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Re-Imagining Initial Sessions in Outdoor Therapy: Implications for Host Leadership, Solution-Focused Practice, Co-adventuring for Change, and What Works

Abstract

Therapy participants, or co-adventurers as we prefer to use in outdoor therapy, quickly decide whether they will engage cooperatively, leave, or passively remain in therapy. The initial session is important in setting the scene for the work, in building a useful therapeutic alliance, and facilitating a scheme of work useful to the change co-adventurers are seeking for themselves. This present article examines international research relating to first session dropouts and implications for increasing hope and expectancy for clients in outdoor therapy practices. Solution-focused practices, host leadership, and outcome research are used to inform an evidenced framework for hosting initial meetings with potential and future clients. Implications are provided to aid practitioners in maintaining three points of contact based on Bordin's (1979) original conceptualization of the therapeutic alliance from initial meetings with co-adventurers.

Keywords

Outdoor therapy; solution-focused practice; host leadership; therapeutic alliance: feedback-informed treatment; outcome-informed practice

1 Introduction

In this paper, we explore the data around engagement in psychotherapy services internationally and argue for more diversity in psychotherapy services, utilising the intentional use of outdoor settings to expand accessibility (Harper & Doherty, 2020). While we do not argue therapy outdoors is more effective than indoor counterparts, we stress that greater contrast of therapeutic services, not simply more models of talking therapies, could improve engagement internationally. Therapy outdoors is simply one additional approach for potentially improving engagement, and the better we practitioners understand what we can offer, the better clients and commissioners can understand what they are buying into.

As practitioners and researchers, we build on our theoretical preference for solution-focused practice in the outdoors (see Dobud & Natynczuk, 2023). This theory led us towards the theory and practice of host leadership, a form of leadership designed to draw others in as active participants (McKergow & Bailey 2014, McKergow & Pugliese 2019). This paper will present process-outcome research and evidence surrounding youth engagement in psychotherapy. To end, we include implications for outdoor therapy providers and metaphors for conceptualising relational engagement in psychotherapy from the very first meeting.

2 Literature Review

We build off Chow's (2018) work in undoing psychotherapy's common intake model to examine how initial sessions can improve engagement and outcomes. First, we examine international trends in engagement in psychotherapy and provide a framework for understanding contextual and relational understanding of therapy outdoors.

2.1 One Hit Wonders

Gibbons et al. (2012) analysed nearly 300,000 Medicaid claims in the United States for people diagnosed with major depressive disorder. Using a sample of 18 to 65 year olds from 1993 and again in 2003, the modal number of sessions attended was one. The reader is left wondering why people who could benefit from therapeutic services disengaged after one visit.

Australia's national youth mental health foundation headspace Australia (2021) received over $52,000,000 AUD of funding in 2020-21. Of the 53,032 treatment episodes administered across the country, one "quarter of all episodes involved one session, 40 per cent had 2-4 sessions, 27 per cent had 5-10 sessions, and the remaining eight per cent had more than 10 sessions" (p. 4). In response, headspace Edinburgh trained their staff in single session therapy (SST). What remains unclear is if SST was preferred by practitioners in response to the high levels of client disengagement after one session or to improve client outcomes.

In the United Kingdom, the Labour Government unveiled the Improving Access to Psychological Therapies (IAPT) after economic evaluations reiterated anxiety and depression as the leading causes of disability in the workforce (NHS, 2008). From 2012-13, more

than 760,000 were referred to IAPT services and about half disengaged before their second session (McInnes, 2014). By 2017, the target for improving access to psychotherapy was met by only 15.8% (Scott, 2018). In 2022, self-referred clients were 300% more likely to attend their first session than those referred by their doctor and only 57% attended a second visit (Sweetman et al., 2022). It appears gatekeeping access to a more diverse range of services and withholding engagement through referral processes created barriers to effective interventions.

Using a sample of 4034 patients seen by 61 psychotherapists, Saxon et al. (2017) examined the differences between therapy completers and those who disengaged despite their practitioner's best clinical judgement. For non-completers, "the modal number of sessions attended was two (31.5%) and 86.9% had stopped attending prior to session 8" (p. 709). Treatment completers attended a modal number of eight sessions, and nearly half of the sample completed therapy before that eighth session (47.1%). When attempting to predict treatment outcome and completion, treatment modality had little variance compared to therapist effects. Simply put, some practitioners elicited better engagement and thus better outcomes than their counterparts irrespective of what therapeutic modality was used. The implication here is for practitioners to monitor client engagement, gather evidence about their own dropout rates, and work to improve client retention.

In 2023, the Australian Medicare system will reduce the number of government funded sessions from 20 to 10. While historically the number of sessions was always 10, the COVID-19 pandemic influenced policy makers to accommodate an additional 10 sessions. According to Hallford's (2022) article in The Conversation, the rationale for reducing the number of sessions is inadequate and may not reduce costs in the long run, an evidenced argument. However, if the majority of those receiving therapy do not attend 10 sessions, then the argument may be less about access as it is engagement. Instead of homogenising clients to a predetermined dose of therapy, we argue throughout this paper that the number of sessions and dose of therapy should be determined by client engagement, outcome, and based on ongoing relational consent throughout the process. The first session is crucial in developing engagement, as we show below.

2.2 Disengagement and Dropout

Like the *headspace* example (2021), one attempt to handle single session episodes of care is to imagine clients do not return because they got all they came for in one session. So called brief therapy approaches presented similar arguments regarding making sure the very first session provides therapeutic benefit (Ratner et al., 2012, Strosahl, et al., 2012). While we agree to not provide or schedule one session too many, and some clients may not return after receiving all they wanted from one session, there is a concern given the rising numbers who leave after one session.

Funded by the National Institute of Mental Health in the United States, Simon et al. (2012) surveyed 2666 clients after their first visit with a psychotherapist. The survey asked participants about satisfaction with the therapy, the clients' view of the therapeutic alliance, and their perception of improvement. After 45 days, 34% of the sample were done with therapy. The authors concluded that "Failure to return after a first psychotherapy visit was also associated with the most unfavorable experience of care, and over 25% of those

not returning reported that the symptoms or problems that prompted seeking treatment were unimproved or worse" (p. 4). The findings suggest it was not the skill of the practitioner delivering the service or the model of therapy provided. There appeared to be ruptures to the therapeutic alliance and a lacking perception of progress, which practitioners routinely struggle to notice (do we have a reference for this? That's for practitioners not noticing).

Therapy participants often disengage due to missing aspects of the therapeutic alliance or a lack of hope they will experience benefit from the therapy (Chow, 2018). The therapeutic alliance includes a relational bond, consensus on the purpose of therapy, and agreement on the means on which the practitioner and client are to achieve progress (Bordin, 1979). When any one of these factors are missing, dropout becomes a probability no matter if the therapy is problem-focused or solution-focused, outdoors, long-term, or brief. Relating to therapeutic progress, the longer a client engages in therapy without experiencing benefit the less likely change becomes (Wampold & Imel, 2015).

First sessions are often riddled with assessments and intakes - that is, a *taking* from the client and less of a *giving* (Chow, 2018). We argue focusing on techniques, assessments, or models of therapy during the initial session may interfere with the building of a strong therapeutic alliance and impact the client's experience of hope inversely. Time during the initial session might be better spent building a useful therapeutic alliance and finding consensus for the purpose of the relationship (Dobud & Natynczuk, 2023).

Additionally, how practitioners conclude their first session may be telling. Using a sample of 9,000 youths across studies by Miller et al. (2007) and Owen et al. (2016), Miller et al. (2020) presented how first and last session alliance ratings impacted psychotherapy outcomes. Practitioners who elicited good alliance ratings on the first and last session provided outcomes on par with tightly controlled clinical trials. However, practitioners whose client alliance ratings improved from poor to good, fair to good, and poor to fair (see Miller et al., 2020, p. 73) obtained outcomes far beyond psychotherapy benchmarks. While it may appear counterintuitive at first glance, especially given rates of first session dropouts, lower alliance ratings at the initial meeting in therapy may be a strong indication of successful therapy, this research also shows that an engaging first session where clients feel safe to provide negative feedback may also provide practitioners the opportunity to demonstrate their commitment to outcome and tailoring to the client's feedback. The client's complaint may actually be a sign of a commitment to making this work.

The gap in our knowledge, in general, is psychotherapy's engagement problem. Many who could benefit from therapy do not engage and many who do disengage prematurely (Miller et al., 2013). Re-imagining initial visits and first sessions requires looking beyond the intake, assessment, or model being delivered. It requires a strong partnership and collaboration, while allowing the space for negative feedback to be taken seriously; a demonstration of the reciprocal real relationship between the practitioner and co-adventurer. Opening the counselling room door and hosting therapeutic interactions outdoors provides numerous affordances, but issues of engagement remain the same as traditional talking therapies (Dobud & Harper, 2018).

In the following section, we explore outdoor therapies as an umbrella or a big tent under which many diverse theoretical orientations and professions can meet. Practices

include adventure therapy, wilderness therapy, nature-based therapy, horticulture, surf therapy, forest therapy, and many others. Within these practices are a range of counselling theories, from solution-focused to cognitive behavioural to trauma-informed. Being quite a diverse and large group of practices, we do not find evidence to suggest these practices are more impactful than traditional talking therapies, though becoming outcome-informed in therapy outdoors may afford the possibility to improve client engagement in psychotherapy.

3 Therapy Outdoors

Taking therapy outdoors seemed to take a boost during the COVID-19 pandemic with time in nature being recognised as beneficial to mental wellbeing with or without a therapist when being close together indoors brought inherent risks (Doughty, Hu, & Smit, 2022). The pandemic certainly caused a revaluation of human interaction with natural spaces on multiple levels (Dickson & Gray, 2022). While encouraging to see psychotherapy delivered in the great outdoors and more of the general population embracing the potential benefits of time in nature, an evidenced practice framework is required as this provides a theoretical rationale for the practitioner's approach, specific techniques, and elements of the treatment approach aimed to improve participants' hope and expectancy (Miller et al., 2020). While adamant practitioners of this approach, solution-focused outdoor therapy practices are by no means the only approach for facilitating client change. To avoid the similar pitfalls of client dropouts, practitioners require a systematic framework to monitor client outcome as objectively as possible (Dobud et al., 2020). We encourage practitioners from all backgrounds, qualifications, and experience to develop their unique practice framework, as recommended by Harper (2018) during a keynote at the 8th International Adventure Therapy Conference, to navigate outcomes clients recognise as useful, while providing guard-rails to catch when our unique bias towards therapy outdoors is not delivering on client preferences or outcome.

For us, solution-focused brief therapy is a methodology which speaks to our psychology and lived experience. We hope our readers will examine how their own practice framework fits with co-adventurers and use this piece as an area for critical reflection.

3.1 Introducing Solution-Focused Practice Outdoors

Though described more fully in Dobud and Natynczuk (2023), solution-focused concepts in outdoor and adventure-based therapies are not new. Gass and Gillis (1995) realised the potential for solution-focused practice to empower client change in adventure experiences. They were attracted to solution-focused practice by its pragmatic utility, aligning with adventure activities to focus on solutions rather than problems, and empowering through co-facilitation. The authors concluded "that solutions "co-constructed" by therapists and clients (or clients alone) are generally more successful in generating lasting client change than those created solely by the therapists" (n.p.). The solution-focused practice Gass and Gillis (1995) presented has evolved (McKergow 2021, Shennan 2019) and we have adapted the aim of co-facilitating change to co-adventuring for change (Dobud & Natynczuk 2023). Co-adventurers are trusted to know what is in their own best interests

and their choices, their observations, and knowledge of what works for them is dignified, respected, honoured, and in this way co-adventurers become their own best intervention. This approach is consistent with the findings of Pringle et al. (2022) when working with complex trauma and adventure therapy from a human rights perspective, and Harper and Fernee's (2021) approach to bringing *relational dignity* to outdoor therapy, and Ringer and Gillis (1996) theories of human change in adventure therapy.

Our preference for solution-focused conversational tools may help adventure leaders, guides, and instructors to facilitate seamless therapeutic conversations within the adventure experience, as opposed to stopping the adventure to accommodate a visiting therapist at a scheduled time (Dobud & Natynczuk, 2023). Our experience is that clients will talk when they need to, and this can be anywhere and at any time. Holding a therapeutic space is a skill indoors and demands extra skill in challenging environments, especially from the initial meeting. Here, we find the metaphor of becoming a good host important when holding space and building a therapeutic relationship.

3.2 Host Leadership Outdoors

Mark McKergow (2014) developed an approach to leadership founded on solution-focused practice and builds off the metaphor of hosting a social event, such as a dinner party. Natynczuk (2019) adapted host leadership to outdoor therapy, drawing on the six functions of the host (initiator, inviter, space creator, gatekeeper, connector, co-participator) and the four positions (in the spotlight, with the guests, in the gallery, and in the kitchen) to describe how they translate to adventure experiences. Dobud and Natynczuk (2023) built on these ideas to inform how *being a good* host is important when first meeting prospective participants. McKergow (2014) describes a host in detail below:

A host is someone who receives certain guests. This is a position with which we are all familiar, at some level. Think about your experience of hosting people in your home or at a celebration. Hosts sometimes have to act heroically - stepping forward, planning, inviting, introducing, providing. They also act in service: stepping back, encouraging, giving space, joining in. The good host can be seen moving effortlessly between them. Hosting has ancient roots and is found across all cultures. We all know good hosting (and good "guesting") at an instinctive gut level. (p. 3)

Natynczuk (2019) described this approach as an evolution of Greenleaf's Servant Leadership model (Northouse 2013), often adopted for therapeutic work using adventure (Gabriel et al., 2020), and itself based on Hesse's (2007) novel about a journey through wild places. Informed by solution-focused practices, host leaders seek to co-create from imagining a better future (McKergow & Bailey 2014) helping to facilitate a harmoniously aligned practice and leadership model for therapy outdoors.

Host leaders reframe the provider/client relationship to host/guest (McKergow, 2015). This alone does much to encourage a shared experience whereby the guest is honoured, respected, and dignified as a co-participant. In our outdoor work, the co-adventurer presents because they want to be involved, free to leave, or stay as they want as active participants (curious, active in contributing), rather than passengers (along for the ride, ac-

cepting what is done for or in some cases to them), or hostages (wanting to be elsewhere though unable to leave, present under protest) (Mele & Shepherd, 2013). This helps to inform how we approach participants from the first meeting.

4 Hosting the Initial Session

While any adventure is full of surprises, our aim is to make our initial adventures as predictable as possible to protect the dignity of co-adventurers and ensure 'guests' feel safe from the word go (Harper & Fernee, 2022, Pringle et al., 2021). Asking co-adventurers about their best hopes may be helpful, as well as inquiring into any pre-session changes (Letham, 2002). Informed by the available evidence (see Gelso et al., 2018), we search from consensus on expectations and what participants are working towards. We work towards a stronger therapeutic alliance and improved engagement as these factors are like to facilitate better outcomes (Gelso et al., 2018). Finding consensus on the purpose of the work together (i.e., the participant's best hopes) can be helpful for reducing first session dropouts as this may communicate the practitioner's investment in the client's lived experience.

In the following discussion, we build off Bordin's (1979) original conceptualisation of the therapeutic alliance using the rock climbing metaphor of *three points of contact* to provide a framework for how practitioners can conceptualise engagement/disengagement to introduce more redundancy for a relational, dignified, and pragmatic delivery of therapy outdoors.

4.1 Maintaining Three Points of Contact: A Metaphor for Building and Maintaining the Therapeutic Alliance from the First Point of Contact.

Using *three points of contact* felt like a useful metaphor for routinely assessing the therapeutic alliance, as originally conceptualised by Bordin (1979), the alliance consists of three main components: 1) relational bond, 2) consensus about the purpose of the therapy (the client's best hopes), and 3) an agreement on how the therapy will be co-constructed to achieve these aims. These are the three points of contact we encourage practitioners to maintain with their co-adventurers. When practitioners cannot identify each of these factors, through the eyes of the co-adventurer, the alliance risks rupturing.

When climbing, the three points of contact typically include two hands, one foot, or two feet and one hand: the principle being to stay balanced with good connection while preparing for the next move. In therapy, practitioners want to maintain these three points of contact and mutual understanding to ensure therapy is moving in the direction of the client's best hopes. Of course, this will look different for each co-adventurer.

As a climber progresses on a climb, a firm foundation is required for the next move to avoid slipping and falling, referred to as deterioration in the psychotherapy literature. Each point of contact should be secure as the therapy is progressed to another phase. Just as the climber thinks to themselves, "Does the belayer have me?" the outdoor therapy practitioner reflects with their co-adventurers on the quality of the relational bond, the purpose of the work together, and if the co-adventurer finds the approach useful. Most important to this is the perspective of the person doing the work: the co-adventurer

/ the climber. To obtain useful feedback from co-adventurers, Miller et al. (2020) recommended practitioners facilitate environments in which clients feel safe to voice concerns about the therapeutic relationship from session one.

The harder the client works, more effort is required and the more the belayer, rope, and anchors have to be trusted. Without both the climber and belayer being ready for the work, the chances of a slip or a fall are high. The same goes for therapy. Bordin's (1979) components of therapeutic alliance are similarly grounded, reliable, and strong, providing a reassuring way to move carefully and deliberately to the culmination of the work, each protected, tested, and vigilantly supported as the work progresses.

4.2 Let the Climber Climb

Everyone's climb will look different. There is no manual to homogenise each climb, guest, or client. Each climber brings diverse styles, speed, reach, strength, stamina, technique, confidence, and so on. The provider can only work with what the co-adventurer brings to the therapy. There is much individual variation in solution finding to reach the end of the climb. The role of the belayer is to support the climber in finding the route for themselves, and to hold them should they want to rest, or suddenly fall. At times, we may need to lower the climber safely to the ground to recalibrate, rest, or reflect on the experience.

The belayer's role is similar in many ways to that of the solution-focused practitioner; to support the co-adventurer to find their own way safely on their journey. The practitioner works towards adapting the session so participants feel their best during the experience. Co-adventurers are trusted to find their own way based on what they determine and communicate to be in their own best interests. To increase a sense of redundancy, practitioners avoid providing unsolicited suggestions, advice, or coercive practices to avoid becoming solution-forced (Nyland & Corsiglia, 1994), which is regarded as unethical.

The work must be done by the climber for the climb to count towards mastery. Likewise, solution-focused practitioners use careful questioning to invite the client to consider how their own efforts have brought them to therapy in the first place and inquire about their successes early on. From the first session, we inquire about the client's motivation, best hopes for a problem-free future, and invite negative feedback on how we can best tailor subsequent sessions.

Like the attentive therapist, a good belayer will respond quickly to requests, such as for a tighter rope. They listen for when the climber is ready to move on and control the rope so that the climber can move unimpeded with a sense of security, freedom, mutual trust and respect. No matter the adventurous experience, all the hard work done is the co-adventurer's: the triumph is theirs alone. No belayer has claimed a route climbed by someone else, and for a solution-focused practitioner, the ultimate accolade is for someone to attribute their change to work they did themselves (Natynczuk & Dobud, 2021). Allowing co-adventurers to own their experience of therapy from session one, as opposed to complying with a dated intake model, could increase engagement and ownership of the process.

5 Concluding Implications for Outdoor Therapies

Adventures are undertakings with an uncertain outcome. Solution-focused practice is similar. We do not know how a session will turn out as we are guided by the client from the initial meeting. Our skill is to understand what someone wants for the work we do together, to listen with an attentive ear for exceptions to the problem, to watch for instances of a preferred future already existing, to remind someone of their strengths and resources, to understand their preferences, to trust they know what they want to be better, and to remain curious in our conversation. Instead of initial meetings beginning with lengthy intakes and assessments (Chow, 2018), we start with the client's best hopes for the work together. Sometimes they arrive unsure, and this is where ensuring three points of contact around the therapeutic alliance (Bordin, 1979) becomes essential to increasing engagement in all approaches to psychotherapy, including outdoor therapy.

References

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, *16*(3), 252.

Connolly Gibbons, M. B., Rothbard, A., Farris, K. D., Wiltsey Stirman, S., Thompson, S. M., Scott, K., & Crits-Christoph, P. (2011). Changes in psychotherapy utilization among consumers of services for major depressive disorder in the community mental health system. *Administration and Policy in Mental Health and Mental Health Services Research*, *38*(6), 495–503.

De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I.K. (2021). More than miracles: The state of the art of solution-focused brief therapy. Routledge.

Dickson, T.J. & Gray, T.L. (2022). Nature-based solutions: democratising the outdoors to be a vaccine and a salve for a neoliberal and COVID-19 impacted society. Journal of Adventure Education and Outdoor Learnng. 22,(4),278-297.

Dobud, W. W., Cavanaugh, D. L., & Harper, N. J. (2020). Adventure therapy and routine outcome monitoring of treatment: The time is now. Journal of Experiential Education, 43(3), 262-276.

Dobud, W.W. & Natynczuk, S. (2023). Solution-focused practice in outdoor therapy: Co-adventuring for change. Routledge.

Doughty, K., Hu, H., & Smit, J. (2022). Therapeutic landscapes during the COVID-19 pandemic: increased and intensified interactions with nature. *Social & Cultural Geography*, 1-19.

Gabriel, J., Sklar, S. and Monu, J., 2020. Teaching and learning servant-leadership in the outdoors. *The International Journal of Servant-Leadership*, *14*(1), pp.217-248.

Gass, M.A. & Gillis, h.L. (1995). Focusing on the "solution" rather than the "problem": empowering client change in adventure experiences. Journal of Experiential Education. 18, (2) 63-69. https://doi.org/10.1177%2F105382599501800202

Gelso, C. J., Kivlighan Jr, D. M., & Markin, R. D. (2018). The real relationship and its role in psychotherapy outcome: A meta-analysis. *Psychotherapy*, *55*(4), 434.

Hallford, D. J. (2022). Seeing a psychologist on Medicare? Soon you'll be back to 10 sessions. But we know that's not often enough. *The Conversation*. Retrieved from

https://theconversation.com/seeing-a-psychologist-on-medicare-soon-youll-be-back-to-10-sessions-but-we-know-thats-not-often-enough-194338

Harper, N. J. (2018). *Searching for the core of adventure therapy*. Keynote address given at the 8th International Adventure Therapy Conference, Sydney, Australia.

Headspace Australia (2021). *Young people's experience at headspace: Evaluation in focus*. headspace Australia. Retrieved from https://headspace.org.au/assets/HSTC184-_-Young-People-Snapshot-Report-_-FA.pdf

Hesse, H. (2017). *The journey to the East*. LPeter Owen Publishers.

Lethem, J. (2002). Brief solution focused therapy. *Child and Adolescent Mental Health*, *7*(4), 189-192.

McInnes, B. (2014). One in two is pretty poor odds. Therapy Today, 25(2).

McKergow, M. (2021). The next generation of solution focused practice. Abingdon. Routledge.

McKergow, M. & Bailey, H. (2014). Host: six new roles of engagement. London. Solution Books.

McKergow, M. (2015). How to be a host leader: approaching leadership in a new way using the familiar techniques of hosting. *Development and Learning in Organizations: An International Journal*.

McKergow, M. & Pugliese, P. (2019). The host leadership field book: Building engagement for performance and results. Solution Books.

Mele, A. R., & Shepherd, J. (2013). Situationism and agency. *Journal of Practical Ethics*, *1*(1) 62-83.

Miller, S. D., Hubble, M. A., & Chow, D. (2020). *Better results: Using deliberate practice to improve therapeutic effectiveness*. American Psychological Association.

Miller, S. D., Hubble, M. A., Chow, D. L., & Seidel, J. A. (2013). The outcome of psychotherapy: Yesterday, today, and tomorrow. Psychotherapy © 2013 American Psychological Association 2013, Vol. 50, No. 1, 88–97

Miller, S., Hubble, M., & Duncan, B. (2007). Supershrinks: What's the secret of their success? *Psychotherapy in Australia*, *14*(4), 14–22.

Mitten, D. (1994). Ethical considerations in adventure therapy: A feminist critique. *Women & Therapy*, *15*(3-4), 55-84.

Natynczuk, S. (2019). Host leadership in outdoor, bush, wilderness, and adventure therapy. Mark McKergow & Pirluigi Pugliese (eds). *Host Leadership Field Book: Building Engagement for Performance and Results*. Edinburgh, Solutions Books. Pp 42-52.

Natynczuk, S. (2021) Co-adventuring for change: A solution-focused framework for 'unspoken' therapy outdoors. *Relational Child and Youth Care Practice*, 34 (4), 58-66. Natynczuk, S. & Dobud, W.W. (2021). Leave no trace, wilful unknowing, and implications from the ethics of sustainability for solution-focused practice outdoors. *Journal of Solution Focused Practices*, *5*(2),7.

NHS (2008). Downloaded from www.england.nhs.uk/mental-health/adults/iapt 19th December 2022.

Northouse, P. G. (2013). Leadership. London. Sage. pp.219-251.

Nyland, D. & Corsiglia, V. (1994). Being solution-focused forced in brief therapy: remembering something important we already knew. *Journal of Systemic Therapies*, *13*(1), 12

Owen, J., Miller, S. D., Seidel, J., & Chow, D. (2016). The working alliance in treatment of military adolescents. *Journal of Consulting and Clinical Psychology*, *84*(3), 200.

Pringle, G., Boddy, J., Slattery, M. & Harris, P., (2022). Adventure therapy for adolescents with complex trauma: A scoping review and analysis. *Journal of Experiential Education*.

Ringer, M., & Gillis, H. L. (1996). From Practice to Theory: Uncovering the Theories of Human Change That Are Implicit in Your Work as an Adventure Practitioner. in Spawning New Ideas: A Cycle of Discovery. Retrieved from https://files.eric.ed.gov/fulltext/ED416064.pdf

Saxon, D., Firth, N., & Barkham, M. (2017). The relationship between therapist effects and therapy delivery factors: Therapy modality, dosage, and non-completion. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*(5), 705–715.

Scott, M. J. (2018). Improving access to psychological therapies (IAPT) - the need for radical reform. *Journal of Health Psychology*, *23*(9). https://doi.org/10.1177/1359105318755264

Shennan, G. (2019). Solution-focused practice: Effective communication to facilitate change. 2nd Edition. Red Globe Press.

Simon, G. E., Imel, Z. E., Ludman, E. J., & Steinfeld, B. J. (2012). Is dropout after a first psychotherapy visit always a bad outcome? *Psychiatric Services*, *63*(7), *705–707*.

Sonder. (2022). *headspace Edinburgh North introduced new service model*. Retrieved from https://sonder.net.au/headspace-edinburgh-north-introduces-new-service-model-to-reduce-wait-times/

Strosahl, K. D., Robinson, P. J., & Gustavsson, T. (2012). *Brief interventions for radical change: Principles and practice of focused acceptance and commitment therapy*. New Harbinger Publications.

Sweetman, J., Knapp, P., McMillan, D., Fairhurst, C. Delgadillo, J. & Hewitt, C. (2022). Risk factors for initial appointment non-attendance at Improving Access to Psychological Therapy (IAPT) services: A retrospective analysis. *Psychotherapy Research*, 10.1080/10503307.2022.2140616

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