in itself would stretch you in a way and you would grow naturally in a way...but if it's facilitated then it's that much more powerful really. (Interview 4; 415-418)*

Participants talked about understanding and using experiential learning theory, however also talked of using goal setting processes in a way that is more usual within occupational therapy. Chris emphasised this when by saying:

*...but we are also using 'ok so how did you go on that' and do a fair chunk of the pre-briefing and the debriefing, and the setting goals, and the looking at how you achieved those goals and didn't achieve those goals and why; and looking at kind of why and we certainly look at 'so you achieved this today so how can you translate that to out there in the real world' sort of thing... (Interview 1; 160-165)*

#### 4.4.2.2 Transferring learning

Although both fields have a focus on transferring the learning back to the home or every day environment, participants spoke of occupational therapy doing this much more pragmatically than adventure therapy, given that occupational therapists usually focus on the lived environment. The potential conflict regarding working with people to make therapeutic change

outside their usual environment and having them return to their usual environment was evident. Six participants talked about considering the usual environment and the importance of helping the client transfer learning to their usual environment, as articulated by Dale:

*I see there's an overlap in that it's transferring the whole time...yeah; it's transferring those lessons and the outcomes back into real life... I did feel like it was all part of the OT stuff at [workplace] but the real kind of the guts of the OT is the merging...is the transference of those lessons from the adventure and the outcomes into the everyday life. (Interview 5; 199-201)*

Chris described occupational therapy as considering the client in a broader context to adventure therapy:

*...it's actually about the bits that they need to do. So it's the building blocks of those occupations that they need to be involved in and I think that OT brings it to a different level of breakdown of the activities rather than in adventure therapy is probably more at that "OK just want these guys to have a great experience and learn something"....we kind of think a little more about kind of the really basic levels of what these YP need to actually go out into the real world sort of thing.... (Interview 1; 270-277)*

Comments that supported this concept were a common theme, and likely reflected the fact that for almost all of the participants the adventure therapy component of their work was incorporated into overall broader mental health intervention. Jamie summed up the concept of adventure therapy being a useful way for occupational therapists to address identified needs:

*So with OT that's what we've found with the kids, that they've wanted to be able to do certain things in their lives like...whether it was leisure or school or their future career, and things like that...or anything...just relationships, you*

*know being able to relate and practice social skills and things like that. But it was actually the some of their psychological issues which was inhibiting that so adventure therapy seems to be able to address some of that stuff through adventure learning and through the activity itself...* (Interview 4; 201-208)

#### 4.4.2.3 Familiar and unfamiliar activities

Another area of potential dissonance is around the use of familiar and unfamiliar activity. Most participants' spoke of familiar activities being usual for occupational therapy and unfamiliar activities (often prescribed or directed) being usual for adventure therapy. However they were also able to justify the use of adventure activities in occupational therapy terms.

The value of using activities that were challenging and had an element of perceived risk was linked to the ability of the client to exceed their expectations to develop insight into their usual and possibly maladaptive responses to challenge and to try new ways of responding to challenge and the stress it causes. Most participants spoke of the importance of helping the client transfer associated learning back to their home environment and lifestyle. The every-day nature of activities usually used by occupational therapists was linked to clients selecting aspects of their every-day life that needed changing, and to therapists' use of skill development and education to facilitate enhanced engagement in essential activities and participation in home communities.

Morgan spoke of merging the familiar daily living activities into adventure therapy programmes, e.g. shared responsibility for cooking whilst camping; and Jamie described adventure activities as: *"not just in your average self-care of...you know it's more in the play/leisure kind of zone,"* (Interview 4; 177-179) intimating it should be a part of everyday life. This same concept was reiterated by Chris and Pat who both considered that some people may

continue with these activities in their leisure time outside of the adventure therapy experience:

*...and sometimes they go ahead and take on some of these activities later, like join a local climbing club or whatever. So even though it's directed in the beginning it becomes their choice... (Interview 7; 73-75)*

Alex was able to give an example of incorporating a traditional occupational therapy intervention into an adventure activity:

*...so instead of just being the rock climbing exercise we would incorporate anxiety management techniques into that, so that they were learning new skills that in a real situation I guess which was different to what they were used to so that they could learn the skills and hopefully apply them to other areas of their lives. (Interview 5; 52-56)*

All participants spoke of adventure therapy having the potential to affect a change in the individual in their home environment, in effect transferring learning from unfamiliar environments and activities to familiar environments and activities. Jamie also talked about the definition of occupational therapy being broad enough to encompass adventure activities:

*I guess OT for me is you know the definition broadens so it's not just the everyday activities, it's you know what you want and need to do with you know in terms of activities in your life...I don't think it needs to be...adventure therapy is not the whole of OT but it's certainly addresses one of the aspects of people's occupations... (Interview 4; 257-262)*

Pat identified that adventure therapy and occupational therapy shared the concept of using activities that the client is highly motivated to participate in to facilitate increased engagement. Pat also qualified a belief regarding adventure therapy being different from occupational therapy in terms of novel activities and environments, by pointing out that occupational

therapists often work with people outside their own environments and do activities with them that are not usual for them:

*...but I know in other places people get their OT in environments that are not their own home, and they get given activities to do that are not what they would usually do, so maybe it's not really different..."* and later *"...and there are OTs who prescribe activities...like certain crafts in hospital and stuff.* (Interview 7; 65-72)

#### **4.4.3 The therapist**

Chris identified that occupational therapists are able to *"really look at the needs of the young people and to grade and adapt the activity to meet the needs of the group and the needs of the individual..."* (Interview 1; 137-138) to a greater extent than others using adventure therapy. This was also identified by Dale when talking about the strengths of an occupational therapist working in adventure therapy –

*I think um the way that were trained to dissect activities and reconfigure it to suit the client, where the clients at, reconfigure it to suit assessment as opposed to therapy and the process of evaluation...um it was a massive advantage."* (Interview 5; 226-229)

Occupational therapists tend to focus on the essential skills necessary for adaptive living, and as Chris said *"relating it to the function that they require to have more normal lives..."* (Interview 1; 283) Chris went on to say that

*...adventure therapy is probably more at that "OK we just want these guys to have a great experience and learn something"....we kind of think a little more about kind of the really basic levels of what these young people need to actually go out into the real world sort of thing....* (Interview 1; 274-277)

Occupational therapy has a focus on use of activity to facilitate adaptive function in the lived environment, and so the use of a specific

activity as potentially a once in a lifetime experience is not as usual as in adventure therapy. Kelly indicated there are times occupational therapists will use activities that are not usual for the client, but qualified it by talking about helping the client identify if there is a way they could continue with the activity themselves if they chose –

*...although there's possibly some things that we do in OT that could be the same kind of....like a really expensive kind of hobby and therefore ...but I always kind of think as well about ways that people could do it that's maybe realistic, that people could maintain it and that could be about low cost or alternative ways of finding how you can participate in this thing. (Interview 2; 160-164)*

Another factor mentioned by participants is the seemingly mundane activities in everyday life that occupational therapists focus on because for clients they are often the essential and difficult tasks; Morgan considers occupational therapy as *"the every-day, the normal, um that and that's not easy stuff, that hard stuff because it's overlooked by people and I'm... that stuff is hugely important"* (Interview 3; 166-169). Some participants talked about introducing everyday activities into the adventure experience creating in effect a merging of the two fields in terms of novel and everyday activities. Examples of activities that were added to the adventure programme included meal preparation and cooking, relaxation sessions, crafts, art, yoga.

Pat talked about the activities in both adventure therapy and occupational therapy being shared with the therapist, and made the point that in occupational therapy these are often everyday activities in the community:

*In OT it's sometimes a bit of a boundary issue – at least to non OT's, you know – other staff, who see us having a coffee with clients, or in a supermarket*

*or whatever...there's real skill in being able to be involved in these ordinary things with people and still be the professional. (Interview 7; 118-121)*

Although thinking that there is no difference in professional boundaries between occupational therapists and adventure therapists, Pat did say that it

*...may be different from other professions. Like you wouldn't see the psychiatrist facilitating a BBQ on the beach, but it's kind of everyday practice for some OTs. With adventure therapy all the staff is involved in the activities and maybe it's more obvious that we need to be because of the nature of the activities. So maybe others looking in wouldn't consider there being a boundary issue... (Interview 7; 126-130)*

#### **4.4.4 Summary**

Participants are using adventure therapy within their occupational therapy work, and indicated they were able to resolve potential conflict between the two fields. Strategies they used to do this included defining adventure therapy in a way that is compatible with occupational therapy's use of any activity, using an occupational therapy model to guide their clinical reasoning and generally using adventure therapy as an approach or technique within their occupational therapy intervention. Participants also incorporated usual occupational therapy concepts and practices into their adventure therapy work e.g. using goal setting as well as debriefing, introducing non-adventure activities to the programme such as cooking and relaxation. The overall focus of intervention remained true to occupational therapy principles regarding enhancing occupational engagement and participation –adventure activities are used as a means to effect a positive change in clients' ability to engage in the everyday occupations they wanted to or needed to. Participants were able to identify aspects of being an

occupational therapist that were strengths for them in their adventure therapy work over other professionals e.g. ability to analyse and grade activities.

*I have circled in thermals so much I am dizzy. The higher I climb the easier it seems to get; the thermals are bigger and it is easier not to lose my way in them. I understand the air better as I manoeuvre in it. I travel as quickly as I can but I must be careful – I don't want to fly out of the lift and sink too low, and I don't want my wing to collapse. If I look back I can see where I have come from – the view is stunning! The air is colder, I have never been this high before. Oh and now I can feel it! The cloud – I can feel the cloud on my face! I am ecstatic! I have a long way to go before I will be landing at my goal but for now the journey is satisfying in itself.*

## **5 Discussion**

### **5.1 Introduction**

This chapter discusses elements of theory and practice of adventure therapy and occupational therapy, exploring both concepts and literature in order to make sense of the findings. The degree of fit between the findings with existing literature from adventure therapy and from occupational therapy will be examined. This is structured under the headings theory and practice. Theory discusses the philosophy, models and approaches used by the two fields, and positions adventure therapy in relation to occupational therapy on a theoretical basis. The practice section explores how participants were practicing adventure therapy, and compares findings with adventure therapy and occupational therapy literature regarding practice. Features in common are identified, and features that are different are considered in terms of how occupational therapists can make adventure therapy work for them and for their clients.

### **5.2 Theory**

#### *5.2.1 Philosophy*

Philosophical beliefs belong to the profession, are shared by members of the profession and support the definition of the profession (Boniface & Seymour, 2012). There are beliefs that are shared or similar between occupational therapy and adventure therapy that provide a comfortable base for occupational therapists to use adventure therapy. However there are a number of occupational therapy beliefs that are not usually a part of adventure therapy philosophy.

### 5.2.2 Occupational therapy philosophy

Occupational therapy's philosophical base is humanistic and client-centred (Finlay, 2004). Occupational therapists view individuals as having an occupational nature that they may experience occupational dysfunction and that occupation can be used as a therapeutic agent (Kielhofner, 2004). Occupational therapists are interested in the physical and social environments within which individuals operate and which influence occupation and health (Kielhofner, 2009). Paterson (2014) sums up occupational therapy's current ideals as "*...the belief in the therapeutic value of meaningful occupation, the importance of the environment and of satisfying interpersonal relationships, and balance in the daily routines of work, self-care and leisure.*" (p.12). Current occupational therapy literature emphasises the link between occupation and health and challenges occupational therapists to work from an occupation perspective (Molineux, 2004). Wilcock speaks to this when saying that occupational therapy's philosophy "*...has to be one that relates to the link between occupation and health*" (Wilcock, 1999, p. 192).

These beliefs are strong, and influence how occupational therapists approach all aspects of their work. Occupational therapists maintain a view of the overall occupational and environmental aspects of the individual, and may use activity as a means to achieving an occupational goal. While adventure therapy also has a view of the individual, activity and the environment these aspects are considered within the therapeutic episode; that is how they use activities and the environment therapeutically. Participants saw that occupational therapy's perspective is broader and grounded in the real lives of clients. Because of this wider perspective participants effectively argued that adventure therapy could be a part of occupational therapy, but that occupational therapy could not fit into adventure therapy.

### *5.2.3 Adventure therapy philosophy*

Adventure therapy's philosophical assumptions and beliefs can be explored in two strands – experiential learning and other therapy beliefs. As stated in the literature review, adventure therapy's use of experiential learning is consistent; however other aspects of the therapy vary widely depending on the context and the therapist.

Adventure therapy philosophy incorporates beliefs about the power of activity to facilitate change, and the influence of the environment (physical and social) in effecting change. Experiential learning is the process used to enable activity and environment to be used therapeutically. The activity based nature of experiential learning (see p. 23) lends itself to a fit with occupational therapy's philosophy in terms of the use of activity to facilitate change. Additionally experiential learning is used in education of occupational therapists (Knecht-Sabres, 2013) and occupational therapists use aspects of experiential learning in terms of their own professional development through professional reflective practice (Kinsella, 2001; McKay, 2009); however its overt use with clients in occupational therapy practice is not evident in the literature. Participants found the experiential nature of adventure therapy compatible with occupational therapy, although the structured way experiential learning is applied in adventure therapy was less familiar to them. Occupational therapists have knowledge of experiential learning theory (Kinsella, 2001), and learn skills in activity facilitation and therapeutic communication as an integral part of undergraduate education and so I surmise are well equipped to use experiential learning. Given the current profile of experiential learning in contemporary education theory, the evidence of its success in adventure therapy (Itin, 1999; Wood, 2014) and its fit with occupational therapists' knowledge and skills in activity facilitation and communication perhaps there is a place for it to be used in other

occupational therapy practice areas. Occupational therapists have a role in facilitating client learning in most practice settings and I advocate the more frequent and deliberate use of experiential learning principles would provide useful structure to this process.

The second strand that adventure therapy philosophy can be explored through is the beliefs that form the structure and practice of the therapy adjunctive to the experiential learning process. The philosophical assumptions of adventure therapy are generally holistic and humanistic, but specific beliefs also vary depending on the health qualification of the practitioner (Hanna, 2012) or the way the intervention is defined and practiced (Crisp, 1996a; Gilbert, Gilsdorf, & Ringer, 2004). If, for example, the adventure therapy purposefully includes time in nature, then those practitioners hold philosophical assumptions regarding the healing and restorative power of nature (Hoyer, 2012). Fieldhouse and Sempik (2014) describe this as green care and identify a number of interventions that are selected primarily for facilitating or enhancing a *“human relationship with the natural world”* (p 313). Examples they give of green care include horticulture, animal assisted therapy and wilderness or adventure therapy. It is likely occupational therapists familiar with green care philosophy will find congruence with adventure therapy’s beliefs regarding the role of nature in healing. However if the adventure therapist uses a psychodynamic approach then their philosophical beliefs will be about the unconscious and the extent of which human function is unintentional and symbolic (Gilbert et al., 2004). Current occupational therapy practice is less often based on assumptions from a psychodynamic perspective and so therapists will likely be less comfortable with psychodynamic practice.

Whilst philosophical beliefs provide an overview to a profession, they do not inform the practitioner on how to translate beliefs into professional

practice. Such translation into practice is commonly done through the use of models; the following section explores the use of models in occupational therapy and adventure therapy.

#### **5.2.4 Models**

A model is *“a way of guiding action (practice) that is much more practical than philosophy”* (Boniface & Seymour, 2012, p. 26). It is a framework used to structure clinical reasoning, frame concepts and provide a language to articulate practice. Conceptual models provide a framework for interpretation and understanding of clinical data, and include theory and practice based tools for applying the theory (Melton et al., 2009). The occupational therapy model that participants most commonly described using (MOHO) is a conceptual model in comparison to practice models which specifically guides the selection of intervention strategies and sit alongside conceptual models (Creek, 2014; Finlay, 2004). I consider the models that structure how the adventure therapy process is conducted to be practice models.

#### **5.2.5 Adventure therapy and models**

The use of models in adventure therapy provides structure for both the particular way experiential learning theory is applied (the adventure therapy process), and for the integration of the mental health practice. The Outward Bound Model is an experiential learning model often referred to in adventure therapy literature and described in the literature review (see p. 25). Adaptations of the Outward Bound Model inform the structure of many adventure therapy programmes. This practice model was not specifically referred to by participants however the way they described how they used the adventure therapy process and the theory behind the process was congruent with the underlying principles of outward bound based models.

The work of Bacon (1987), although dated remains a useful way of conceptualising current variations of the Outward Bound Model. He identifies that the Outward Bound Model mainly differs in the debriefing component of the process. He outlines three particular variations, two of which are based on his understanding of the evolution the Outward Bound Models and the third developed as a result of his work on metaphor (Bacon, 1983). The Mountains Speak for Themselves model places most emphasis on the power of the experience to facilitate therapeutic change, and does not rely on facilitated processing (i.e. guided processing of the experience through talking in a debriefing session) – the strength of this model is reliant on the professionals’ ability to provide progressively challenging experiences to facilitate a sense of mastery and peak experience. In terms of how activity is used, this model probably fits well with occupational therapists because of their existing skills in activity selection, adaptation and grading; and with occupational therapy beliefs regarding the therapeutic benefit of engagement in activity.

The second, named by Bacon (1987) as the Outward Bound Plus model is the result of different mental health professionals entering adventure therapy and incorporating cognitive and reflective techniques into the debriefing process such as cognitive behavioural therapy (CBT) theory. This could be incorporated by for example asking the individual to talk about the influence of thoughts prior to the experience on their performance, and plan what situations in real life they might work on changing thoughts to change performance. This increases the therapeutic potential of adventure for clients with specific clinical problems and brings increased value and richness to the adventure therapy process for them. Bacon describes its strengths as integrating known therapy theory with the adventure process. However these “known therapy theories” have been primarily talk based. Bacon

identifies challenges in this emphasis with the therapeutic process becoming overly focused on talk techniques and less adventure or experiential, and therefore more difficult for staff to facilitate the debriefing. Occupational therapists have potential to adapt the Outward Bound Plus model to incorporate occupation based material into the debriefing process, and some participants described using the adventure therapy process as if they were already doing this. There is potential for occupational therapists to incorporate an occupational focus into debriefing and develop their own adventure therapy practice model. Whilst the CBT example (see above) is aligned with occupational therapy due to the focus on changing performance, another occupationally focused example is having the individual identify the elements of the activity that were most enjoyable, and identify opportunities for involvement in activities in their home environment that include similar elements.

Bacon then worked on maintaining the experiential nature of the adventure process but increasing therapeutic benefit by developing a third outward bound based model, the Metaphoric Model (Bacon, 1987). This model integrates metaphor into briefing or frontloading, thereby setting the group up to work in a specific way - for example telling a group prior to their problem solving challenge that often the loudest and most confident people get to make decisions in groups or organisations, and that this means some very valuable ideas from quieter people are often missed. The group is likely to consider this as they discuss and plan their problem solving strategy, and spontaneously discuss it at the debriefing session. This potentially enhances the therapeutic benefit of the experience with little additional need for facilitated talk. Participants did talk about use of metaphor in their work, and it is reasonable that occupational therapists who are skilled in

psychotherapeutic approaches and use of metaphor could use this model whilst maintaining focus on clients' occupational identity and function.

Recent adventure therapy literature advocates the use of adventure therapy by qualified mental health professionals and encourages the development of discipline specific ways of using adventure therapy (Itin, 1998; Lovato, 2012). There is no evidence in the literature that occupational therapists have done this, although participants described aspects of their adventure work as occupational therapy. Although the outward bound derived models referred to above continue to be used, most adventure therapy models incorporate theory specific to the clinical practice of the therapist's discipline. An example is an assessment model called CHANGES proposed by marriage and family therapist Michael Gass (1995) which incorporates clinical assessment into adventure based activity; and a model based on cognitive behavioural theory termed the ABC-R (affect, behaviour, cognition, relationship) proposed by recreation therapist and counsellor Lorri Hanna (2012). These models provide a way for clinicians to incorporate experiential learning principles into their therapy, or vice versa, and are examples of models that occupational therapists could use with their existing knowledge and skills. The way the models are developed will depend on the theoretical and practice background of the theorist, the planned practice context, and who the model is intended for. It is evident that on one hand incorporating clinical models into adventure therapy practice is developing the therapeutic safety and legitimacy of adventure therapy practice, but on the other hand adds to the confusion of what adventure therapy is and how it is done.

Therapy is defined by Crisp (1997) as a "*method of clinical practice, including a set of techniques based on a theory of personality, behavioural and psychological problems and process of change.*" (p.8). As change is the goal of any

therapy, it is not surprising that models of change are identified in the literature and talked about by participants. Models of change in adventure therapy literature are developed for the adventure therapy process, or are models applied from therapies used by mental health professionals. Change in adventure processes often relates to clients' processing the disequilibrium purposefully facilitated in the adventure therapy process. However therapists who use adventure therapy incorporate other models relating to change, for example the trans-theoretical model of change (Prochaska & Velicer, 1997). This stages model assesses readiness to change behaviour and provides strategies to guide the individual through the change. It is philosophically aligned with humanistic therapies, and utilised by health professionals working with individuals wanting to make behavioural change. Participants talked about the change as a result of the adventure therapy process, and identified the trans-theoretical model of changes as one they and their colleagues use in their therapy. This demonstrates compatibility in the use of these models between occupational therapists and other adventure therapists.

#### ***5.2.6 Occupational therapy and models***

Occupational therapists use both profession specific conceptual models and generic health models in their practice. The findings revealed participants' almost exclusive use of the Model of Human Occupation (MOHO) a conceptual occupational therapy model that can be used in any clinical setting (Kielhofner, 2008) which was briefly described in the literature review. Kielhofner (2009) states models "*provide specific theory, resources and evidence to undertake the therapy process...*" and that therapists can use knowledge "*that originates in other fields but that is used along with the unique occupational therapy paradigm and conceptual practice models*" (p. 14). Participants used the MOHO to describe how they incorporated components

of adventure therapy different from occupational therapy into their work. The systems theory underpinning the MOHO helped participants put the adventure therapy practice into the context of the individuals' usual life and justify their adventure therapy work in occupational therapy terms. The MOHO provides a structure that allows therapists to work an occupational therapy specific way and merge their use of adventure therapy with their overall occupational therapy.

There is potential for more overt use of occupational therapy informed models such as the MOHO in occupational therapists' use of adventure therapy. By using for example MOHO informed assessment tools such as the Role Checklist or The Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS) (Forsyth et al., 2014; Kielhofner, 2008) assessment data would be presented for the team in occupational terms. The client would understand issues within in the context of occupation rather than emotions and behaviours. This would provide opportunity for occupational therapists to work as specialists and offer a view that is different from usual psychotherapy based perspectives for the adventure therapy team, thereby enhancing both the service to the client and overall understanding of occupational therapy.

Participants identified that their use of the MOHO is not evident in their communication with colleagues, or in their clinical note writing. Most participants did not have other occupational therapists on their immediate team, and whilst the use of the MOHO may have influenced their thinking and their practice, usual ways of talking and writing about intervention, progress and outcomes was professionally generic in nature. In my experience this is also true of occupational therapists working in other mental health settings, and demonstrates both the strength of the use of a model in maintaining discipline specific practice, and the influence of generic roles in

diluting the teams' recognition of discipline specific practice. Occupational therapists using the MOHO (and other occupational therapy conceptual models) find a structure for clinical reasoning, a language to articulate reasoning and a perspective for the multidisciplinary team different from other disciplines. Given this experience and participants' use of the MOHO I encourage occupational therapists using adventure therapy to talk and write about their work using the structure and language provided by their model of choice. They will likely need to explore options to ensure they are meeting generic documentation requirements; however it is important occupation specific focus is overt.

Exploration of models in use in occupational therapy and adventure therapy help position the two fields in terms of structure and frameworks for practice. Therapists generally select from approaches for their intervention, to this end the next section explores approaches within the two fields.

### ***5.2.7 Approaches***

*"An approach can be seen as the interface between the professions own unique model(s) and its practice"* (Boniface & Seymour, 2012, p. 26). An approach can be shared by many professions and is the identified intervention method; the application of the approach varies depending on the professional using it and the context it is used in. In some contexts one approach is applied by all team members, in others different team members will select different approaches (Boniface & Seymour, 2012). *"Approaches describe the principles of practice, enabling therapists to be consistent in their way of working"* (Creek, 2014, p. 43). All occupational therapists select from a variety of approaches, depending on the model they are using and the practice context.

### 5.2.1 *Psychological approaches*

Occupational therapy's body of knowledge draws from other professions and occupational therapists are used to integrating theory from other disciplines (Creek, 2014; Kielhofner, 2009). Mental health occupational therapists tend to use approaches from psychology, particularly from positive psychology theory, such as positive cognitive behavioural therapy (Bannink, 2013), solution focused therapy (Hawkes, Marsh, & Wilgosh, 1998), mindfulness (Langer, 1989), and motivational interviewing (Miller, 2013). These approaches are client centred, have strengths focus, and seek solutions and positive change rather than being deficit focused. They are compatible with strengths based and recovery philosophies advocated in mental health service provision in New Zealand. An example of an approach that is based on positive psychology philosophy is solution focused therapy (Hawkes et al., 1998). Here the focus is on the client's perception of a positive future (ascertained by asking the "miracle question" about the client's view of their life if there was a miracle and the problem that brought them to therapy was solved), on the strengths and resources the client has to achieve that future, and on strategies to make the necessary steps to change.

These positive psychology approaches are starting to feature in adventure therapy literature (Berman & Davis-Berman, 2005; Wasserburger, 2012) and participants identified they were familiar with them. However participants indicated their confidence in using psychology based approaches was hindered by limited training in their application and by the emphasis on talking in them. The psychology approaches utilise what I term "talk as therapy", this is where the spoken interaction itself is the therapy and there is considerable emphasis placed on what to say and how to say it. This is in contrast to what I term "talk within therapy", where the interaction is related to safe and effective facilitation of the therapy for example a physiotherapist

explaining an exercise or an occupational therapists facilitating an activity. Because occupational therapy has such an occupation focus, both as a means and purpose of therapy, occupational therapists are less likely to select therapies that are talk as therapy. Positive psychology approaches are talk as therapy and most of the post graduate training in these approaches teaches how to apply them as talk as therapy. In my experience a skilled occupational therapist will develop ways of either having an occupation focus to the talk therapy, or incorporate it with activity as means to an occupation end. Occupational therapists have historically used creative activities such as art in a psychodynamic way or to implement psychology based therapies (Lloyd & Papas, 1999). There is potential for rediscovery of this use of activity, for example using an art session for the client to answer the miracle question described above. There is a need for more specific post graduate occupational therapy training regarding the application of psychology based approaches to give occupational therapists more confidence in using talk as therapy. There is also potential for occupational therapists to incorporate more activity as a means to utilising psychology based approaches.

### *5.2.2 Adventure therapy as an approach*

The debate over whether or not adventure therapy is a profession is summarised in the literature review (see p.19 ). What constitutes a profession is outside the remit of this research, suffice to say that there is no profession of adventure therapy in New Zealand, and people practicing in the field (including these research participants) do not tend to call themselves an adventure therapist. Participants asserted they were working as occupational therapists and some even said they were not clear on what exactly an adventure therapist is. Contemporary international adventure therapy literature considers an adventure therapist to be a qualified mental health clinician who either incorporates adventure therapy as an approach into their

work, or incorporates specialist approaches from their profession into the adventure therapy (Itin, 1998; Wasserburger, 2012). It is therefore deduced that in New Zealand mental health professionals who are using adventure therapy are likely to be using it as an approach.

Participants indicated that they were using adventure therapy as an approach in their occupational therapy. Their use of adventure therapy as an approach is consistent with definitions of approach given above, they were using it as an identified intervention method; it was shared with other members of the team and provided consistency in intervention. Their adventure therapy was not all of their therapy; rather they used the adventure therapy process as a component of the overall therapy.

Occupational therapists are likely to be drawn to adventure therapy as an approach due to the use of activity and experiential learning, however the influence of psychology, psychotherapy and counselling disciplines on the development of adventure therapy in recent years has influenced the extent to which psychology based approaches are incorporated. This means structure of the usual adventure therapy process involves as much emphasis on talking as on activity. The talking component is both “talking within therapy” and “talking as therapy”. Briefing involves instructing clients in the skills required to complete the activity e.g. kayaking skills, and setting up the challenge or problem for the group to work through e.g. kayaking across a lake and taking required camping equipment. This is talking within therapy; the interaction is to facilitate the activity. Throughout the activity the adventure therapist recognises moments in the group or individual’s experience appropriate for facilitation of self-awareness, insight and adaptation that will facilitate therapeutic change. These interactions are talk as therapy; the therapeutic benefit is related to what is said and how it is phrased. Metaphor is often consciously used to assist with transferring the

learning to home life, for example *“think about how you usually approach something hard that stretches out in front of you, and about how you might approach this kayak trip so that you succeed”*. At the end of the challenge the adventure therapist facilitates a debriefing session where clients are encouraged to make links between their performance and behaviour during the activity to what is usual for them, find metaphors of their own, and give feedback to each other – these are also examples of talk as therapy.

The adventure therapy process effectively uses the activity as a means to an end; however it has an emphasis on the talking that occurs as much as the actual activity. I suggest occupational therapists have a closer affinity with talk within therapy than talk as therapy, and that further education as identified above would enhance their comfort and skill in the talk as therapy components of adventure therapy.

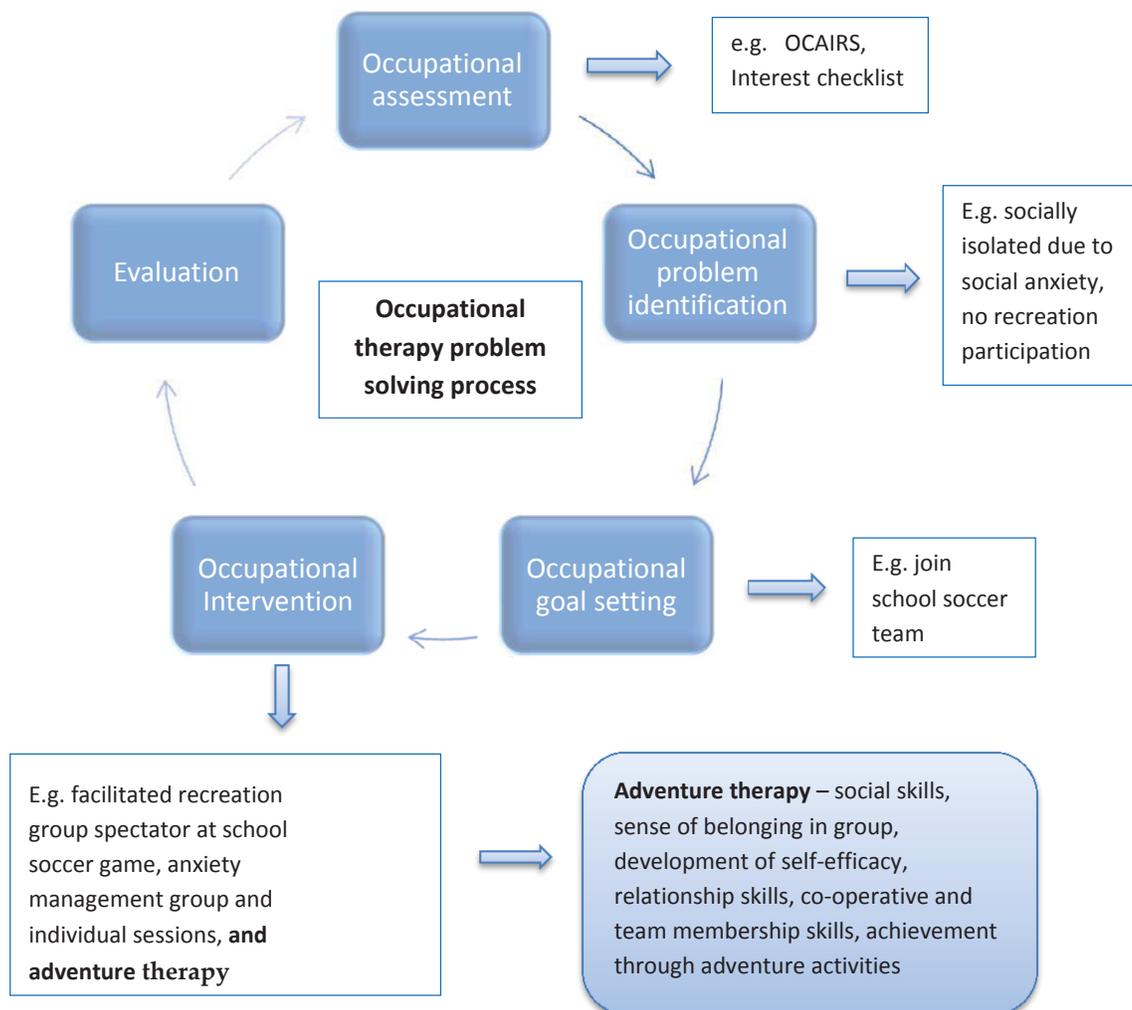
There are times during adventurous activities where individuals become stressed and emotions run high, and where there is conflict (Berman, Davis-Berman, & Gillen, 1998). The therapist needs to be skilled in managing this conflict and the group safely. Participants indicated this was difficult for them. Use of adventure therapy demands knowledge of group development theory and skill in facilitating group development, as well as overall group facilitation skills and use of psychology based approaches. Occupational therapists learn about group process and gain group facilitation skills in their training as it is common for occupational therapists to be involved in facilitating groups where the activity is not an end in itself (Hagedorn, 2000). However participants did not feel adequately skilled in group therapy facilitation at the level used in adventure therapy. The emphasis on using talking as much as engagement in activity may explain this discomfort, which indicates a need for occupational therapists to have additional group facilitation training.

In order for occupational therapists to select any approach that is new to them, they need to consciously acquire the necessary knowledge and skills. Occupational therapists consider for example CBT as an approach that they can learn and apply within their occupational therapy. If they choose to use CBT they are likely to get post graduate training or attend a course. This gives them some skills and opportunity to practice and subsequent confidence in incorporating it into their occupational therapy. Some of the participants demonstrated they were integrating adventure therapy skills into their occupational therapy; others seemed to be applying adventure activities as an occupational therapist. For example, participants using the stress an activity created for the client as adventure therapy helped the client understand how the stress made him behave, and linked it to how these behaviours might be problematic at home. Participants using the activity as occupational therapy were helping the client learn and use stress management techniques in the activity to reduce the level of arousal. Consciously acquired knowledge of the adventure therapy process and skills in using it authentically as an approach will enhance occupational therapists ability and confidence, however they are hindered in this due to lack of training opportunities in New Zealand.

Therapeutic recreation in the USA is similar to mental health occupational therapy as it is practiced in New Zealand (Crisp, 1996a) and there are several parallels between therapeutic recreation and occupational therapy regarding the use of adventure therapy. Some recreation therapists who use adventure therapy are challenged by differences in philosophy and practice between therapeutic recreation and adventure therapy. Specific recreation therapy models have been developed to guide their practice, for example the Leisure Ability model (Bullock, 1998); and that profession is identifying how to fit adventure therapy into their models (Ewert et al., 2001;

Jennings & Guerin, 2014). It seems therapeutic recreation as a profession is beginning to use adventure therapy as an approach. An absence of occupational therapy equivalent literature indicates the occupational therapy profession is not at this stage yet, which is likely a reflection on the small number of occupational therapists involved in adventure therapy. Australia and New Zealand may have the highest number of occupational therapists working in adventure therapy; it would be encouraging to see their practice reflected in professional literature.

The diagram below illustrates how adventure therapy could be integrated into the occupational therapy process at the intervention stage.



Having discussed the philosophy, models and approaches used in adventure therapy and by occupational therapists it is clear that there are features of the two fields that are well aligned, and features of adventure therapy that differ from occupational therapy. Occupational therapists who learn to use adventure therapy as an approach in their occupational therapy intervention have a useful tool for activity as a means to an occupational end. The following section defines practice, discusses the practice of adventure therapy in relation to occupational therapy, and considers activity as therapy, environment as therapy, and perspectives each field has of the individual.

## **5.3 Practice**

### ***5.3.1 What is practice?***

Practice is the intervention; it is the *“carrying out of the profession’s roles, guided by approaches, defined by a model and influenced by a philosophy, by an individual professional who generally believes a particular overview of the world.”* (Boniface & Seymour, 2012, p. 28). It is the way approaches are applied in practice that illustrates the therapist is working within their professional scope. How adventure therapy is applied by occupational therapists will help determine if adventure therapy can legitimately fit within occupational therapy.

### ***5.3.2 How is adventure therapy practiced?***

There seems to be two fundamental ways of defining contemporary adventure therapy practice – either as a therapy that uses a variety of mental health approaches, or as an approach for mental health professionals to use in their therapy. Whilst I have not found literature that directly articulates this comparison, theorists writing about adventure therapy models seem to

support either one view or the other. Ames (2014) defines adventure therapy as *“the prescriptive use of adventure experiences provided by mental health professionals...”* (p.1) and continues on to describe how different mental health professionals integrate their specific theoretical frameworks into the adventure therapy. This is in contrast to Gillen and Balkin (2006) who advocate seamlessly integrating adventure therapy into existing group counselling services for its efficacy in reaching clients who do not respond to talking therapies; or Itin (2001) who states *“Adventure therapy at this point then appears not to be a profession but rather a set of techniques or tools used by a variety of professions.”*(P.82). Participants were employed as occupational therapists and used adventure therapy as a component of their occupational therapy work; most of their colleagues were mental health professionals. The findings indicate that participants selected adventure therapy as one of their approaches to occupational therapy practice. Maintaining their identity and practice as registered occupational therapists provided professional safety for the therapists and clarity for clients and the wider community that they are occupational therapists. Occupational therapists can be encouraged by such descriptions of the relationship between adventure therapy and other therapies, and be explicit about their use of adventure therapy as an approach, incorporating it into their occupational therapy models.

The adventure therapy process described in the literature review provides the specific process that the experiential component of adventure therapy tends to follow. How this approach is applied is determined by the context as much as the therapist. The activities are often adventurous and have associated risk, many activities are facilitated by a number of diverse staff at the same time, and they require planning and equipment. This requires the staff to work closely as a team when facilitating the activities, and provide reasons for the adventure therapy process to be used generically

by all therapists on the team. The fact that participants were consistent in their descriptions of the adventure therapy process and were able to talk about for example use of eustress and challenge by choice demonstrates their understanding of and adherence to the process. At these times participants did not seem to need to justify its use on occupational therapy terms, and did not seem to consider the generic nature of its application an issue. This not needing to justify may be due to the therapeutic use of activity in the process (and so they considered it to be occupational therapy), to the need for the occupational therapist to work in with the rest of the team due to the nature of the activities and the adventure therapy process, or to the participants understanding and acceptance of the process.

### ***5.3.3 Generic and specialist approaches***

Crips (1996a) supports discipline specialist intervention within adventure therapy, citing that it is often used as a part of multi-disciplinary therapy, where the therapies are provided either concurrently, consecutively or in combination, with the intention that *“the different therapies combined will have a complimentary and compounding therapeutic effect”* (p. 14). Adventure therapy literature describes a wide variety of practice regarding both the extent of adventure based work and the therapy provided within or as well as the adventure therapy. Gass (1993a) advocates the practice of adventure therapy to *“enhance established treatment objectives and to provide a richer therapeutic environment for change so that therapy is more successful”* (p.5). This was the experience of all the participants, who were part of multidisciplinary teams and who used adventure therapy in conjunction with other occupational therapy, or used adventure based activities for short periods of time within an overall occupational therapy programme.

There has been debate in occupational therapy literature in recent years about the risks of generic work (that any mental health clinician can carry

out) over specialist work (that requires specific occupational therapy professional or post graduate training), with encouragement in the literature for occupational therapists to ensure they are practicing as specialists (Cook, 2003; Fox, 2013). Some participants described aspects of their work as generic, or were specifically employed in generic roles. That the psychological approaches participants used are shared with their colleagues likely contributed to participants' perception of their work being generic. There are advantages to team members selecting the same approaches; including a shared understanding of what each other is doing and consistency for the client. However there is risk that if they are used in the same way by all mental health clinicians then the work does become generic and the advantages of tapping into the specialities within a multidisciplinary team are lost.

In considering generic and specialist work in relation to adventure therapy, it may be helpful to think of the activity facilitation (the adventure therapy process) and the integration of adjunctive mental health therapy (which may be in the debriefing) as two separate phases. I believe there are grounds for the adventure therapy process to be utilised in a generic way by the members of the team (remembering that the context will influence how this process is applied) and the debriefing process and the adjunctive therapy to provide clinicians opportunity to work either as specialists in their field, or to practice generically in their approach. Therefore an occupational therapist may choose for example to use alternative debriefing and processing techniques to talk to ensure clients are making connections between the experience and their usual occupational performance. Smith (1993) describes a number of alternatives to traditional facilitation of debriefing, including the use of relaxation, guided fantasy, small group work (e.g. clients working in pairs), journaling, group exercises and games. These are all techniques that

occupational therapists working in mental health are familiar with and skilled in, and would clearly be within the scope of occupational therapy practice. (Finlay, 2004; Schwartzberg, 2009). A psychologist on the other hand may choose to use group discussion with a focus on emotion, have clients explore emotional states during and after the experience and make direct links between their feelings and how the group were communicating and functioning at the time. Although the adventure therapy process is most authentically facilitated generically, occupational therapists can maintain their specialty in the mental health therapy adjunctive to that process.

Boniface and Seymour (2012) state that: *“In order to remain an occupational therapist when using any, or indeed a number of approaches to intervention, the therapist simply needs to use them under the umbrella of an occupational therapy model...”* (p. 27). Using shared approaches in discipline specific ways and within discipline specific models helps protect professional identity. Participants identified both discomfort with the extent and depth of the talking aspect of the therapy, and comfort in being able to apply the approach within their occupational therapy. It was apparent that (perhaps without even being aware of it) their use of MOHO influenced how they applied adventure therapy. Despite feeling ill equipped to use the psychology based approaches with confidence, being mindful of occupational therapy philosophy and using an occupational therapy model likely empowered therapists to maintain their occupational therapy specialty whilst using adventure therapy as an approach. There is potential for occupational therapy to clarify what is unique to the profession that can be developed as an aspect of adventure therapy, bridging the adventure experience to occupational outcomes for the client via occupational therapy rather than psychotherapy. There is also potential for occupational therapists

to claim specific skills in using activity based processing methods into the adventure therapy process.

#### *5.3.4 Skills required*

Adventure therapy typically uses adventurous activities, such as kayaking, climbing, and high ropes course work. These activities require therapists to have the necessary hard skills in order to safely teach and manage the activity. Adventure therapy also often uses contrived problem based or team building activities, and typically facilitates these activities in groups. The technical skills are skills that occupational therapists or other health professionals do not routinely acquire in their training. This research found that a variety of adventure therapy service models exist in New Zealand. Some for example incorporate weekly adventure experiences into mainstream mental health service programmes, and others provide multi-day journeys. Most facilities that participants worked in employed qualified health professionals. Some facilities require therapists to learn hard skills; others contract in outdoor pursuits instructors. Therefore occupational therapists choosing to use adventure therapy may need to up-skill to the level required at the employing facility, or work alongside a dedicated outdoor instructor with the necessary hard skills. As with mental health professionals internationally using adventure therapy, occupational therapists entering the field will need to develop new skills unless they have gained them outside their professional work. Occupational therapists often learn to do new activities to support client choices e.g. a craft or game, but in those instances it is acceptable from a risk perspective for the therapist to be at a novice level as well as the client. However there is inherent risk of physical and psychological harm in many adventurous activities that facilitators can only manage through being competent in the activity and the process themselves. Occupational therapists should have confidence that their existing activity

facilitation skill base is an advantage over many other therapists entering adventure therapy, who have more likely used talk as therapy, but need to be mindful of the skills gap.

Generic adventure therapy skills include knowledge of the weather, outdoor risk assessment and management and advanced first aid. Risk management featured prominently in the interviews with participants believing they did not have sufficient skills or knowledge when entering the field; however it was also acknowledged that other mental health settings do have risk factors to manage e.g. forensic mental health settings. Perhaps managing the risk in adventure based activities stimulates a higher level of awareness for therapists because of the integral risk involved in the activity itself, (the focus is primarily on the activity) and because the activities are not usual activities to be using as therapy. In other settings the risk is more closely connected to the individuals' current mental state (the focus is on the individual). In my experience understanding the concept of risk and risk management per se provides a sound basis for then recognising and managing various risk situations as they arise in any setting. Occupational therapists are skilled assessing individuals' cognitive, physical and emotional states and at activity and environmental analysis. These are valuable skills that can be drawn on in risk assessment and management processes. Occupational therapists who choose to work in adventure therapy will need specific outdoor risk assessment and management training to augment existing clinical skills in this area.

### *5.3.5 The therapist*

Itin (1998) is a social worker who has used adventure therapy as an approach in his work and been influential in defining the parameters of adventure therapy. He describes three paths to becoming an adventure therapist – an outdoor adventure professional who starts working in a

therapy context, a qualified mental health professional who starts to use adventure therapy and a “dual trained” professional (i.e. a qualified mental health professional and a qualified outdoor pursuits instructor with knowledge of the adventure therapy process). There are very few training facilities internationally that train therapists in both adventure based activity facilitation and therapy skills; and none in New Zealand. Itin advocates the health profession qualification as the most important prerequisite for an adventure therapist, and this pathway is most prevalent in recent adventure therapy literature (Gass et al., 2012). Specific disciplines most involved in adventure therapy work are psychologists, counsellors, social workers, recreation therapists (in USA) and occupational therapists (in New Zealand and Australia) (Crisp, 1996a; Itin, 1998). Therapeutic recreation is a profession almost unique to USA and has similarities with occupational therapy in philosophy, definition and process. Bullock and Mahon (2001) describe philosophical beliefs of therapeutic recreation that are compatible with occupational therapy’s, based on the therapeutic value of activity. The process of therapeutic recreation parallels the basic occupational therapy process, including emphasis on occupation as a fundamental component of each step of the therapy process. Recreation therapists also consider the environment, and analyse and modify it in order to enable recreational engagement and participation. Recreation therapists in the USA use adventure therapy as an approach within their work, and are developing their profile and practice in this area (Ewert et al., 2001). If recreation therapists in the USA work in similar ways to mental health occupational therapists in New Zealand then I argue New Zealand occupational therapists can similarly practice adventure therapy. Research and academic writing from therapeutic recreation will likely be a useful resource for New Zealand occupational therapists using adventure therapy to explore.

Participants identified the importance of the therapeutic relationship in both occupational therapy and adventure therapy practice. The role of the therapist is perhaps more malleable in adventure therapy than usual occupational therapy, particularly on journeys or camps where clients and staff are sharing adventure based activities and are living together. Specific roles that participants mentioned were therapist, encourager, teacher, role model, challenger; and it was identified that therapists needed to be very conscious of the role they were choosing and of how they were using themselves in the process. These insights are evident in both occupational therapy and adventure therapy literature. Although many relate to any therapeutic relationship the difficulties around maintaining professional boundaries are likely more relevant in adventure therapy due to the extended duration of some interventions (over days) and the close social proximity (e.g. camping together). Participants identified that occupational therapists are skilled in adjusting to the demands of maintaining professional boundaries while sharing daily life experiences with clients due to their usual practice of working with clients in their own homes and communities as much as in hospitals or interview rooms.

### *5.3.6 The therapy*

Despite the extent of shared practices between adventure therapy and occupational therapy there remain some areas of distinct difference. These differences are significant and are an integral part of adventure therapy. Participants identified four key aspects of adventure therapy that are at odds with how occupational therapists usually use activities and environments therapeutically: the concepts of challenge by choice, purposeful use of eustress, a focus on unfamiliar and challenging activities and use of a novel environment.

To illustrate the differences, it might be helpful to explore the use of some of these concepts and relate them to usual occupational therapy practice. Eustress (positive use of stress) in adventure therapy is facilitated through novel environment and challenging activity to produce disequilibrium as the individual moves out of their comfort zone. Through trying different behaviours and attitudes the individual eventually masters the activity and equilibrium returns, with an accompanying sense of achievement and resultant learning about self and changes that can be made in responses to stress in the future (Nadler, 1993). Occupational therapists are more familiar with facilitating stress management through arousal reduction methods such as relaxation, managing stressors so that they are not overwhelming (and disequilibrium is not encountered), and developing resilience to stress.

Challenge by choice relates to the level to which clients choose to be involved in the activities presented. In practice different adventure therapy programmes will interpret the amount of choice differently. Some for example will allow the client to choose not to participate in the high ropes course activity, others will allow the client to choose the extent to which they participate but require them to at least climb up on to the high rope, and others will require them to complete the whole ropes course but select which extra challenges available to complete. A group culture of respecting individuals' choices is usually developed, however the influence of the group both in terms of support and in terms of competitiveness between members often enables or impels individuals to accept challenges and achieve beyond their personal expectations (Carlson & Evans, 2001; Gass, 1993a). Challenge by choice may help alleviate some of the ethical concerns proponents of client centred intervention have regarding prescription of activity, however the fact remains that activities are selected for clients that are deliberately unfamiliar

and difficult. Occupational therapists usually work alongside clients when selecting activity, with either the client having full autonomy or as much autonomy as safe and possible within the environment. Occupational therapists seek the “just right challenge” which places enough demand on the individual to promote learning, but does not create anxiety (Rebeiro & Polgar, 1999).

These differences require the therapist to understand the theory behind adventure therapy in order to know why activities and environments are used in that way, and therapists may need to work on reconciling such conflict in their minds before applying the approach.

Because adventure therapy is applied in different ways by different disciplines, occupational therapists can on one hand be comfortable with not necessarily incorporating all of the adventure principles into their process, but on the other hand need to be mindful of maintaining consistency with colleagues. Looking again at the stress example, occupational therapists often work with clients who are learning to manage stress in order to prevent relapse of stress induced symptomology, for such individuals introduction of challenge could be counter-productive. There is a growing body of research advocating that it not be used indiscriminately in adventure therapy, that reinforcing safety and security within the challenge may enhance coping and therefore learning, and that people do not necessarily learn well when under stress (Davis-Berman & Berman, 2002; Leberman & Martin, 2002). This example illustrates the evolving nature of adventure therapy, and I argue illustrates that adventure therapy used by occupational therapists as an approach can be adapted to fit both the profession’s theoretical bases and clinical practice.

### 5.3.7 *Activity as therapy*

Occupational therapy is one of the few professions that uses activity as a means to effect a clinical change as well as having an end point focus to therapy. Despite differences between therapists on the models and approaches they select, *“they should all take an occupational perspective”* (Molineux, 2004, p. 9). Occupational therapists focus on the overall occupational engagement of individuals, and use occupation to effect a change towards enhanced occupational engagement. Gray (1998), building on the work of Trombley (1995) provides a way of conceptualising occupational therapy’s use of activity as means *“...which refers to the use of therapeutic occupation as the treatment modality to advance someone toward an occupational outcome.”* (p.358) or occupation as ends *“...which can be the overarching goal of all occupational therapy interventions.”* (p.357). Gray proposes that occupational therapists will have best success in using “occupation-as-means” if they maintain focus on “occupation-as-end”, and work from both perspectives in unison. The data show that participants were working from both perspectives. Their use of adventure therapy is occupation as means where challenging activities, often contrived and a one off experience are used to facilitate learning of skills and developing insights that will support changes in occupational identity and engagement. Their overall therapy focus may remain as occupation as ends where the real life occupational roles and performance of the individual are the focus. The way that they framed activities for their clients and their emphasis on finding meaning and purpose wherever possible (despite the actual activities being novel and prescribed) enhanced their ability to use adventure activities as a means to change in overall occupational terms.

That occupation is a determinant of health is an integral component of occupational therapy philosophy. Molineux (2001) describes how this belief is

not solely in the domain of occupational therapy, and discusses occupation's profile increasing with for example the development of the discipline of occupational science (Yerxa et al., 1989) and the emphasis on occupation in the World Health Organization's definition of health (Molineux, 2001; Wilcock, 1999). The increased research on occupation has both provided occupational therapists with more evidence for their professional identity and practice, and has exposed occupation to others. Molineux challenges occupational therapists to both embrace others' growing acceptance of the role of occupation in health, and to protect their specific place in occupation through research and through assertively communicating occupation in what they say, write and do. Participants certainly talked about their work in terms of occupation. Whilst few specifically used contemporary occupation terminology such as occupational deprivation, balance or alienation they seemed to have these concepts in mind when talking about their focus on client's occupational lives, and justifying their work in terms of occupation for health. Occupational therapists who use adventure therapy are in a position to respond to Molineux's challenge. I encourage them to ensure they use occupational therapy models, language, and tools with confidence; and that they communicate occupation for health and as a means of promoting health to service users and colleagues assertively.

Occupational therapists have knowledge and skill in analysis and adaptation of both activity and environment, and become skilled at doing this consciously and quickly. Creek (2014) identifies the core skills of occupational therapy as "*...activity analysis, adaptation, synthesis and application.*"(p.32). Detailed activity analysis is done in conjunction with analysis of the individuals function in order to ascertain capacity for the demands of the task and to facilitate learning or improvement in capacity. Such skills are profoundly useful in adventure therapy practice, where

activities are selected, graded, modified and framed purposefully to meet individual needs and planned outcomes. Whilst some adventure therapy literature identifies the sequencing and grading of activities to be an integral component of adventure therapy practices, how to do it is not described (Association for Experiential Education, 2014; Gilbert et al., 2004; Gillen & Balkin, 2006; Newes & Bandoroff, 2004). Occupational therapists can be confident they have expertise in activity sequencing, grading and adaptation to enhance their work in adventure therapy and to share with adventure therapy colleagues.

Adventure therapy has a prescriptive approach to activity, where experiences are intentionally created to meet clients' needs (Ames, 2014). Occupational therapists who are working from the contemporary paradigm (Kielhofner, 2009) may feel uncomfortable with prescribing activity in this structured way, although there are other practice areas in mental health occupational therapy where activities may be prescribed e.g. art activities in an inpatient setting. Participants seemed able to support the adventure therapy process because they believed in the potential benefit of it for their clients. However participants qualified their use of activity in adventure therapy by incorporating occupational therapy concepts, for example by selecting activities in terms of meaningfulness for the clients, or incorporating autonomy and choice which is consistent with occupational therapy's client centred approach (Boniface & Seymour, 2012; Creek, 2014). This insistence on incorporating meaningfulness or client choice is one significant way in which the practice of adventure therapy and occupational therapy's use of adventure is different.

Facilitated processing of the experience is an integral part of adventure therapy described in most of the literature. However there is some discussion about the value of allowing the activity to speak for itself and letting the

processing occur naturally over the days or weeks following the activity. Woodcock (2006) questions the need for typical group debriefing process following the activity, and advocates allowing the therapeutic benefit to emerge from engagement in the experience itself. He proposes that if action is the goal of therapy, then action can in itself be the primary therapeutic medium, and that adventure therapy has an advantage over other therapies here due to its action orientated approach. He concludes that of the professions involved in facilitating adventure therapy the most appropriate are the “...*action orientated professions such as therapeutic recreation and psychosocial occupational therapy*” (p. 8).

This argument gives credence to occupational therapists being well suited from a philosophical perspective to work as adventure therapists. I believe occupational therapists can more assertively acknowledge therapeutic value on engagement in the activity itself. In terms of frontloading/briefing and debriefing processes occupational therapists can incorporate an occupational performance perspective. An example is having the client identify an activity at school that makes him as nervous as he is now before kayaking the rapid, how he usually approaches that school activity, what he will do differently in approaching the rapid that might make it easier and (in debriefing) what he will do differently when approaching that activity at school. Maintaining this occupational focus will enhance the fit between adventure therapy and occupational therapy philosophy. Participants demonstrated this fit in practice by using experiential learning theory and structured use of activity (i.e. the adventure therapy process) in a way that is different from usual occupational therapy practice and maintaining an overall holistic and client centred approach. This was evident not just in their clinical reasoning but in how they described presenting activities.

There are other therapies that use specific activities such as art therapy, music therapy and drama therapy. In New Zealand these therapies, which are based on psychotherapy principles, are increasingly evident (Creative Therapies Association of Aotearoa, 2014). However in contrast to adventure therapy in New Zealand they have a clear qualification pathway established that covers the activity and the therapy, and are registered or aligned with professional organisations. Occupational therapists often use these activities, but as occupational therapists (Lloyd & Papas, 1999). There are some post graduate qualifications or courses that occupational therapists can do that qualify them to use these activities as a psychotherapeutic approach. Interactive drawing therapy (IDT) is one that some participants described using. IDT is an approach that uses drawing as a means of accessing and using client developed metaphor and which draws on psychotherapy techniques (Withers, 2006). Whilst the way that occupational therapists use creative activities will vary depending on their post graduate training, it will be different from how registered art therapist or music therapist (for example) practice. An occupational therapist may use art with individuals or groups, as a leisure pursuit, as a means of facilitating communication, as a means of creative expression or as an assessment tool (for cognition, mental state and function). These uses will be therapeutic for the client and allow the therapist to gain insights regarding how the client is feeling or thinking which may aid in diagnosis and therapy (Lloyd & Papas, 1999). Art therapists will use the art as the therapy or art in the psychotherapy; the art is an alternative means of expression and communication with the intention of in itself furthering a person's emotional growth and healing (Edward, 2004).

Adventure therapy does not have the same clarity – there is no recognised training that results in an individual qualifying as a health professional in adventure therapy. Christchurch Polytechnic Institute of

Technology does provide a short course in adventure therapy as part of their sustainability and outdoor education program, which I consider is more a therapeutic experience as defined by Becker (2010, see above) than adventure therapy. In essence adventure therapy has the activity, and seeks ways of making it therapeutic. The way is through the adventure therapy process (Nadler, 1993) commonly alongside psychotherapy. Occupational therapy has the therapy, and seeks activity in its application. Occupational therapists can apply the adventure therapy process alongside occupational therapy as a legitimate means to an occupation end approach. There is potential for occupational therapy to enhance the immediate development of adventure therapy in New Zealand. There is opportunity for occupational therapists to contribute to defining adventure therapy as it is practiced in New Zealand; to grow the therapy through increasing its scope and use; and to refine it as an accepted occupational therapy approach.

### *5.3.8 Environment as therapy*

The view that the environment has an impact on health is shared between the two fields, however again the adventure therapy focus is narrower than occupational therapy's. Occupational therapy's view of the environment encompasses the whole of the individual's usual physical, social and cultural environments, and considers the way the individual influences and is influenced by their environment (Kielhofner, 2009). Occupational therapists understand that individuals seek environments that are congenial to their needs, and adapt environments to meet their needs; the way people perform and what they become is influenced by their environment (Kielhofner, 2008). Whilst adventure therapists adapt the aspect of the environment that is being used for the therapy for example for contrived adventure based activities; or select the environment purposefully for the therapy experience e.g. mountain biking trail or a river for kayaking, this

view of the environment is for the activity itself and the use of these environments are usually a one off experience. Occupational therapists will analyse and adapt the environment for therapy purposes, but this is normally the individual's usual environment to facilitate adaptive occupational function.

### *5.3.9 Physical environment*

In much of the adventure therapy literature there is an emphasis on the healing and restorative nature of outdoor environments (Fieldhouse & Sempik, 2014; Hoyer, 2012). Humans' separation from the natural environment and immersion in over-stimulating built environments that demands direct attention is believed to cause cognitive fatigue and eventually anxiety and depression. Kaplan (as cited in Hoyer, 2012, p. 105) posits that nature "...elicits deep-seated and automatic responses by individuals in the absence of extensive information processing." There is a growing body of knowledge from the emerging field of eco-psychology providing evidence of the effect of over use of direct attention and the therapeutic benefit of time in nature (Fieldhouse & Sempik, 2014; Hoyer, 2012). Participants acknowledged the healing influence of nature, and also purposefully included relaxation strategies into their adventure therapy practice. Stress management and relaxation are usual occupational therapy practices. Literature from eco-psychology is being drawn on to inform adventure therapy literature and would be useful for occupational therapists' understanding of the stress response related to the built environment and relaxation potential in natural environments.

Walsh and Golins (1976) Outward Bound Model purposefully places the learner into a unique and unfamiliar physical environment (which may or may not be an outdoor setting) in order to create contrast to daily life for the learner, to create stress (for the positive use of stress as discussed above) and

because of the power of learning through direct and natural consequences. The contrast enables *“participants to see the generalities in their lives and gain a new perspective on the old, routine and familiar behaviours to which they are accustomed and where their lives are situated”* (Wasserberger p. 75). Familiar patterns of behaviour are disrupted, and alternative strategies to cope with the environment are employed. Although the original model called for any unfamiliar physical environment to provide this contrast, Wasserburger asserts that if the environment is natural the conditions *“manifest to create a powerful medium for therapy”* (p.76). Occupational therapists generally do not select an environment specifically for its unfamiliarity and consequent challenge, and so will need to understand adventure therapy theory to appreciate the value in using the environment in this way.

Adventure therapy considers natural and direct consequences for decisions or behaviour that the environment provides as an important aspect of the therapy. Individuals learn through feedback from the environment or through direct consequences of their involvement in the activity. If, for example, they do not pack and carry all of their food to make the walk easier, then they will be hungry in the evening. The directness and immediacy of the feedback (often called ‘reality orientated feedback’) is considered to be more effective than being given feedback verbally after an event (Kimball & Bacon, 1993; Wasserburger, 2012). Experiences are sometimes used metaphorically or by making comparisons to assist people make links with behavioural patterns in real life, for example other things the individual might do to take the easy path, and the consequences of that. Participants acknowledged the value of consequences in learning, and did not seem to consider this as different from occupational therapy. It could be that occupational therapy uses *“reality orientated feedback”* on a day to day basis and could be more explicit about this in diverse practice settings. Consequences in usual

occupational therapy have direct impact as they are in the individuals own environment, and new learning can be implemented directly– the individual who successfully packs lunch for school is less likely to be hungry at lunch time.

#### *5.3.10 Social environment*

Adventure therapy also uses an unfamiliar social environment, where individuals become part of an intentionally formed group for the duration of the adventure therapy experience. The group is considered integral to the effectiveness of therapy, in contrast to occupational therapists view of the individual as primary. This application of group-work in adventure therapy includes emphasis on group process and group development, and views the group as an entity in itself (Walsh & Golins, 1976). Groups are established in order to create a safe environment for clients, with group norms based on trust, respect, cooperation, cohesiveness, and caring. The group provides support, feedback and opportunity for clients to develop interpersonal and intrapersonal skills; and enables clients to experience a shared experience, sense of belonging, fun and a positive experience. There is an emphasis on teamwork towards shared goals and objectives, tasks are purposefully selected for the need for cooperation and reciprocity (Wasserburger, 2012). Despite their understanding of and belief in these features, participants felt uncomfortable and ill equipped by their occupational therapy training to facilitate this type of group process effectively. Therefore they drew on current occupational therapy groups that tend to have an educational focus, or to where individual needs were being met in a group setting in order to ensure that the intervention had meaning for the individual and the individual had some choice and autonomy. Although participants attributed their discomfort to lack of group facilitation skills, it seems that their underlying philosophical beliefs about the client and therapy influenced their

attitudes and practice. Again, understanding the theory behind using the social environment in this way is likely to enhance occupational therapists comfort with the approach.

#### *5.3.11 Differences in use of environment*

Successful use of novel physical and social environments in adventure therapy is reliant on the individuals' experience of disequilibrium and resultant adaptation to reduce the dissonance. Occupational therapy's view of the ideal therapeutic environment is one that provides opportunity for meaningful occupation. In occupational therapy the demands of the environment are ideally at a level that the individual has capacity for – if the demands are too low the individual is bored and underperforms, too high and the individual becomes overwhelmed or anxious (Kielhofner, 2008). The role of the occupational therapist is to enable a good fit between the individual, occupation and environment to enable adaptive function. This is in direct contrast to the adventure therapy process of purposefully creating demands that are “too high” and therefore precipitating anxiety. These very different views of therapeutic use of physical and social environment were clearly identified by participants. However their awareness of the clients' usual physical and social environments, and focus on the roles and occupations they engaged in enabled participants to use adventure therapy as a discrete intervention within the occupational therapy process. I consider that occupational therapists' ability to use the physical and social environments in this way would be enhanced through understanding and direct application of the adventure therapy process theory.

#### *5.3.12 Individual*

Occupational therapy is client centred, views the individual as an occupational being with affective, cognitive, physical and spiritual

components, and is holistic (Finlay, 2004; Law, Polatajko, Baptiste, & Townsend, 1997). The adventure therapy process is structured, directed and generally emphasises the group over the individual (Wasserburger, 2012). Participants seemed to recognise the incompatibility of this process with client centred care. Whilst they used experiential learning theory with the adventure activities they extended their focus beyond the adventure activity to daily occupation. Participants linked engagement in adventure activities to enhanced wellbeing physically and socially, and considered affective, cognitive and behavioural impacts of intervention. Law et al. (1997) emphasise the importance of considering spirituality through all phases of occupational therapy intervention, and Urbanowski and Vargo state that *"Spirituality is viewed as the personal experience of meaning in everyday life"* (as cited in Law et al., 1997, p. 43). Despite the adventure therapy process limiting opportunity for client choice or autonomy, Levack (2003) in the only piece of New Zealand occupational therapy literature found directly related to adventure therapy proposes that adventure therapy has a legitimate place in occupational therapy practice because it works in the spiritual domain of the individual. Participants described reinforcing with clients on-going positive aspects of experiences such as sense of belonging, building good memories from adventure experiences, and developing self-identity. Whilst spirituality was not directly discussed, this is perhaps how they were working.

Despite it being a group process, planned outcomes from adventure therapy are most commonly described in relation to the individual. How to ensure individual needs are met and learning is transferred to the home environment is a challenge for adventure therapy. Kimball and Bacon (1993) identify that transferring learning from the experience to real life is difficult, in part due to the extreme difference between the environment of therapy

and the individuals' usual environment. Gass (1999) proposes numerous methods to enhance transferring, however most are reliant on the individual being able to use goal setting, make metaphorical links, and the therapist knowing the individual well. Provided occupational therapists are using the adventure therapy process as a part of occupational therapy, they are likely to have a good understanding of the individual's home environment and of the practical issues in their life. Occupational therapists are skilled at using goal setting and follow up sessions are likely be in or specifically related to the individuals own environment and preferred occupations. These are strengths in terms of facilitating transfer of learning effectively. Participants identified that clients often enjoy the adventurous activities but that continuing them in real life is difficult because of lack of finances or opportunity. This created conflict for participants who would not usually facilitate engagement in activities that are inaccessible to the individual, and illustrates how carefully and creatively occupational therapists may need to follow up on the adventure experience to help clients find and engage in enjoyable accessible occupations in their home environment.

Despite adventure therapy theory incorporating the group as an integral ingredient, some mental health professionals utilise an adaptation of the adventure therapy process with individuals (Davis-Berman & Berman, 1994), and it is not uncommon for individual counselling sessions to be incorporated into the process (Hill, 2007). Individual adventure therapy sessions may be based in a room or a local park, and involve simple activities experientially, often including use of metaphor, analogy or symbolism (Alvarez, 2012; Newes & Bandoroff, 2004; Stauffer, 2012). The expansion of adventure therapy in this way is surprising given how different it is from espoused adventure therapy theory regarding use of group and novel environment. However it is also testament to adventure therapy's pathway to

peoples' understanding of the therapeutic power of involvement in occupation. I believe this supports its applicability to occupational therapy as a means to an end approach. There is potential for occupational therapists to use the adventure therapy approach in individual therapy sessions, using familiar environments and low risk activities that do not require expensive materials or equipment.

## **5.4 Summary**

Occupational therapy and adventure therapy share philosophical beliefs regarding the role of activity in influencing health and wellbeing. Both fields use activity and the environment in therapy. However occupational therapy's focus is broad and considers the individuals overall physical and social environments, occupational identity and engagement. Adventure therapy uses activity and the environment within the therapy episode.

Occupational therapists utilise activity in therapy as a means to an achieving an occupational goal, or as an occupational end in itself. Adventure therapy prescribes activities within the therapy episode as a means to facilitate specific change on a psychological or psychosocial level. Occupational therapy uses activity as therapy, whereas adventure therapy uses activity within therapy. Occupational therapy's usual focus is on the individual and therapy is within clients' usual physical and social environments. The environment is adapted to support and enhance occupational engagement. Adventure therapy focuses on the group as much as the individual and purposefully uses unfamiliar and prescribed social and physical environments. The environment is adapted to increase challenge. Although these two ways of using activity and environment therapeutically are different, occupational therapists can legitimately use the adventure

therapy process in occupational therapy as an approach to intervention if achievement of therapeutic goals is likely to enhance occupational function. Occupational therapists cannot use adventure therapy as all of their occupational therapy - adventure therapy will fit into occupational therapy as an approach to intervention, occupational therapy will not fit into adventure therapy.

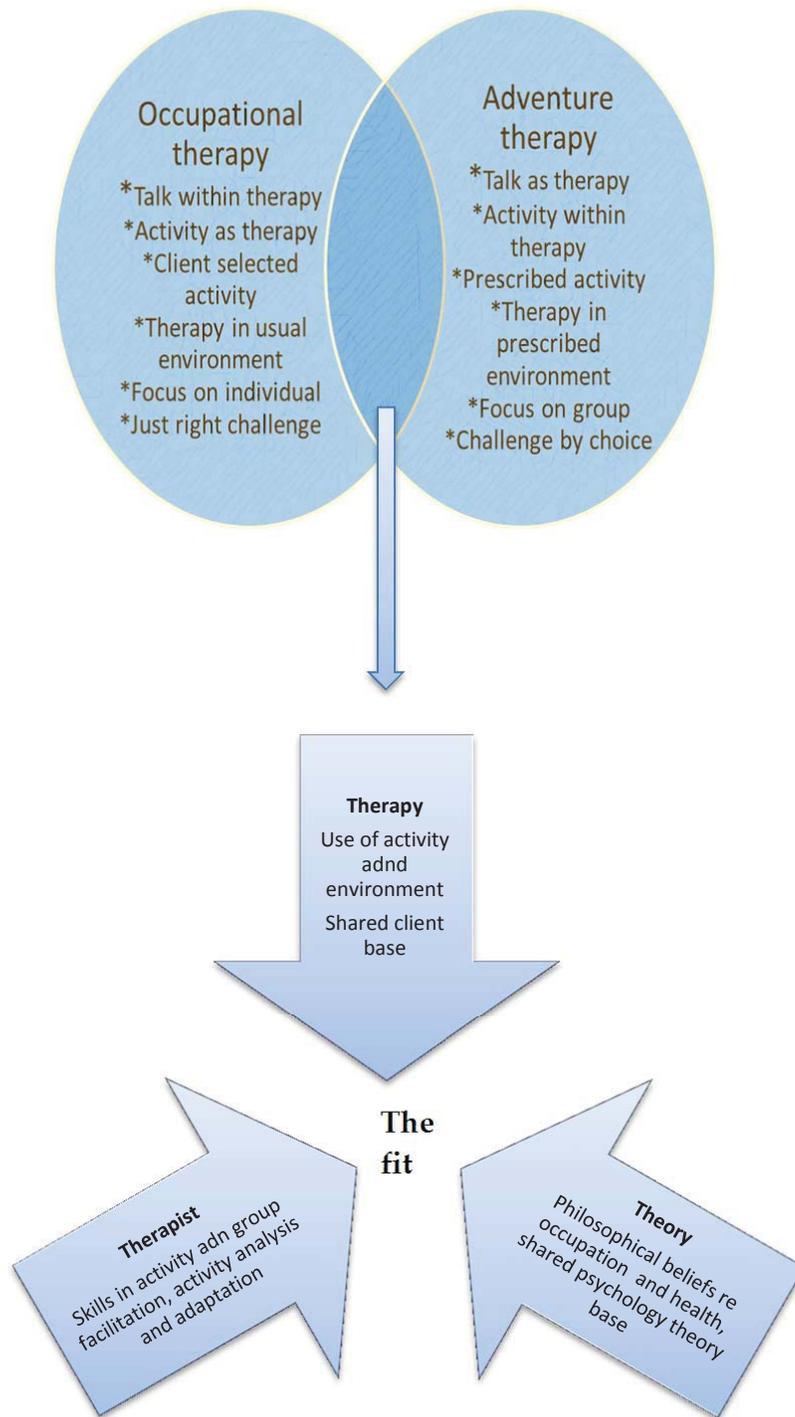
Occupational therapists have skills and knowledge in activity facilitation, analysis and adaptation. They are also skilled in group facilitation and use of psychology based interventions including solution focused therapy, cognitive behavioural therapy, and motivational interviewing. However occupational therapists are more familiar with using talk within therapy than talk as therapy. This is different from other mental health professionals involved in adventure therapy, who tend to come from a psychotherapy or counselling background and therefore use talk as therapy. Occupational therapists can approach this difference in two ways. Post graduate training in applying the psychology based therapies would enhance their skill in using talk as therapy. Selection of activity based methods of facilitating learning from the adventure experiences would utilise their skills in activity as therapy and increase the diversity in service provision for the client.

There are distinct differences between the two fields usual use of activity therapeutically. Adventure therapy's use of eustress and challenge are at odds with how occupational therapists usually work with stress and challenge. However participants indicated belief in the power of adventure therapy to enhance therapeutic outcomes for their clients, and acknowledged benefits of the approach despite the dissonance caused by the philosophical and practical differences. Some participants managed the dissonance by adapting aspects of adventure therapy process to fit better with usual

occupational therapy practice, others were more familiar with the theoretical base of adventure therapy and therefore accepting of it. In order for occupational therapists to legitimately select and use the adventure therapy process as an intervention approach they require education and training on its theory and application.

The diagram below outlines key differences between adventure therapy and occupational therapy; the overlap indicates the extent of fit between the two fields.

*I have flown out of my thermal and I can't find another one. The sun has moved behind the ridge as I sink lower so now I am flying in shade. There will be no more lift so the flight must end. The grassy patch beside the river looks like a perfect landing spot, and this is the valley that is my goal. I set up to land into the late afternoon breeze so that I will touch down gently. I fold and pack my wing slowly, thinking about my flight and reliving some of the extraordinary moments. There will be time to look at the flight log, talk with my mentor and analyse how it was, but for now I am just pleased I flew and touched cloud-base and landed at goal.*



## 6 Conclusion

This research explored the fit between occupational therapy and adventure therapy as it is known in New Zealand.

Internationally there is debate about what an adventure therapist is and the qualifications an individual must have to be an adventure therapist. From this research it is evident that New Zealand mental health services using adventure therapy value registered health professional qualifications first, and then seek appropriate adventure therapy skills and knowledge. Occupational therapists are defining adventure therapy as the therapeutic use of adventure activities; and are either using adventure therapy as occupational therapists or are using adventure therapy closer to adventure therapy foundation theory, depending on their experience and post graduate training. In New Zealand there is no specific adventure therapy training; therapists develop their skills in the use of adventure activities through outdoor education courses or their own leisure experience. Some facilities will contract in outdoor leader professionals. This is in line with practice internationally. Occupational therapy as a discipline shares some philosophical assumptions, some knowledge and skills and some practice techniques with adventure therapy. As a result of this research I believe it is clear that occupational therapy is closely aligned with adventure therapy. Mental health professionals of any discipline require education and training in adventure therapy in order to have required knowledge of the process, and the necessary hard skills to practice safely. Formal opportunities for therapists to learn adventure therapy theory and principles in New Zealand are scarce; there is certainly potential for an appropriate training establishment to fill this gap.

Usual adventure therapy practice includes elements that are similar to or the same as occupational therapy, such as the therapeutic use of activity and a clinical process of assessment, planning, intervention and evaluation. Features that are more specific to adventure therapy practice than other therapies include prescribed activity, challenge by choice, conscious use of metaphor, eustress, and use of novel environments. Occupational therapists use conceptual models to structure their practice, and select from specific approaches to guide intervention. This research shows that adventure therapy can be considered an approach to intervention available for therapists from a variety of professions to use. As an approach it is compatible with occupational therapy conceptual models. By conceptualising the adventure therapy process as an approach to occupational therapy intervention, occupational therapists are more likely able to resolve any conflict in their minds regarding the aspects of adventure therapy that are different to occupational therapy, and use the approach authentically. Because of existing similarities in practice occupational therapists are well positioned to learn and apply adventure therapy principles. However if occupational therapists choose to use adventure therapy in their practice they need to learn the associated techniques to ensure they are not simply using adventure activities as occupational therapy. Occupational therapists will require training in the adventure therapy process in order to understand and use it as an approach; opportunities for such training are limited in New Zealand.

It is evident that mental health professionals tend to use adventure therapy as a part of but not all of their therapy. The adventure therapy component may be incorporated into a weekly routine, or a discrete group session, or a one off journey or camping experience. How the rest of the therapy is conducted is dependent on the professional's qualification.

Occupational therapists using adventure therapy are working from both a generic perspective and as occupational therapy specialists; and are using occupation focused theory and conceptual models (specifically MOHO) to inform their work. More overt use of occupational therapy theory would further enhance diversity in the service provision for clients and other professionals' understanding of occupational therapy practice. Adventure therapy fits well with occupational therapy as a means to an end approach, but is not all of occupational therapy. Occupational therapists who use adventure therapy should use it *as a part* of their intervention, but not their sole intervention.

Occupational therapists consider the individuals usual physical, social and cultural environments in their practice. This is a strength when helping clients transfer their learning from the adventure experience to their familiar environment; occupational therapists are likely to have intervention goals specific to change in the lived environment of the individual. Occupational therapists also focus on the overall occupations that the individual engages in and wants to engage in. This understanding also enhances occupational therapists' ability in assisting clients integrate learning from their adventure therapy experience into their real life. Occupational therapists are skilled at using activity as therapy, have the potential to influence clients in terms of their occupational lives, and consider outcomes from an occupational perspective this. Occupational therapists should maintain their specialist practice within the team, but feel comfortable working generically when facilitating the adventure therapy process. Because occupational therapists use many of the same approaches as other therapists but apply them from an occupational perspective, occupational therapists are well positioned to work as adventure therapists. This difference in application has the potential to add diversity to overall team function, expand therapy opportunities for the

client, and illustrates the value of having occupational therapy specialists within the multidisciplinary team. Occupational therapists need to use adventure therapy as a part of their occupational therapy, as a means to an end, adventure therapy on its own is not occupational therapy. It is not client centred, it is not holistic, it uses the environment and activities in ways that are not usual for occupational therapy and it is removed from the client's real world.

Occupational therapists have skill and expertise to offer adventure therapy in activity and environmental analysis and adaptation. Occupational therapists practice with a focus on occupation and use activity as their primary therapeutic media. Adventure therapy is the therapeutic use of adventure based activities. The two fields share skills and knowledge regarding selection of activity to meet therapy goals and activity adaptation and modification; however occupational therapists have specific training to the level where they are more adept at these skills, and integrate them into most of their practice. Adventure therapy and occupational therapy also share views regarding the importance of the environment, and purposefully select or modify the environment to meet individual needs. Again, occupational therapists are trained to do this more extensively than other disciplines using adventure therapy. Occupational therapists can claim their expertise in these areas.

Adventure therapy involves the use of experiential learning philosophy and models, and so incorporates group facilitation of learning through briefing and debriefing. Adventure therapy also occurs in environments and uses activities that heighten emotions for participants, with the potential for conflict and difficult group dynamics. There is extensive use of group development theory and practice regarding consciously attending to the developmental needs of the group. This focus on the group over the

individual, and the extent of talking, is more intense than is usual for occupational therapists. Adventure therapists tend to draw on techniques and knowledge from psychotherapy or counselling. Occupational therapists have fundamental skills in group facilitation and work with groups, but it is more common for this work to be group education. However occupational therapy has a history of using psychoanalytical and psychodynamic approaches to group work. These skills are more aligned with the skills adventure therapists use. Occupational therapy may have moved away from this with the contemporary focus on occupational identity and engagement, but there is no reason why occupational therapists cannot develop the skills necessary and legitimately incorporate these approaches into their occupational therapy work.

Adventure therapy is particularly well suited to facilities that provide services for youth who are at risk or who have challenges to their mental health. This fits with client populations that occupational therapists often work with. Adventure therapy programmes that use a variety of outdoor adventure based activities such as kayaking and climbing are not accessible to all New Zealand services, due to resourcing issues (both human and equipment). However, as this research has highlighted, adventure therapy philosophy, theory and principles do not need to use high adventure based activities. Whilst these research participants all defined adventure therapy as the therapeutic use of adventure based activities, some adventure therapy literature defines it as the use of experiential learning theory and adventure therapy process in any group, or even individual activity. Group activities that employ many adventure therapy principles can be facilitated in urban environments, residential settings or hospitals and therefore be accessible to a wider group of staff (as there is less need for hard skills and expensive equipment) and client populations. I believe this research has illustrated that

experiential learning and adventure therapy principles are compatible with occupational therapy and can be learned by occupational therapists. Occupational therapists in a variety of settings can apply adventure therapy and experiential learning principles to their intervention.

The adventure therapy process places emphasis on talk as therapy and uses activity within the therapy; the talking therapy includes use of positive psychology therapies and conscious use of metaphor. Occupational therapy focuses more on activity as therapy, and uses talk within therapy. From their undergraduate training, occupational therapists are familiar with but not skilled at using talk as therapy. Occupational therapists require post graduate training in order to competently implement interaction aspects of the adventure therapy process.

Occupational therapists have discrete skills, knowledge and philosophical beliefs that are a good fit with the requirements of adventure therapy and that are not shared with other mental health disciplines e.g. using activity as therapy, grading and sequencing activity and sharing activity experiences with clients. Adventure therapy is an emerging field in New Zealand with a limited pool of practitioners and expertise; and adventure therapy is diverse in the way it is interpreted and applied internationally. By maintaining professional boundaries through using adventure therapy as an approach to occupational therapy intervention, occupational therapists should feel confident that they can use it legitimately. I encourage New Zealand occupational therapists in general to consider integrating experiential learning theory and adaptations of the adventure therapy process into their practice in diverse settings. Occupational therapists who are using adventure therapy should maintain their occupation focus and use adventure as a means to occupation based outcomes, integrate activity into talk based aspects of adventure therapy and seek ways of expanding the

use of activities in application of some psychology based therapies. Managers employing occupational therapists in adventure therapy should feel confident that there is a good skills and knowledge base, ensure they have training in adventure therapy specific theory and skills, and encourage occupational therapists to share their expertise with non-occupational therapy colleagues.

The diagram on the next page captures the discussion in a visual format, portraying the differences between adventure therapy and occupational therapy that potentially caused dissonance in participants. A view of how they manage this dissonance and potential consequences are depicted, with some strategies for effectively managing the differences and enhancing fit between occupational therapy and adventure therapy.

**Adventure therapy includes:**

- Unfamiliar physical environment
- Prescribed social environment
- Prescribed activity
- Eustress
- Challenge by choice
- Conscious use of metaphor
- Emphasis on talk as therapy
- Activity within episode of therapy
- Therapy outside usual systems
- Focus on group over individual
- Outcomes related to psychosocial and psychological

**Creates dissonance in occupational therapist due to:**

**Occupational therapy customary practice of:**

- Usual physical environments
- Usual social environments
- Client centred philosophy and practice – client chooses activity
- Manage stress
- Just right challenge
- Emphasis on activity as therapy
- Therapy within usual systems
- Focus on the individual
- Occupational outcomes

**Therapist manages dissonance by:**

Maintenance of practice within occupational therapy scope  
Enhanced practice as specialist occupational therapist  
Using adventure activities as occupational therapy rather than adventure therapy  
Confusion about what adventure therapy is  
Dilution or change to usual adventure therapy practice  
On-going discomfort with level of talk as therapy

**This can lead to:**

- Maintaining overall occupation focus
- Using adventure therapy as a part of occupational therapy
- Incorporating occupational therapy practice into adventure therapy process
- Using occupational therapist skills and knowledge that are a strength in adventure therapy process
- Using MOHO
- Adapting adventure therapy practice to incorporate autonomy and choice
- Understanding adventure therapy process

**Help alleviate the red through:**

- Use adventure therapy as approach to intervention phase
- Further training in talk as therapy
- Use creative activities in place of talk as therapy
- Training in adventure therapy process theory and practice

## 6.1 Recommendations from this research

Following are some recommendations for occupational therapists, managers or employers of occupational therapists in adventure therapy and for education and training providers.

### 6.1.1 *Recommendations for occupational therapists*

Occupational therapists should maintain occupational therapy specialty practice and use activity as means and as ends; adventure therapy should be utilised as an approach to occupational therapy intervention. Adventure therapy is often facilitated by a team, occupational therapists need to determine with the facility and colleagues how the adventure therapy process is applied so requirements regarding generic work are known. Occupational therapists need to ensure that client assessment is thorough and that the planned adventure experiences are clinically safe and not contraindicated, particularly regarding eustress.

If occupational therapists learn about the underpinning theory and usual practices of adventure therapy they will be better equipped to use it authentically and not simply as occupational therapy with adventurous activities. In addition occupational therapists need to ensure they are adequately qualified in the adventure activity prior to using it, and in generic adventure skills (risk management, first aid, weather etc.).

Occupational therapists require post graduate training in application of psychology based therapies and in group facilitation; however should also be creative with use of activity alongside of or in place of talking, including games and creative activities.

Occupational therapists should embrace the potential for using experiential learning principles and aspects of the adventure therapy process in diverse ways and settings – it does not need to use high end adventure activities or a wilderness environment.

Occupational therapists should explore and add to occupational therapy literature regarding use of adventure therapy.

### ***6.1.2 Recommendations for employers***

Employers of occupational therapists in adventure therapy work should be cognisant of the potential need for training as outlined above.

Employers and managers should understand the specific strengths occupational therapists bring to adventure therapy that are not usual in other mental health professionals but required by adventure therapists, and encourage them to share this expertise within the facility. Some examples are activity analysis, grading, sequencing and adaptation; environmental analysis and adaptation, and assessment of the individuals' capacity for the demands of the activity (physically, cognitively and emotionally).

Managers should employ and support occupational therapists to work as specialists, recognising their occupational view of the individual which differs from the psychological focus of many other mental health professionals. This specialty would add diversity to the clients experience of therapy within the facility, to the service the team is able to offer, and could enhance the teams' understanding of the individual.

Managers should recognise and use occupational therapists abilities in using activity creatively to facilitate insight, learning, and interaction. These skills can be used in debriefing adventure therapy experiences to augment talk based processes and at other stages of therapy with individuals who do

not respond well to talk based therapies. This will add to options available for client intervention.

Managers should enable and encourage team processes such as allocation of clients and documentation to reflect differences in occupational therapy from other mental health professions.

### *6.1.3 Recommendations for training providers*

There is a need for appropriate tertiary training in adventure therapy in New Zealand. Occupational therapists (and most likely other mental health professionals) do not have access to quality education and training at a tertiary level. The knowledge and skills that would be appropriate for inclusion in such education and training include adventure therapy theory, facilitation skills for application of the adventure therapy process (for groups and individuals, in outdoor and non-outdoor environments), and generic adventure therapy skills.

There is adequate education and training opportunities for technical outdoor adventure activity skills in New Zealand, there is potential for such a training provider to work in partnership with a therapy education provider.

## **6.2 Limitations to the study and recommendations for further research**

All studies have some limitations which themselves create opportunities for future research. The limitations in this study relate primarily to the researcher and the targeted participants.

As acknowledged in the introduction, I have considerable experience working in mental health and I have used adventure therapy. My expertise in this area made me reticent about questioning participants too much as I did

not want them to feel threatened. In hindsight I believe it would have been useful for me to probe more, particularly regarding their understanding of some of the more sophisticated adventure therapy theory. The extra detail may have enabled me to understand more fully the theory from adventure therapy they were drawing on.

This research deliberately targeted only occupational therapists using adventure therapy, in order to keep the size and scope of the project manageable. It would be interesting to explore other mental health professionals' use of and perceptions about adventure therapy in New Zealand, particularly with a view to ascertaining the extent of generic and discipline specific practice. Is there a clear practice difference between occupational therapists and other therapists within teams that use adventure therapy?

I have heard anecdotally that some New Zealand managers who employ occupational therapists into adventure therapy roles value their expertise, and consider they are well suited to the demands of the work. Employers and other disciplines' perspectives of occupational therapy in adventure therapy would have added another dimension to this research in terms of establishing fit. What exactly is it that managers and other non-occupational therapy adventure therapists value in occupational therapy?

This research included exploration of adventure therapy literature to gain an understanding of the theoretical bases informing the field, which was predominantly from psychology and psychotherapy in the USA. It would be interesting to know specific theories and therapies these disciplines in New Zealand draw from, how much they integrate into adventure therapy and how much is adjunctive therapy. Are there discernible differences between the practices of adventure therapy in New Zealand from the practice of adventure therapy in the USA?

There is a growing emphasis on occupation in research from a number of disciplines. The concepts of occupation as a determinant of health and as an intervention for health are becoming evident via the growing field of occupational science from which many disciplines draw, and national and international bodies such as the World Health Organisation. It would be interesting to know the extent to which other disciplines using adventure therapy (or in fact any therapy) are considering occupation based outcomes.

### **6.3 Personal reflection**

This research has allowed me the opportunity to explore, conceptualise, discover, consider and generally immerse myself in adventure therapy concepts, theory and use for some months now. I remain convinced of its power, reassured of its applicability to the New Zealand context and excited by its potential for fit within occupational therapy practice in New Zealand. I challenge the occupational therapy profession to take the novelty and excitement of adventure therapy further in how it is used and where it is used. I encourage occupational therapists to step up and embrace an adventurous way – after all, can any of us live a full life cautiously?

*My flight taught me so much. I used all the skills I had, and developed more. I kept control of my wing; I turned steeply and glided quickly. I flew closer to terrain and coped with turbulence. I understood thermal sources and trigger points, wind and ridges, bubbles and rota. I used that knowledge to help me climb and travel. Of course next time I will do better. I will launch at just the right moment with more confidence. I will spend less time circling in a thermal just maintaining altitude and I will move on to the next one quicker. I will remember to piece the information together more consciously – the terrain, the movement of grass and trees, the sun and shade, the clouds forming and breaking up, the birds circling, how my glider feels. I will keep flying.*

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## 8 Appendices

## Appendix 1

### Background, Justification and Literature Review

*Link the literature to your own project. Explain why the project is needed and how your project fits into the local, national or international context for your discipline*

Adventure therapy is an emerging profession and has a number of definitions. The processes by which adventure based activities form a therapeutic program vary (Gass, 1993b; Gillis, 1995; Russell, 2001). The diversity of programs, facilities, staff qualifications and skills, populations served and research conducted all contribute to confusion and a lack of cohesion within the field (Alvarez & Stauffer, 2001; Autry, 2001). Attempts have been made to define adventure therapy by examining the settings it is conducted in, the qualifications of the practitioners, the theoretical base and activities being used and the client population (Crisp, 1996b; Gillis, 1995; Itin, 2001; Russell, 2001).

Most of the debate around definitions comes from USA literature and I deduce may be somewhat reflective of the user pays health system and a population base able to support the myriad of programs on offer. Data on the use of adventure therapy by occupational therapists (internationally or in Aotearoa/New Zealand) is limited, and no literature exploring the theoretical or skill fit between the two professions was found. Most definitions of adventure therapy incorporate concepts of goal directed facilitation of outdoor or adventure based activities, promoting change in self-concept, psychosocial processes and relationship and coping skills. Adventure therapy is utilised with a variety of populations, most commonly with young people in either mental health, justice or education settings.

Literature regarding adventure based therapies predominantly acknowledges experiential learning theories as their primary underlying theoretical base. Whilst specific components vary considerably (such as what constitutes adventure, the extent that risk and stress is included, the practice models of the program, and the health related theories utilized), references to experiential learning theory are consistently included. Experiential learning as a concept and theory is familiar to occupational therapists in Aotearoa/New Zealand, and is often utilised in client education and therapy programs.

Most theories which underpin adventure therapy are also used in other types of psychological therapy and some attempts to identify what is unique or different about this therapy have been made. Adventure therapy specifically focuses on the use of unfamiliar environments, positive use of stress and conscious use of metaphor and processing (Adams & Sveen, 2000; Alvarez & Stauffer, 2001; Berman & Davis-Berman, 2005; Gillis, 1995). Aspects shared by many mental health therapies include group developmental theories, group facilitation and management skills (Adams &

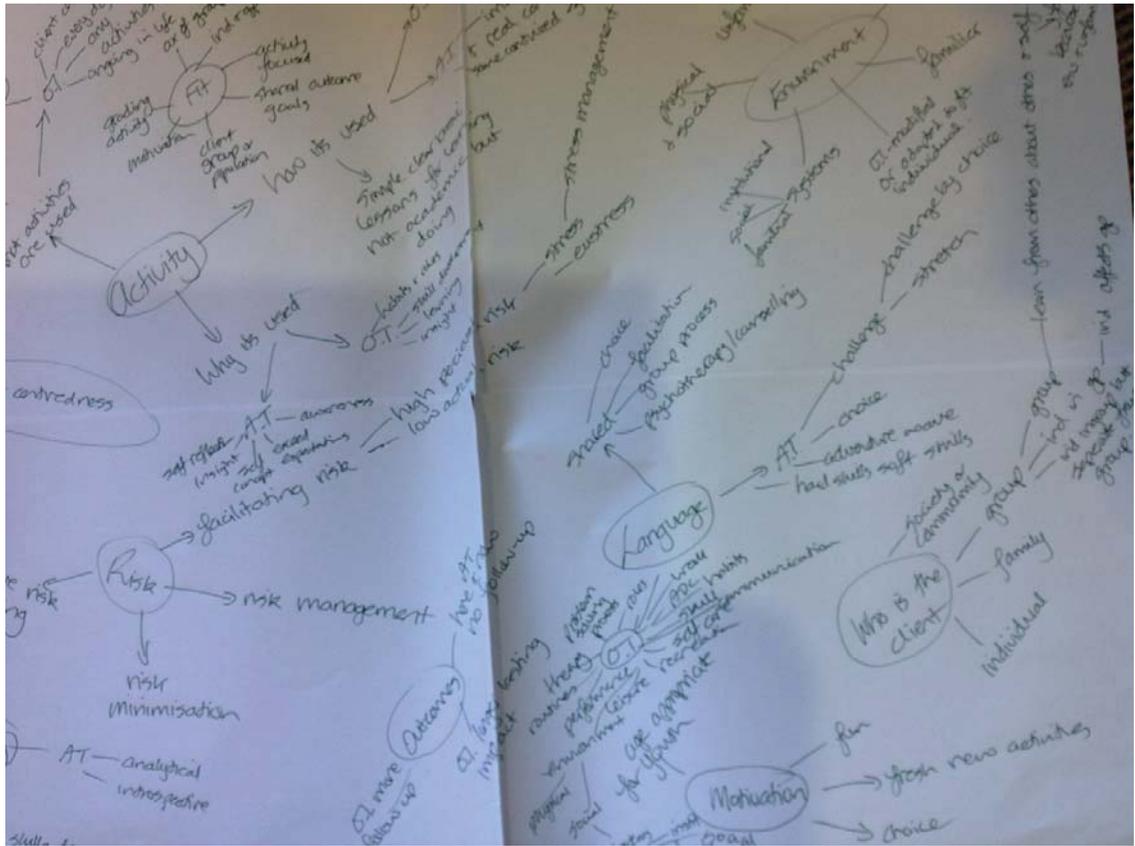
Sveen, 2000; Berman & Davis-Berman, 2005; Gillis, 1995), brief intervention therapies and general counselling skills

Literature that directly explored the fit between occupational therapy and adventure therapy was limited to two theoretical articles and a critically appraised topic.

Levack (2003) proposed that the use of adventure therapy has the potential to have a positive effect in an individual's spiritual domain. She also advocates that therapy through doing is legitimate occupational therapy, and emphasizes the use of activity to facilitate positive change aspect of adventure therapy. This was reinforced by Frances (2006) who summarizes literature evidencing the physical, psychological and emotional benefits of engagement in these activities. Literature from adventure therapy (in the absence of occupational therapy research in this area) was appraised by Sullivan (2011), who argues that occupational therapy's use of task analysis, group development and leadership, motivational interviewing, stages of change, strengths base, engagement and learning through doing and therapeutic use of self positions the profession well to work in adventure therapy.

From the literature reviewed it would seem that occupational therapists are well positioned to work as adventure therapists, provided they acquire additional training and develop skills in the adventure activity facilitation and the specific additional theoretical bases of adventure therapy. However no literature was found that specifically explored occupational therapy's fit with adventure therapy, or how occupational therapists are using adventure therapy.

Appendix 2





④ Content that is a match with O.T.

Adams & Sween An Holistic Model of Case Counseling  
① includes a lot of theory that is taught in O.T programme  
② underlying theories of learning, therapy approaches & group development

Cripp S. International Model of Best Practice  
Advocates O.T. as closest match due to paradigm of therapeutic use of activity.

Fletcher & Idinake ABC an innovative.  
① includes a description of ABC including selection of appropriate activity.  
② theories utilised are taught in O.T. cognitive, rational emotive behavioural, reality, behavioural, narrative, constructivist

\* Frances, K. Outdoor Rec as an Oa to ↑ Quality of life.  
\* is an O.T.  
\* defines outdoor rec as an occupation.

\* Gillen MC & Balkin RS  
\* use of activity as therapy  
\* matches in terms of knowledge base & skills

\* Hill.  
\* therapy, groupwork, theories etc all familiar to O.T.  
\* goal setting etc etc.

\* Ikin  
\* talks about an O.T.ist needs a degree eg TR.

\* Kevac, H.  
① O.T.  
② examines the 2 disciplines AT & OT.  
③ performance camp = spirituality  
Leads of stuff!!

Appendix 5

Data bases - use ERIC, CINAHL, O.T. Source, Google Scholar, ProQuest.

A.T. & O.T. - 8 hits

Lithers Jordan O.T. & AT specific NZ.  
Woodcock mentions O.T. but just in passing.  
Pruy, Lewick, Crisp & O'Donnell  
Kirkman, Sullivan Ewert et al  
for defs.

ABK & O.T. - 2 hits, background relevance, not AT

Experiential learning & O.T. 329 hits mostly ed of O.T. & for reflective practice.  
+ adventure = 11 hits Not used - Rox.

Adventure based therapy & O.T. - 0

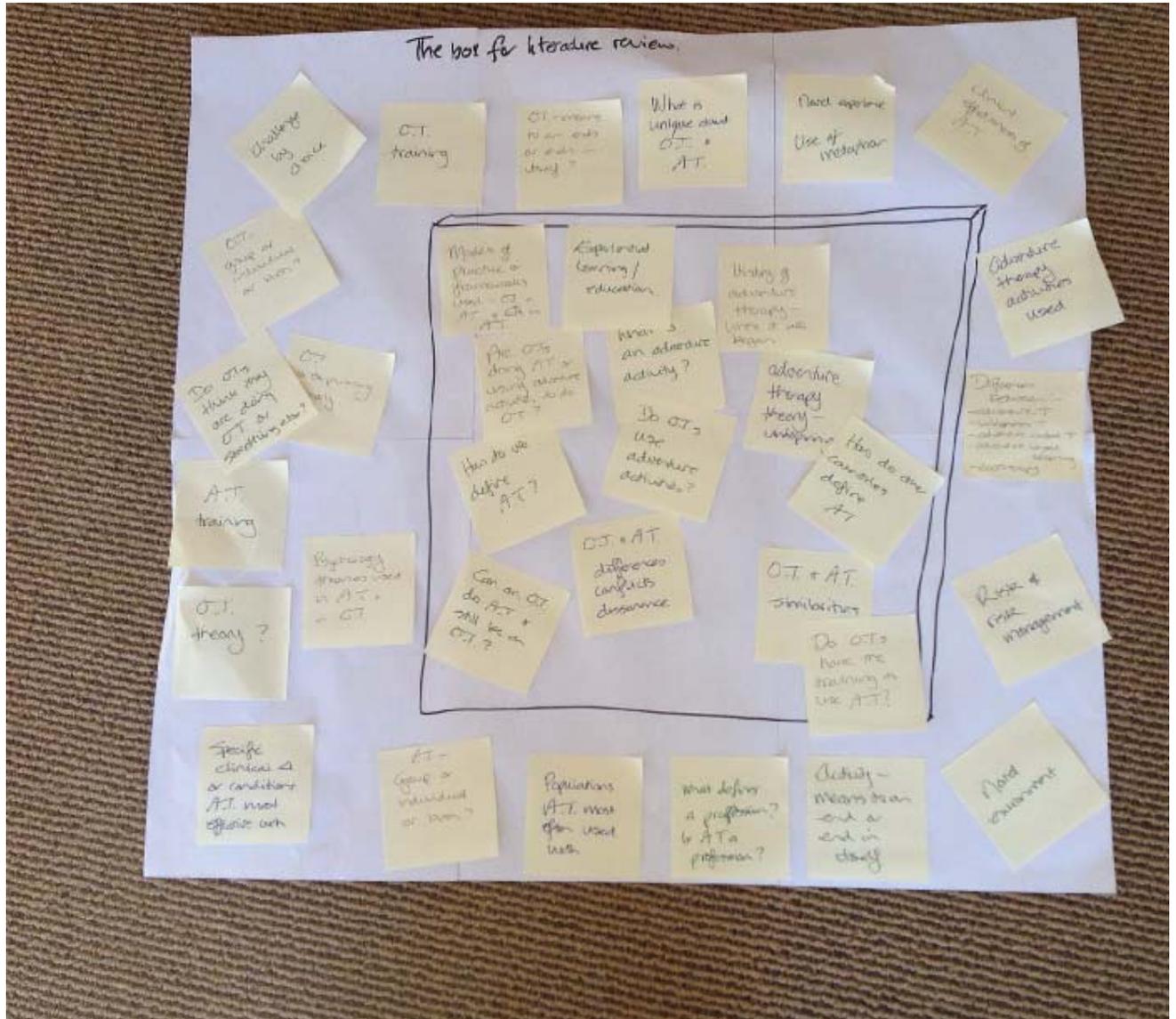
Outdoor education & O.T. - 8 hits Same re outdoors & physical rehab or recreation use, not AT.

Wilderness therapy & O.T. 4 hits - Crisp, Lewick, Sullivan, Woodcock.

Nature therapy & O.T.  
Green therapy 11 hits Using natural environments therapeutically of last ~~decade~~ - but not AT.

? Maybe my Recreation Therapy & AT  
→ ? parallels & O.T. here.....

Appendix 6



## Appendix 7

30 October 2013

Helen Jeffery

School of Occupational Therapy

Otago Polytechnic



Dear Helen

The Ethics Committee has reviewed your application and commends you on its thoroughness. We have one recommendation, and some general remarks. We do not require any further action from you and therefore approve this application and wish you the best for its successful completion.

**Recommendation:** The right to withdraw.

One of our reviewers suggests that the participant should have the right to withdraw material provided during a focus group.

**Action:** We therefore ask you to consider this and if possible allow the participants this right.

**General remarks**

I attach two reviewers' comments regarding the wider scope of your research.

**Reviewer 1:**

The literature on adventure therapy appears to be developing and as such is difficult to define. The review by Sullivan (2011) seems to be most relevant and would provide good guidance through this "emerging profession". From a lay perspective I visualise adventure therapy to be outdoor-related activities. The strength of this proposal is that the issue related to definition is covered in the interview questions. These will be helpful to the Occupational Therapy profession in understanding "the fit".

**Reviewer 2:**

I think this is a really interesting piece of work. I get the impression that there is a need to broaden the literature search to include a counselling and allied professions based research, which might give rise to some useful theoretical insights from disciplines other than OT. Allied to this it may be sensible to broaden the inclusion criteria to those working in adventure therapy who aren't OTs in order to get a better overview and a more complete insight.

While these remarks may further inform your project, the Research Ethics Committee has approved this application and wishes you well with it.

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Research Ethics Committee

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## Appendix 8

### **Research Participant Information Form**

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#### **Project title**

Occupational Therapy and Adventure Therapy in New Zealand– Is There a Fit?

#### **General introduction**

Adventure therapy is an intervention increasingly used in clinical mental health settings, in educational services, non-government organisations and specialist services, most commonly with adolescents and young adults.

Facilities that use adventure therapy in New Zealand are increasingly employing occupational therapists. Given the populations that adventure therapists work with, the use of activity within the therapy and the intended outcomes from the therapy, it would appear that occupational therapists are well equipped to work in this field. However there has been no research conducted regarding the use of adventure therapy by occupational therapists, nor has there been any exploration of the fit between the two fields in either adventure therapy literature or occupational therapy literature.

I am an occupational therapist, and I have experience utilising adventure therapy techniques in my occupational therapy work. I have also worked as an outdoor instructor using adventure based activities for personal and team development. I have an on-going interest in the field and curiosity about its development and potential use in New Zealand. I am currently enrolled in Masters in Occupational Therapy by thesis; this is the research project that will allow me to meet the requirements to gain this qualification.

#### **What is the aim of the project?**

This research aims to explore the theories utilised by occupational therapists in New Zealand who are working in adventure therapy. The purpose of this research is to ascertain the fit between occupational therapy as a profession and adventure therapy as it is known in New Zealand, in order to:

- Improve service delivery by occupational therapists working in adventure therapy.
- Identify knowledge and skills required by practitioners working in adventure therapy that are not met by occupational therapy training.

#### **What types of participants are being sought?**

Participants for this research will be New Zealand occupational therapists who are working (or have worked in the past 10 years) using adventure therapy in New Zealand.

Although the intention of this research is not to specifically explore aspects adventure therapy theory and practice in relation to Maori culture, it is acknowledged that data of specific relevance to Maori may emerge. I will use academic cultural supervision to assist me interpret and represent data in a way that is meaningful for occupational therapists working with Maori.

### **How will potential participants be identified and accessed?**

Participants will be sought through occupational therapy and adventure therapy networks in New Zealand, and through word of mouth. These networks may include New Zealand Association of Occupational Therapy, New Zealand Occupational Therapy Board, Project Adventure New Zealand, and Adventure Development. Potential participants are being contacted initially by email, mail or phone and asked if they would like to be involved. People will also be asked if they know others I could interview.

### **What will my participation involve?**

Should you agree to take part in this project you will be asked to participate in an interview of no longer than 45 minutes, conducted by myself. This will be either face to face, or by computer, depending on your location. The interview will be recorded, transcribed and a written copy given to you for verification and clarification. Following the interview, you may be invited to participate in a focus group – again, this will depend on your location.

There will be no cost to you other than time; I am able to negotiate an interview time that best suits you.

The interview questions will be related to the way you define adventure therapy, the theories you draw from in your practice and the things you do as an adventure therapist. There will also be some questions related to your perception of any gaps between the knowledge and skills a qualified occupational therapist has on graduation and the knowledge and skills necessary to safely practice in adventure therapy, as you know it.

You will not be asked questions about, or be required to share information on specific clients, or on work colleagues.

If a focus group is conducted, the discussion will be facilitated related to themes identified in the interview data, with a view of exploring or adding depth to the data. The data for the focus group will be managed in the same way as for the individual interviews.

### **How will my confidentiality be protected?**

The names of individually interviewed research participants will be known initially only by me. The content of the data will initially be seen by my academic supervisor, the person transcribing the interviews and myself. The person transcribing the interview will have signed a confidentiality agreement regarding non-disclosure of any data transcribed to anyone else, and will not have access to your identifying information, other than your first name if I use it

during the interview. Once you have seen the transcribed data, you may choose whether you would like to have your own name used in the write up of the research, or if you would like to choose a pseudonym. If you choose a pseudonym this will be used in all future writing related to the research. Other research participants will not have access to the transcript of your interview.

The name of your workplace will not be used without your express permission.

Data gathered in another interview that refers to you will not identify you without your express permission e.g. if a colleague or manager is interviewed.

If you use any information regarding a client in your interview in order to illustrate a point you are making, any data that may help identify the client will be excluded from any of the research write up.

If you attend a focus group then the information you choose to share will be known by other focus group participants. All group participants will be asked to keep the contents, and specifically who said what, confidential.

### **What data or information will be collected and how will it be used?**

Data collected will be about your qualifications and experiences as an occupational therapist using adventure therapy. You may decline to answer any question should you choose, and you may turn the recorder off at any stage.

The interview will be transcribed and you will be shown a copy of this for the purpose of checking it for accuracy.

The data will be used to identify information to assist me in answering the research questions I have developed in order to meet the aims of the research. Information you share that is not directly relevant may not be used.

Whilst writing my thesis, my primary (occupational therapy academic) and secondary (outdoor education academic) supervisors will read it. If there is data relevant to or specifically pertaining to Maori culture, the material will also be read by my Maori cultural supervisor.

Once completed, the written thesis will be available for staff and students of occupational therapy (or other interested parties) to read via the Occupational Therapy School at Otago Polytechnic. I will provide you with a summary of the results.

Results of this project may be published in an occupational therapy or outdoor education related journal, or presented at a conference, but any data included will in no way be linked to you without prior consent.

## **Data Storage**

The data collected will be securely stored in such a way that only those mentioned above will have access to it. I work from home, and have specific office space that includes a lockable filing cabinet where all printed or handwritten notes and tapes of interview recordings will be secured. I work on a computer that is password protected, and is not networked to any other computer or system.

At the end of the project any personal information will be destroyed for any raw data on which the results are based. The raw data will be retained in secure storage for a period of seven years, after which it will be destroyed.

## **Can participants change their minds and withdraw from the project?**

You can decline to participate without any disadvantage to yourself of any kind. If you choose to participate, you can stop participating in the project at any time up to the point of when you have read the transcript of your interview, without having to give any reasons. You can also withdraw any information that has already been supplied until the stage agreed on the consent form.

If you choose to attend a focus group, you can choose to leave at any time. Any identifying data can be removed from the focus group data; however your specific input into the focus group will not be removed.

## **Are there any risks to participants?**

The interview questions will require you to share information about your use of theory and your professional practice. The questions will not be personally intrusive. You can end the interview at any stage, or take a break and return to it if necessary. You can ask to have anything you have said deleted from the interview until 10 days after I have provided you with the transcript of the interview. If you disclose aspects of your work that I believe indicate you may not be practicing ethically or safely, I will recommend you take this to your supervisor. I will not contact anyone else about my concerns.

## **What are the benefits of the research?**

I expect that this research will result in enhanced clarity of differences and similarities between occupational therapy and adventure therapy, and may contribute to the identification of the need for further education and training required by occupational therapists choosing to work in this field.

## **What if participants have any questions?**

If you have any questions about the project, either now or in the future, please feel free to contact either:

Helen Jeffery (researcher)

Email: [Helen.Jeffery@op.ac.nz](mailto:Helen.Jeffery@op.ac.nz)

Ph: 022 3032738

Ph: 003 4098328

or: Linda Wilson (primary supervisor)  
Email: [Linda.Wilson@op.ac.nz](mailto:Linda.Wilson@op.ac.nz)  
Ph: 03 4796043

Any additional information given or conditions agreed to will be noted on the consent form.

## Appendix 9

### Consent Form

---

#### Project Title

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

- My participation in the project is entirely voluntary and I am free to refuse to answer any particular question
- I am free to stop participating at any time
- I can choose to withdraw any information provided without giving reasons and without any disadvantage until the point at which the data is beginning to be analysed. This will be 10 days after the point where I have read and checked the transcribed interviews for accuracy, and either selected to use my name or a pseudonym.
- Regarding the focus group, I am aware I cannot withdraw any information provided during a focus group once it is complete.
- My data will be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for seven years after which it will be destroyed. If it is to be kept longer than seven years my permission will be sought.
- I will receive a book voucher to the value of \$25 on completion of this project, as a token of appreciation from the researcher.
- The results of the project may be published or used at a presentation at a conference but my confidentiality will be preserved unless I otherwise agree.
- I will have access to a copy of the research findings on request.

I agree to take part in this project under the conditions set out in the Information Sheet.

..... (signature of participant)

..... (date)

..... (signature of researcher)

**This project has been reviewed and approved by the Otago Polytechnic  
Research Ethics Committee**

## Appendix 10

### **Interview questions:**

Can you please tell me a little about the facility or organisation you work for, and about your job?

Do you consider yourself to be working as an occupational therapist, or an adventure therapist, or a bit of both?

What are the kinds of things you do in your day to day work?

How would you define adventure therapy?

What do you think are the differences between adventure therapy and occupational therapy (if any)?

What do you see as the similarities or way in which the therapies complement one another?

What contradictions do you feel exist between the two either philosophically or practically?

Is there a specific model or framework you use to guide your work? What is it?

When you think about the theory you use in your work, do you think it comes from occupational therapy, or adventure therapy, or from counselling/psychotherapy? Or from somewhere else?

Can you talk to me about the theories you use or draw from in your work? What do you consider to be the main theory or theories you use?

Think back to when you first graduated as an occupational therapist. What knowledge and skills would you have needed then in order to use adventure therapy that you weren't introduced to in your occupational therapy training?

Is there anything you would like to add?

## Appendix 11

112 So, what do you think the differences are between AT and OT if  
113 anything?  
114 Well OT is a whole profession... I see AT as a kind of a legitimate part of  
115 OT really because like it is using therapeutic... using meaningful activity as  
116 a therapeutic media... and it's kind of looking at occupational function and  
117 trying to aid these YP to um to do things to improve their function and  
118 improve their ability to manage their lives and to kind of do the normal  
119 occupational roles of being a school member, a family member, a friend um  
120 all or those sorts of things are the legitimate kind of roles for the YP at this  
121 age group that I work with and I think AT aids improvement in those roles...  
122  
123 So you're talking about ways AT compliments OT and fits in nicely  
124 with OT...  
125  
126 I think so, for sure...  
127  
128 Can you talk about how you use activity therapeutically... think about  
129 how an OT would do that and how and AT would do that, can you see  
130 similarities or any differences  
131  
132 I can certainly see some similarities in regard to the encouragement to step  
133 outside comfort zones and kind of to experience new experiences and to  
134 kind of um give the YP an appreciation for the outdoors and different  
135 activities and an ability to try new things... and that sort of stuff... I think the  
136 difference that an OT brings to that role is the ability to grade, you know to  
137 really look at the needs of the YP and to grade and adapt the activity to  
138 meet the needs of the group and the needs of the individual... so we can

Profession debate!  
Is AT a profession?  
How? or  
why not?  
Using AT as OT

lots of fun...  
is that OT here a  
is that usual in  
AT?  
would counselors  
say do it different

language -  
capture the  
things that are  
usual in AT.

so do we grade  
different from AT?  
surely they do no...

## Appendix 12

03/07/17

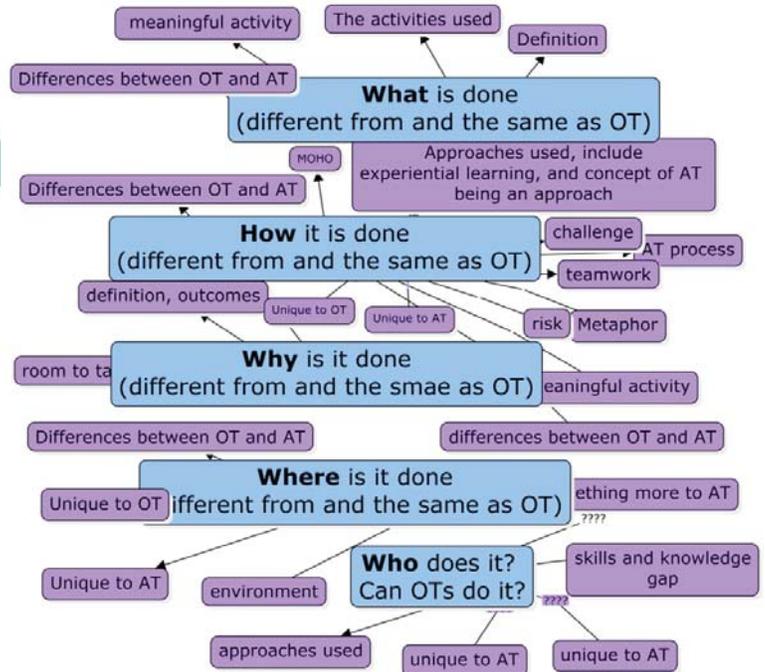
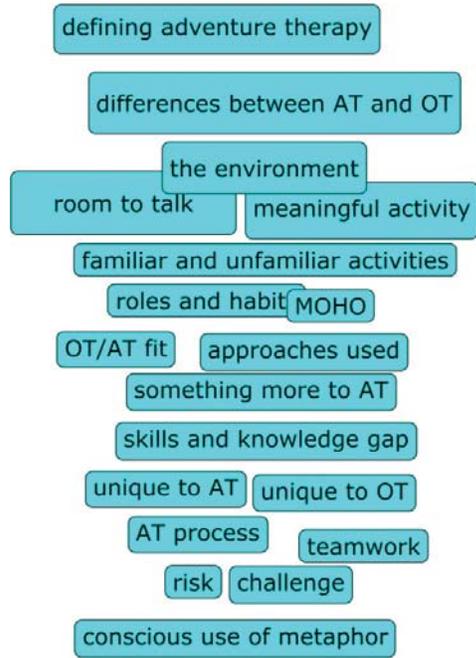
Themes	Interviews
<del>① Motivation</del>	<del>2</del>
① Adventure activity is a medium for change ✓	1 2 3 4 5 6
① AT out of usual life / environment ✓	2 3 4 6 7
① Generic work ✓	1 2 3 4 6 7
① Reflection ✓	2 3 4 6
① CCE ✓	1 2 6
① interpersonal relationship → skill <sup>communication</sup> development	1 4
- ① debriefing ✓	1 3 4 6
- ① best time work for the moment ✓	1 4 5
① transfer of learning ✓	1 3 4 5 7
① OT is a profession ✓	1
- ① team building / teamwork ✓	1 2 3 4 6
① out of comfort zone AT & OT ✓	1
① modern setting ✓	1 3
① AT mix of child & adult learning style ✓	1
① AT a legitimate part of OT, integrated ✓	1 2
① AT different from usual activities ✓	2 3 4 6 7
① Roles ✓	1 2 3
① Ability to create space for people to grow ✓	2 3 4 7
① OT grades activity to fit the ind ✓	1
① Project adventure grades act too ✓	1
① learning thru doing OT & AT ✓	1 6
- ① grade challenge ✓	2 4
- ① Risk taking & adventure is positive AT ✓	1 5
① goal setting ✓	2 3 4 7
① Psychology theory COT / DBT	1 2 3 4 5 7
- ① Unknown or unexpected ✓	2 4 5
① MOBO ✓	1 2 3 4 6 7
- ① Exceed expectations ✓	2
- ① Challenge by choice ✓	1 4 7
① AT are off, OT more consistent ✓	2
- ① Adventure waves ✓	1
- ① Use of metaphor ✓	2 3
- ① experiential learning ✓	1 4
① feel good without drugs	2
① groupwork AT & OT ✓	1 3
① OT is everyday activities & exp ✓	2 3 5 6 7
① activity & demand analysis ✓	1 5
- ① therapeutic relationship	2 3 7

## Appendix 13

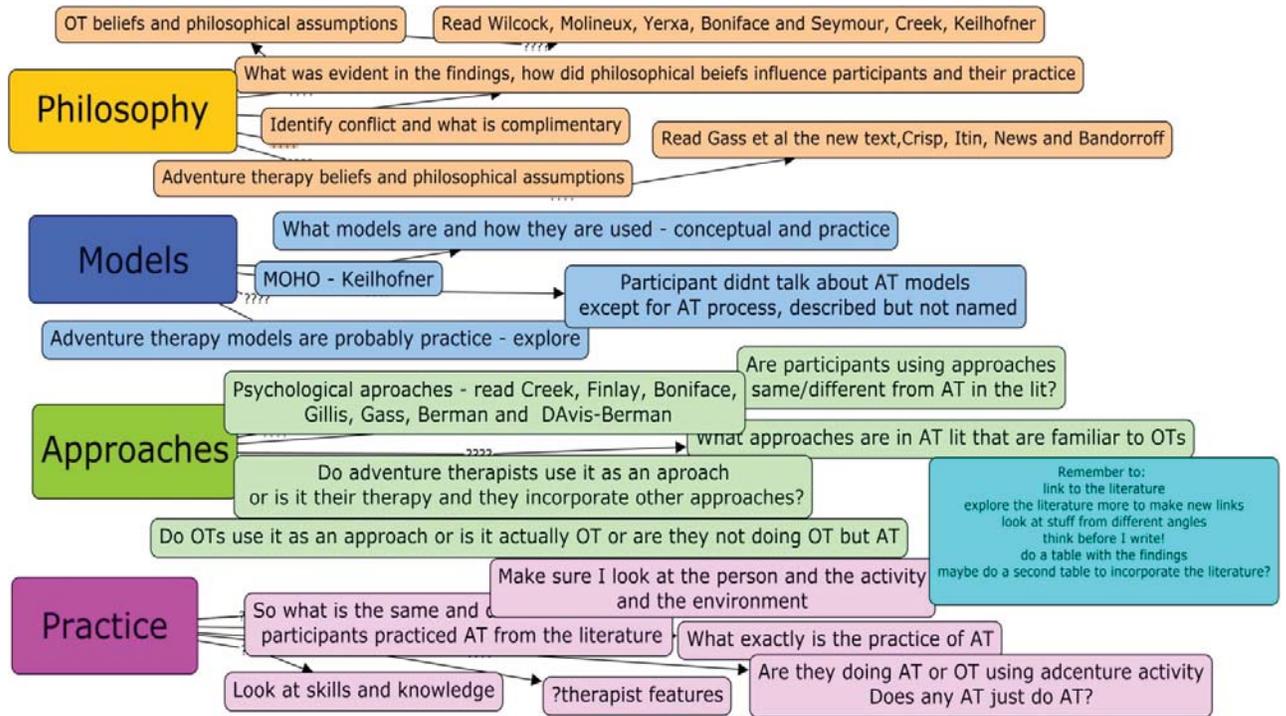
Interview 1 of 3.

Confirming	Novel	Feelings
<p>ETs more adept at demand analysis (277)</p>	<p>ET breaking down to a more specific use. Use A.T. for building blocks for cars along road (261) → Roadway again</p> <p>Able to be more precise &amp; appropriate if recipient is structure work for some facility (295)</p>	<p>Interested - there is something new here</p>
<p>Didn't get from ET. several hard numbers, 1966 over 1<sup>st</sup> dist (300)</p>	<p>Need not wait until process of finalization in ET mind (322)</p>	<p>Frustrated - I can't say of skills - ET!!</p>
<p>Outdoor env is not a usual env (350)</p>	<p>Conscious use of segment in AT (325)</p>	<p>Interested - should read on this??</p>
<p>Environment &amp; noise may need to be more careful 354-359.</p>	<p>Need more drawing description theories (330)</p> <p>Left skills in A.T. is not from design as need to be more precise and adaptive &amp; change a rule 342-347</p>	<p>Surprised &amp; flexible, interested re changing a rule...</p>
<p>Really his behavior is one way, it's not that off to a lot of ET. positive - F&amp;S ET others.</p>		<p>Yes!! excited.</p>

Appendix 14



Appendix 15



Appendix 16

<p>Occupational Therapy O.T. is a profession. Everyday activities Real activities!! Usual physical environment</p> <p>Social environment + systems known Change sought more often linked to the activity + here + now.</p> <p>Focus on everyday roles and engagement in habits + activities to support those</p> <p>Skill development in everyday activities</p> <p>Working with usual systems + maybe changing/modifying systems</p> <p>Grading the activity      Life skills Modifying the activity</p> <p>Individuals in the group</p> <p>Therapeutic value in participating in activity itself.</p>	<p>Adventure therapy Is NOT a profession Novel + not everyday activities Real consequences!! Novel physical environment, usually outdoors.</p> <p>New social environment (group)</p> <p>Activities used as a motivator - fun.</p> <p>Activities used to facilitate challenge + discomfort.</p> <p>Change sought is not integral to the activity itself → learning needs to transfer</p> <p>Skills (in activities) sought to succeed in the experience itself, not real life activities</p> <p>Briefing + debriefing, frontloading, conscious use of metaphor</p> <p>The whole goes as an activity Focus on changing behaviours.</p> <p>Motivational Interviewing + stages of change Activity has value with debriefing.</p>
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