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# National University of Ireland, Cork

**Psychology's Role in Surf Therapy and the Use of Non-Traditional Spaces and Activities by Clinical Psychologists**

Thesis presented by

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Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology

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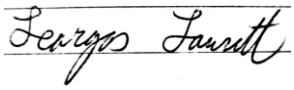
**Declaration:**

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism



**Dedication:**

**For Carolyn,**

**We made it**

**.**

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## Overall Abstract

Clinical psychology is primarily practiced in clinic settings, but clinical psychologists are often required to leave the clinic room to provide therapeutic interventions. When they do, areas of research around conducting therapy in nature, assertive outreach, and psychologically supported activities such as surf therapy may be able to provide guidance. Incorporating knowledge from clinical psychology into such interventions has the potential to enhance client outcomes. In order to explore the concept of psychologically informed, non-clinic-based interventions, this thesis focuses on two areas, study one looks at what can clinical psychology contribute to surf therapy interventions and study two asks what are the experiences and perspectives of clinical psychologists when they leave the clinic room to practice. Study one is a scoping review of surf therapy interventions incorporating psychologically informed components. The results of the review suggest that incorporating psychological theory is potentially beneficial but a theory of change linking them to outcomes is lacking. The included studies also provided little detail on the theory informing as well as the practicalities of these elements. Future research would benefit from more detailed reporting of intervention methodology to facilitate replication and inform clinician practice. Study two involved conducting semi-structured interviews with clinical psychologists in Ireland to garner their perspectives and experiences of working outside of clinic rooms. Seventeen clinical psychologists took part, and the data was analysed using reflexive thematic analysis. Four main themes emerged with several subthemes. The four themes were: *"What!?, leave the sanctity of my clinic space?" Traditional spaces as safe, "We've KPIs to hit" Organisational pressure, Enhancing therapy* and *Wherever you are, you're still a psychologist.* Each theme provides insight into the clinician identified barriers and facilitators to practicing outside of the clinic space, as well as the potential benefits and professional issues involved. These findings demonstrate how clinical psychology can be

taken beyond clinic rooms and be used to reach a wide range of clients who may struggle with traditional clinic-based talk therapies.

# Chapter 1: Introduction

'I know of a cure for everything: salt water. In one way or the other. Sweat, or tears, or the salt sea.' Seven Gothic Tales by Karen Blixen, (1934)

## Overview

Mental health conditions are a leading cause of disability and illness worldwide (James et al., 2018). A variety of biological, psychological, and social interventions, including medication, exercise, diet, social supports, and time in nature, can contribute to recovery from mental health conditions (Grajek et al., 2022; Harandi et al., 2017; Leichsenring et al., 2022; Mahindru et al., 2023; White et al., 2019). It is almost a truism to say that psychological talk therapies are some of the most effective interventions for mental health difficulties. Evidence supports the use of psychological talk therapies for conditions such as depression, anxiety, post-traumatic stress disorder, eating disorders, and others (Dragioti et al., 2017; Hay, 2013; Jericho et al., 2022; Leichsenring et al., 2022, 2023; Lewis et al., 2020; Munder et al., 2018; NICE guideline, 2022; Pellizzer et al., 2026; Tan et al., 2026). However, talk therapies are not suitable for or appealing to everyone. Incorporating elements of traditional talk therapies, informed by psychological theory, with other approaches may make them more effective and acceptable to individuals for whom traditional talk therapy is not appropriate (Anderson & Brownlie, 2011; Armbruster & Kazdin, 1994; Roseborough et al., 2016). One such adaptation is the use of the talking therapy approach outside of the traditional clinical setting and another is the use of adventure-based therapies using natural environments and resources (Conlon et al., 2018; Cooley et al., 2020). The overall aim of this thesis is to help understand how clinical psychology can be used outside of clinic rooms as an intervention for mental health conditions and to incorporate psychological theory into other interventions to enhance other therapeutic activities. The focus of the initial study in this thesis was on how clinical psychology theory and practice is used to enhance and support an existing nature-based

therapy already in use in local mental health services, namely surf therapy. The second study explored the views and experiences of clinical psychologists in Ireland in relation to the use of therapeutic interventions outside of traditional clinical spaces. Both surf therapy and talking therapy outdoors have seen growth in practice in recent years. There has been an increase in the study of surf therapy as an intervention for a range of presenting issues and the Covid-19 pandemic led many clinical psychologists to adopt outdoor practices, initially out of necessity (Cooley et al., 2023).

**Terminology Employed**

There is no clearly agreed-upon term for therapeutic interventions outdoors or in nature. Approaches in nature are often modalities that deliberately combine positive traits of nature along with individual or group therapeutic activities (Fernee et al., 2017). Revell et al. (2014) use the term outdoor therapy to refer to "an intentional psychotherapeutic relationship through which some or all of the programme/sessions have taken place in an outdoor setting (i.e. wilderness, nature, adventure activities, gardening etc)." (Revell et al., 2014, p. 282). Supporting this, Harper and Dobud (2024) suggest that the term outdoor therapies replaced adventure therapy and ecotherapy, although they consider them sub-fields of outdoor therapy. The term nature-based interventions has been used recently for where the focus of an intervention is on connecting with nature (Kaleta et al., 2025) although others refer to this as nature-based therapy (Bonham-Corcoran et al., 2022). Others still use 'nature-based therapy' as a term used for conducting traditional therapy in a natural environment (Harper & Dobud, 2024). The term 'nature-assisted therapy' has been used to encompass horticulture therapies and wilderness therapies (Annerstedt et al., 2011). These terms are obviously not yet clearly defined or delineated and have changed over time. In this thesis I will use the term nature-based therapy to refer to interventions common to clinical psychology practice but conducted in natural environments.

A similar issue to the lack of consistency of terms is that outdoor therapies often lack any psychotherapeutic element or a term to separate those that do from those that do not. Many of these interventions focus purely on time in nature and the benefit of certain activities (Fernee et al., 2017). The definition of surf therapy, which is the focus of the first study in this thesis, does not necessarily include any psychological elements beyond the activity of surfing (International Surf Therapy Organization (ISTO), 2019), although this does not preclude their inclusion. I will use the term 'surf therapy' to refer to interventions aimed at improving participants mental health by engaging in surfing, whether psychological components are incorporated or not.

**Literature review**

When psychological therapy began with Freud, it looked very different to today's psychological therapy (Ellenberger, 1970; Shedler, 2022). When I use the term traditional therapy in this thesis I am not referring to Freud's methods and practices, but current practices within psychological therapy which are typically delivered in clinical settings and use a named theoretical modality or modalities, such as Cognitive Behaviour Therapy (CBT) or its subsequent third wave therapies, or psychodynamic approaches in their modern iteration, or approaches which integrate multiple modalities. There is robust evidence supporting the use of these approaches for the treatment of a wide range of conditions (Abbass et al., 2006; Dragioti et al., 2017).

Clinical psychologists carry out a wide array of tasks including assessment, intervention (direct and indirect, individual and group), consultation, and more and are expected to be able to use therapeutic models such as CBT, family systems, psychodynamic, humanistic, and third wave approaches such as acceptance and commitment therapy (ACT), dialectical behaviour therapy (DBT) and compassion-focused therapy (CFT) (Carr, 2012). Clinical psychologists typically work within clinic rooms and some research has examined

what factors of therapy rooms are influential in patient experiences and outcomes (Hagerup et al., 2024; Punzi & Singer, 2018). The importance of the clinic room has primarily been investigated with relation to psychodynamic therapies, which emphasises continuity in location. but clinical psychologists are expected to carry out a wide range of interventions and tasks including assessments (Bondi & Fewell, 2003). With clinical psychology increasingly being delivered in premises which were not designed specifically for the purpose of therapeutic interventions, little research has examined how clinical psychologists view or experience the rooms they find themselves working in (Punzi & Singer, 2018). Punzi and Singer investigated how clinical psychologists perceive the spaces they use and found participants believed the rooms were important for several reasons, including consistency, and could be more or less supportive of the work done in them when delivering all forms of interventions. Punzi and Singer (2018) also found frustrating factors for clinical psychologists including logistical barriers and the competition between disciplines in adapting rooms for the work of therapy. Research that included psychiatrists in the participants as well as psychologists found that environments are not neutral but are experienced as active ingredients in the delivery of therapy (Hagerup et al., 2024). This suggests a complex relationship with space for clinical psychologists, especially those working on multidisciplinary teams where they may have little control over the spaces they see clients in.

The therapeutic frame is a collection of conditions that allow psychological therapy to take place and are typically kept stable throughout treatment. While the therapeutic frame is emphasised in psychodynamic therapies, it is still used and referenced within other approaches, and within the therapeutic frame a stable location is frequently referenced (Gray, 2013). Some conditions of the frame are a consistent private setting, a set time and session length, the fee and confidentiality on the part of the therapist (Gray, 2013). Besides the therapeutic frame, there are common factors which are also relatively stable across

approaches (Cuijpers et al., 2019; Wampold, 2015). These common factors are thought to be more influential in the outcomes for patients than the individual characteristics of specific therapies (Wampold, 2015). These therapeutic common factors include the therapeutic alliance, positive regard, the therapist, genuineness, cultural adaptation, and expectations (Wampold, 2015).

Supporting the idea that clinical psychologists typically carry out their psychological therapies in clinic-based settings, a survey of clinical psychologists in the United Kingdom (UK) found that only 34% of participants had ever had any experience of working outdoors, prior to the Covid-19 pandemic (Cooley et al., 2023). At the time of writing, the American Psychological Association (APA) has no guidelines on delivering psychological therapies outdoors, however the British Psychological Society (BPS) first published guidelines on how to engage in working outdoors in 2020 (Cooley & Robertson, 2020). Similarly, neither organisation has guidelines on working in client homes, although depending on the team a psychologist works on, this can be an expectation (Division of Clinical Psychology, 2008; Iqbal et al., 2012; Lavender & Hope, 2007; O'Keeffe & Russell, 2019).

Although traditional psychological interventions have strong evidence bases for their efficacy, they are not suited to every group or individual. Estimates of attrition in therapy vary widely but it is a very real issue. One estimate is between 29 and 52 percent of children referred to outpatient psychological therapy drop out (Armbruster & Kazdin, 1994). In a more recent study, dropout was above 50%, with very few clients reaching the dose definition for the evidence-based intervention guidelines, and many more studies have identified the challenge of attrition (e.g. Gaskell et al., 2023; Linardon et al., 2025; Roseborough et al., 2016; Warnick et al., 2012). Even if interventions are effective, they cannot work if they cannot keep patients engaged long enough to experience positive effects. Research has found that receiving preferred treatment is negatively associated with treatment dropout and

positively associated with the therapeutic relationship (Windle et al., 2020). Therefore, approaches that aim to be more patient-centred and adapt to the needs of clients are one way of attempting to address this issue.

There is a growing body of research on the benefits of therapies delivered outside of clinic spaces, for example, through assertive outreach services, and through the incorporation of natural environments (Cooley et al., 2020; Jiménez et al., 2022). 'Assertive outreach' is a community-based approach adopted by many mental health teams in order to engage clients who have been difficult to engage using traditional methods and who are a group historically under served by psychology (Mulder, Jochems, et al., 2014; Mulder, Ruud, et al., 2014). Assertive outreach typically involves a multidisciplinary mental health team engaging patients in the community (Stein & Test, 1980). Disengagement from services among those with significant mental health difficulties is not uncommon (O'Brien et al., 2009). Those who are most vulnerable, including those from minority backgrounds, those experiencing deprivation, and those with a dual diagnosis are most likely to disengage (Kendrick et al., 2000; O'Brien et al., 2009). An important service-level predictor of engagement is the presence of assertive outreach (O'Brien et al., 2009). These groups and individuals typically find it challenging to engage with mental health services due to resource issues, or organisational challenges and paradoxically, those most in need may have the lowest motivation to engage with services (Mulder, Jochems, et al., 2014). While assertive outreach has been shown to be effective in reducing rates of hospitalisation (Bond et al., 1995), it is typically used more by mental health nurses and other professions rather than clinical psychologists (Jiménez et al., 2022).

In using assertive outreach, clinicians often find themselves delivering therapy in community settings, including clients' homes. Conducting therapy in the homes of clients is not typical except with older adults, where it is a growing area of interest and practice,

presenting numerous potential benefits and challenges, while also meeting the specific needs of the population (Catty et al., 2002; Davison et al., 2017; Van Citters & Bartels, 2004; Yang et al., 2009). Outside of older adults, home treatment is also typically facilitated for those with specific anxiety disorders like agoraphobia (Jannoun et al., 1980). There is no guidance currently on delivering psychological therapy in the community, but it is an area that can present new challenges to practitioners such as issues of confidentiality and maintaining boundaries (Rogers, 2014), while also presenting opportunities for reaching marginalised communities (Elgharbawy & Bove, 2025). Research to understand the views and experiences of psychologists around these non-traditional ways of working is lacking.

Another community setting used in assertive outreach is the natural environment and as mentioned above, there has been a surge in the use of the outdoors for conducting talking therapy among clinical psychologists in the UK post-Covid-19 (Cooley et al., 2023). Spending time in nature is associated with good health and wellbeing and these benefits may contribute to the interest in these approaches (James et al., 2021; White et al., 2019). Nature-based activities have been shown to improve mental health across adult populations (Coventry et al., 2021). Nature's restorative impact may support the renewal of personal resources, better allowing individuals to deal with challenging situations which may arise in normal therapy (Berto, 2014). This extends to even reducing the physiological symptoms of stress and the impact of negative mood (Berto, 2014).

Being in nature positively impacts mood, promoting emotional balance (Fu et al., 2025) and interventions whereby people are recommended to spend time in nature, called green prescriptions are growing in popularity and use, showing promising impacts on physical and mental health outcomes (Adewuyi et al., 2023; Nguyen et al., 2023). 'Blue space' is a form of nature exposure characterised by bodies of water that is also being explored for its possible benefits for mental health (Britton et al., 2020; Gascon et al., 2017).

Although blue space interventions are often considered nature-based, similar to green space interventions, some have argued blue space offers unique advantages and experiences such as the level of engagement in the sensory environment (Britton, Kindermann, Domegan, et al., 2020).

Reviews of nature-based interventions rarely consider whether included interventions have additional therapeutic activities or components, what these components are, or how they fit into a theory of change for participants, but focus primarily on the time in nature or the activity (Harper et al., 2021; Kaleta et al., 2025). For example, in Annerstedt et al.'s (2011) review of nature-assisted therapies, several included interventions have additional elements such as group therapy or CBT and it is difficult to then parse out individual effects, although some included papers did direct comparisons with treatment as usual (i.e. Jelalian et al., 2006) which compared CBT and Peer Enhanced Adventure Therapy with Cognitive Behavioural Group therapy and aerobic exercise in overweight adolescents.

Further evidence on nature-based interventions supports their adoption into clinical psychology practice. A systematic review that included three meta-analyses found a small pool of evidence for approaches that involve nature, including horticulture therapy, wilderness therapy, or any therapeutic approach where nature plays a significant part. These results show approaches involving nature are effective in reducing symptoms in a wide range of mental health conditions; however the definition of the therapy is so broad it is difficult to understand what is effective besides time in, and engaging with, nature (Annerstedt et al., 2011). When only including high-evidence grade studies, the results remained largely positive (Annerstedt et al., 2011). This review is promising but used such a heterogenous inclusion of studies it is hard to draw conclusions regarding specific interventions or the role clinical psychology may play in them. It does show that the area of nature-assisted therapies shows promise and requires further research.

Included among nature-based interventions are adventure therapies which are approaches that sometimes include wilderness therapy, camping and adventure education activities. It is a broad field with little consistency in form besides using adventure experiences to improve psychosocial outcomes (Bowen & Neill, 2013). A meta-analysis of adventure therapy found it is effective for improving clinical outcomes and sustaining these at follow up with a pooled short term medium effective size of g=0.47 (Bowen & Neill, 2013). Wilderness therapy, a form of outdoor therapy, has been found to be more effective when it includes additional psychosocial elements such as family therapy, individual therapy, and/or group therapy (Wilson & Lipsey, 2000). However, there is often little detail provided on psychotherapeutic elements incorporated into wilderness therapy (Bettmann et al., 2016), or with nature-based interventions in general (Busk et al., 2022). Although adventure therapy as a title does not always include surf therapy, it is related in that it uses experiential learning and connection with nature as pathways for change (Bowen & Neill, 2013).

A scoping review of therapeutic nature-based programmes for trauma found positives associated with nature-based activities such as reprieve from trauma-related symptoms (Stevens & Truong, 2024). It also found social connectedness was a frequently reported finding from qualitative research, but one that had little attention from quantitative measures. Studies reported participants having the opportunity to create new social identities with others who have had shared experience (e.g. brain injuries), away from pathologizing environments. This suggests that research into these programmes may miss important outcomes by focusing measures on symptom reduction and missing where outdoor programmes enhance wellness. These positive but difficult to measure impacts, are often captured by an evaluative approach called ripple effects mapping, which aims to capture long term changes and consequences of participation in interventions which may be missed by standard measures (Chazdon et al., 2017). Ripple effects mapping was used to evaluate a surf therapy intervention by Wilkie et

al. (2022) who found long-term positives for participants who took part, such as an increase in community participation and the adoption of personally rewarding activities.

While the primary goal of outdoor therapy may not be to get the benefits of exercise and movement, exercise has a strong evidence base for improving mental health outcomes (Bigarella et al., 2022; Ciacchella et al., 2025; Fausto et al., 2023; Rahmati et al., 2024; Singh et al., 2026). In addition, those with mental health conditions are at higher risk of physical health problems and exercise may be especially beneficial for them (Scott & Happell, 2011). A systematic review of exercise interventions with children and adolescents found that exercise reduces depression and anxiety symptoms, and exercise programmes should be considered as part of comprehensive care plans (Singh et al., 2026). This review did not look specifically at interventions where psychological or psychosocial elements were included, but purely at exercise interventions. Approaches that combine these elements may be more effective (Conlon et al., 2018).

With these benefits to being in nature, helping to resource individuals by connecting them more with the natural world during psychological therapies may have additional benefits during and after interventions. A growing area of interest and practice is delivering psychological therapy while walking, with interesting implications for practice, such as changes in the therapeutic frame (Cooley et al., 2023). The Covid-19 pandemic was an important stimulus for sessions being held outside of the clinic (Joschko et al., 2023; Yang et al., 2023). Nature became an important resource in supporting psychological wellbeing for people (Patwary et al., 2022). Carrying out regular psychology sessions outside was found to be acceptable and desirable to both clients and psychologists in an inpatient setting during the pandemic (James et al., 2021). Despite the growing interest in outdoor practices, there are still barriers (individual and organisational) to be overcome in the adoption of these practices

and research needed on their efficacy (Burrell et al., 2025; Cooley et al., 2020; Rishbeth, 2022).

The British Psychological Society produced guidelines on conducting talk therapy outdoors, including during walking (Cooley & Robertson, 2020). Clinicians who regularly use walk and talk therapy highlight its appeal in moving 'stuckness' and building a more collaborative alliance (Revell & McLeod, 2016). However, it is not without its drawbacks, such as challenges in maintaining confidentiality (Revell & McLeod, 2016). In trials, walk-and-talk psychological therapy appears effective, but larger scale research is needed (Dickmeyer et al., 2025; Koziel et al., 2022). One comparison study found similar results from indoor and outdoor psychological therapy sessions (Dickmeyer et al., 2025), and early economic evaluations of nature-based approaches suggest they may be effective, and cost effective, treatments (Busk et al., 2022). Although the psychological therapy being delivered was supportive counselling rather than more active intervention, it demonstrates the acceptability and feasibility of these approaches. Another of the purported benefits, that it may be more acceptable to hard to reach groups, requires further investigation to explore this possibility (Dickmeyer et al., 2025). Despite this growing interest, there is little research with clinical psychologists and their use of these approaches as part of ordinary practice.

In an online survey of people who had engaged with outdoor therapies, participants identified being outdoors, having time to reflect, and group processes as the most important elements (Revell et al., 2014). Similarly, an examination of client experiences of nature during psychological therapy found that clients felt nature enriched their experiences of therapy (Meuwese et al., 2021). A point for consideration is that some therapists working with children note that while these approaches offer many benefits they are not without their challenges such as ethical and safety concerns (Lane & Reed, 2023). Clinicians also needed to figure out how to deliver therapy outdoors on their own, connecting theory with nature in

an unsystematic way (Lane & Reed, 2023). In taking therapy outdoors the therapeutic frame is altered fundamentally, in some ways for the better, but with additional challenges such as balancing a more fluid therapeutic relationship, managing boundaries, and confidentiality (Jordan & Marshall, 2010; Naor & Mayseless, 2021).

In some interventions, conventional approaches are combined with nature-based ideas such as in the University of Copenhagen's Nacadia therapy garden approach which integrated ACT with environmental ideas including permaculture. The intervention was found to be as effective as CBT in the treatment of stress, with additional positive consequences possibly not captured by measures of symptom reduction, such as more openness to nature-based approaches (Corazon et al., 2012; Sidenius et al., 2017; Stigsdotter et al., 2018). Currently, as an emerging area there are various developing frameworks and guidelines (Gobster et al., 2022; Naor & Mayseless, 2021b). Supporting psychologists to leverage the benefits of natural environments and time outdoors for clients is an important endeavour, helping to overcome barriers to engagement and to better meet the needs of diverse populations (Bowen & Neill, 2013; Cooley et al., 2020; Elgharbawy & Bove, 2025).

From an organisational perspective, clinical psychologists often experienced barriers to implementing outdoor walking therapy (Cooley et al., 2020). Clinical psychologists reported feeling like they were going against cultural norms within organisations and that using the outdoors was more permissible for other professions (Cooley et al., 2020). In research with organisational leaders, similar issues related to dominant cultures arose, but a path forward using models of safe uncertainty may be useful for facilitating the use of these approaches with appropriate clients (Cooley et al., 2020; Mason, 1993). However, this research was done with clinicians who use these practices regularly and so the perceived and experienced barriers and necessary facilitators may be different for clinicians less familiar or experienced with these approaches (Cooley et al., 2020).

Research has been carried out on the impact of indoor environments on health and wellbeing, and reviews of the physical therapy environment have found common elements that impact experiences (Morrey et al., 2020; Pressly & Heesacker, 2001; Ulrich, 1991). In one review, Morrey et al. (2020) found that there is a paucity of high-quality empirical research on the relationship between the therapy room and client outcomes, with many included papers examining the meanings of these spaces for therapists and clients. There is little research on how the themes found in these papers might translate to outdoor therapy spaces, though there is some research on spaces that integrate a level of nature into them (Hagerup et al., 2024), where some of the themes coincide with those from therapists who use outdoor spaces such as nature as co-therapist (Cooley et al., 2020).

**The Current Thesis**

Focusing on one area of nature-based therapy, the first study in this thesis looks at surf therapy. This was chosen as one the supervisors of this thesis (LS) delivers a surf therapy intervention in an adult mental health service, alongside an occupational therapist colleague; this intervention has run for several years with promising results. I attended a session of this group as an observer and was struck by the participants' enthusiasm for the intervention and their accounts of its efficacy. Research evaluating this intervention is currently in preparation. The first use of surf therapy began in 1996 (*Surfers Healing*, n.d.) and the first published research in the area was by Morgan (2010). The ways in which surfing may be beneficial for individuals' health are numerous, including exposure to blue spaces, sensory input from the environment, exercise, and learning and mastering a skill (Gascon et al., 2017). The sensory feedback from an activity such as surfing can include things like the motion of the waves, and the coldness and salinity of the water, for example (Benninger et al., 2020). This may be beneficial for mental health outcomes as a regulating environment, as Gascon et al. (2017) found in a systematic review of the area that exposure to nature and blue spaces was

associated with improved mental wellbeing. Finally, the connections of exercise to both positive mental and physical health outcomes are well established (Marquez et al., 2020; Rahmati et al., 2024).

The evidence for an impact of surf therapy as an intervention to improve mental health/wellbeing is inconsistent, with a paucity of high-quality research found in the area of treating mental health conditions in adults (Benninger et al., 2020; Carneiro et al., 2024; Knowles et al., 2026). The mechanisms through which surf therapy may work are also poorly understood, with positive impacts attributed to; blue space, social elements, learning a new skill, physical exercise, being a resilience builder, and more. One view of surf therapy is as an exercise intervention that attracts individuals who would not sign up for, nor participate in, standard psychotherapeutic approaches but are more amenable to partaking in a surf group (Benninger et al., 2020). Much surf therapy research has reported it was designed to appeal to hard-to-reach groups, although to the best of our knowledge the success of recruiting difficult to engage groups has not been measured (Franceschi et al., 2024; Knowles et al., 2026; Leonard et al., 2024; Marshall et al., 2021; Sarkisian et al., 2020). Surf therapy's strength may not be in the unique benefits of the intervention but in its appeal to hard-to-reach groups who would not engage in traditional therapies.

Many surf therapy interventions use additional psychological interventions either adjacent to or incorporated into the surf therapy (Benninger et al., 2020; Knowles et al., 2026). A previous review of the area by Benninger et al (2020), noted the lack of standardisation of this element of surf therapy and recommended it be made clear in future research if surf therapy is supplemented by additional components, and if so how. A more recent review of surf therapy for adults, suggests additional components add to the interventions in different ways and could be tailored for different population needs (Knowles et al., 2026). In wilderness therapy, studies frequently do not report all the elements of the

intervention and therefore the theory of change within these is a black box (Fernee et al., 2017). Surf therapy has a similar issue. The additional activities in surf therapy interventions - including shared development and socialising (in a class setting) (Morgan, 2010), the use of psychological knowledge during delivery (such as when it is delivered by clinicians who integrate clinical training and techniques into the surfing environment), or as a standalone exercise/ wellbeing intervention (Benninger et al., 2020) - may promote psychological wellness. This is further explored in Study 1.

In Study 2, the thesis turns to the views and experiences of clinical psychologists in delivering psychological therapy outside of the clinic setting, whether through nature-based therapy, assertive outreach, or other psychological therapy outdoors. There is scarce research on clinical psychologists' experiences, or use of, nature-based therapy and where they are included it is usually incidentally (Naor & Mayseless, 2021b) or psychology is available to participants but not directly a part of the intervention (Conlon et al., 2018). In an exploration of the practice of therapy in nature, Berger (2010) revisits personal instances of practicing in nature, and notes that they needed to be integrative and adaptive, drawing from many theories and models to be effective. As a result of clinical psychologists training in a wide variety of approaches, and an expectation to be able to adapt to situations and clients, they may be well placed to deliver therapy in nature.

Little is known specifically about clinical psychologists' work outside of the clinic room. Recent research looking at clinical psychologists' experiences of working in nature shows that those who use nature find it beneficial (Felder, 2026). This research combined with findings from Cooley et al., (2020) and guidelines from the BPS (Cooley & Robertson, 2020) could help psychologists bring nature into their practice and gain the associated benefits including those related to time spent in nature and expanded practice possibilities.

There are many barriers to overcome for the adoption of nature-based interventions, some are cultural and systemic, others are from the side of the clients and the mental health practitioners (Burrell et al., 2025; Mitchell et al., 2024). In interviews with mental health clinicians, including psychologists, participants saw a wide range of potential benefits to nature-based approaches, but also noted barriers to implementing them (Tambyah et al., 2022). A key feature named as a barrier to adoption/implementation is organisational culture and policy. In investigations to barriers to commissioning nature-based interventions (specifically a form of therapeutic horticulture) commissioners said that a lack of knowledge, and a culture that prioritises traditional medical approaches, were the main barriers (Wood et al., 2024). This organisational barrier can remain even after training in these approaches (Mitchell et al., 2024).

Little is known about the current practices of clinical psychologists in Ireland, and how the dominant organisations such as the Health Service Executive (HSE), local geography, training programmes etc. may create facilitators and barriers to these practices. There may be several reasons that clinical psychologists have difficulty adopting these approaches, including those related to their professional self-efficacy and identity formation (Schubert et al., 2023). A scoping review by Schubert et al., on the literature related to clinical psychologists' development of professional identity found that they have challenges accepting the role of expert, experiencing high levels of self-doubt. Working within a recovery model was found to be made more challenging by disruptions in integrating personal and professional identity. In Ireland, this may be exacerbated by the dominance of the biomedical model and the structure of mental health teams as being led by consultant psychiatrists, as professional insecurity may result in psychologists defaulting to the dominant model or view (Schubert et al., 2023). However, research in systems with more horizontally organised multidisciplinary teams suggests psychologists on those teams have

similar issues (Wilson, 2025). The review also found that clinical psychologists value integrating personal and professional values into their professional identity, this means for psychologists who value nature and the environment, there are opportunities to bring together these values within their practice (Schubert et al., 2023; *Special Interest Group for Addressing Climate and Environmental Emergency*, n.d.).

Clinical psychologists have also been found to be under-represented in assertive outreach teams (Roe et al., 2006), although it is not known whether this is true currently, or in Ireland specifically. Roe et al. (2006) highlight potential reasons for this, including gaps in training and systemic factors, while highlighting the potential importance of clinical psychology's place on these teams. Clinical psychologists on healthcare teams can bridge evidence-practice gaps, provide supervision, deliver therapy, and provide compassionate leadership (Juggernauth, 2025; Roe et al., 2006). Study two will address the lack of research on clinical psychologists' use of non-traditional therapy spaces as part of nature-based therapy, assertive outreach, or using activities to enhance therapy.

The overall aim of this thesis is to help understand how clinical psychology can be used outside of clinic rooms as an intervention for mental health conditions and to enhance other therapeutic activities, including surf therapy, and to understand the experiences and perceptions of clinical psychologists when conducting interventions outside of the clinic. These are further broken down and discussed in the individual chapters.

## References

Abbass, A. A., Hancock, J. T., Henderson, J., & Kisely, S. (2006). Short-term psychodynamic psychotherapies for common mental disorders. *The Cochrane Database of Systematic Reviews*, (4), CD004687. https://doi.org/10.1002/14651858.CD004687.pub3

Anderson, S., & Brownlie, J. (2011). Build it and they will come? Understanding public views of 'emotions talk' and the talking therapies. *British Journal of Guidance & Counselling*, *39*(1), 53–66. https://doi.org/10.1080/03069885.2010.531385

Annerstedt, M., Währborg, P., & Sveriges lantbruksuniversitet. (2011). Nature-assisted therapy: Systematic review of controlled and observational studies. *Scandinavian Journal of Public Health*, *39*(4), 371–388. https://doi.org/10.1177/1403494810396400

Armbruster, P., & Kazdin, A. E. (1994). Attrition in child psychotherapy. In *Advances in clinical child psychology* (pp. 81–108). Springer.

Benninger, E., Curtis, C., Sarkisian, G. V., Rogers, C. M., Bender, K., & Comer, M. (2020). Surf therapy: A scoping review of the qualitative and quantitative research evidence. *Glob. J. Community Psychol. Pract*, *11*, 1–26.

Berger, R. (2010). Nature Therapy: Thoughts About the Limitations of Practice. *Journal of Humanistic Psychology*, *50*(1), 65–76. https://doi.org/10.1177/0022167809333999

Berto, R. (2014). The Role of Nature in Coping with Psycho-Physiological Stress: A Literature Review on Restorativeness. *Behavioral Sciences*, *4*(4), 394–409. https://doi.org/10.3390/bs4040394

Bettmann, J. E., Gillis, H. L., Speelman, E. A., Parry, K. J., & Case, J. M. (2016). A Meta-analysis of Wilderness Therapy Outcomes for Private Pay Clients. *Journal of Child and Family Studies*, *25*(9), 2659–2673. https://doi.org/10.1007/s10826-016-0439-0

Bigarella, L. G., Ballotin, V. R., Mazurkiewicz, L. F., Ballardin, A. C., Rech, D. L., Bigarella, R. L., & Selistre, L. da S. (2022). Exercise for depression and depressive symptoms in older adults: An umbrella review of systematic reviews and Meta-analyses. *Aging & Mental Health*, *26*(8), 1503–1513. https://doi.org/10.1080/13607863.2021.1951660

Blixen, K. (1934). *Seven Gothic tales*. Penguin.

Bond, G. R., McGrew, J. H., & Fekete, D. M. (1995). Assertive outreach for frequent users of psychiatric hospitals: A meta-analysis. *The Journal of Mental Health Administration*, *22*(1), 4–16. https://doi.org/10.1007/BF02519193

Bondi, L., & Fewell, J. (2003). 'Unlocking the cage door': The spatiality of counselling. *Social & Cultural Geography*, *4*(4), 527–547. https://doi.org/10.1080/1464936032000137948

Bonham-Corcoran, M., Armstrong, A., O'Briain, A., Cassidy, A., & Turner, N. (2022). The benefits of nature-based therapy for the individual and the environment: An integrative review. *Irish Journal of Occupational Therapy*, *50*(1), 16–27. https://doi.org/10.1108/IJOT-06-2021-0015

Bowen, D. J., & Neill, J. T. (2013). A Meta-Analysis of Adventure Therapy Outcomes and Moderators. *The Open Psychology Journal*, *6*(1), 28–53. https://doi.org/10.2174/1874350120130802001

Britton, E., Kindermann, G., Domegan, C., & Carlin, C. (2020). Blue care: A systematic review of blue space interventions for health and wellbeing. *Health Promotion International*, *35*(1), 50–69. https://doi.org/10.1093/heapro/day103

Burrell, M. W., Barton, J., Reinhardt, G. Y., & Wood, C. J. (2025). Psychological, psychosocial and physical barriers preventing nature-based intervention participation

in adults with mental health disorders: A scoping review. *Journal of Health Psychology*, *30*(8), 1735–1750. https://doi.org/10.1177/13591053241270410

Busk, H., Sidenius, U., Kongstad, L. P., Corazon, S. S., Petersen, C. B., Poulsen, D. V., Nyed, P. K., & Stigsdotter, U. K. (2022). Economic Evaluation of Nature-Based Therapy Interventions—A Scoping Review. *Challenges*, *13*(1), 23. https://doi.org/10.3390/challe13010023

Carneiro, L., Clemente, F. M., Claudino, J. G., Ferreira, J., Ramirez-Campillo, R., & Afonso, J. (2024). Surf therapy for people with mental health disorders: A systematic review of randomized and non-randomized controlled trials. *BMC Complementary Medicine and Therapies*, *24*, 376. https://doi.org/10.1186/s12906-024-04674-0

Carr, A. (2012). *Clinical psychology: An introduction* (1. publ). Routledge.

Catty, J., Burns, T., Knapp, M., Watt, H., Wright, C., Henderson, J., & Healey, A. (2002). Home treatment for mental health problems: A systematic review. *Psychological Medicine*, *32*(3), 383–401. https://doi.org/10.1017/S0033291702005299

Chazdon, S., Emery, M., Hansen, D., Higgins, L., & Sero, R. (2017). *A field guide to ripple effects mapping*. University of Minnesota Libraries Publishing.

Ciacchella, C., Collacchi, B., Fiorillo, A., Sampogna, G., & Cirulli, F. (2025). Impact of structured physical activity on youth's mental health: A review of umbrella reviews. *International Journal of Social Psychiatry*, *71*(7), 1219–1234. https://doi.org/10.1177/00207640251342425

Conlon, C. M., Wilson, C. E., Gaffney, P., & Stoker, M. (2018). Wilderness therapy intervention with adolescents: Exploring the process of change. *Journal of Adventure Education and Outdoor Learning*, *18*(4), 353–366. https://doi.org/10.1080/14729679.2018.1474118

Cooley, S., Jones, C. R., Kurtz, A., & Robertson, N. (2020). 'Into the Wild': A meta-synthesis of talking therapy in natural outdoor spaces. *Clinical Psychology Review*, *77*, 101841.

Cooley, S., & Robertson, N. (2020). *The use of talking therapy outdoors*.

Cooley, S., Taylor, E., Ceslikauskaite, K., & Robertson, N. (2023). Outdoor therapy: Maverick or mainstream? A survey of clinical psychologists. *Clinical Psychology Forum*, *1*(370), 21–31. https://doi.org/10.53841/bpscpf.2023.1.370.21

Corazon, S. S., Stigsdotter, U. K., Moeller, M. S., & Rasmussen, S. M. (2012). Nature as therapist: Integrating permaculture with mindfulness- and acceptance-based therapy in the Danish Healing Forest Garden Nacadia. *European Journal of Psychotherapy & Counselling*, *14*(4), 335–347. https://doi.org/10.1080/13642537.2012.734471

Coventry, P. A., Brown, JenniferV. E., Pervin, J., Brabyn, S., Pateman, R., Breedvelt, J., Gilbody, S., Stancliffe, R., McEachan, R., & White, PiranC. L. (2021). Nature-based outdoor activities for mental and physical health: Systematic review and meta-analysis. *SSM - Population Health*, *16*, 100934. https://doi.org/10.1016/j.ssmph.2021.100934

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). The Role of Common Factors in Psychotherapy Outcomes. *Annual Review of Clinical Psychology*, *15*(Volume 15, 2019), 207–231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

Davison, T. E., Koder, D., Helmes, E., Doyle, C., Bhar, S., Mitchell, L., Hunter, C., Knight, B., & Pachana, N. (2017). Brief on the Role of Psychologists in Residential and Home Care Services for Older Adults. *Australian Psychologist*, *52*(6), 397–405. https://doi.org/10.1111/ap.12209

*DCP Briefing Paper No 30: The role of psychologists in Crisis Resolution Home Treatment (CRHT) Teams: Cover* (p. bpsrep.2008.inf143). (2008). British Psychological Society. https://doi.org/10.53841/bpsrep.2008.inf143

Dickmeyer, A., Smith, J. J., Halpin, S., McMullen, S., Drew, R., Morgan, P., Valkenborghs, S., Kay-Lambkin, F., & Young, M. D. (2025). Walk-and-Talk Therapy Versus Conventional Indoor Therapy for Men With Low Mood: A Randomised Pilot Study. *Clinical Psychology & Psychotherapy*, *32*(1), e70035. https://doi.org/10.1002/cpp.70035

Dragioti, E., Karathanos, V., Gerdle, B., & Evangelou, E. (2017). Does psychotherapy work? An umbrella review of meta-analyses of randomized controlled trials. *Acta Psychiatrica Scandinavica*, *136*(3), 236–246. https://doi.org/10.1111/acps.12713

Elgharbawy, H., & Bove, C. (2025). Beyond the office: The role of clinical outreach services in counselling with Indigenous youth and families. *Clinical Psychology Review*, *120*, 102615. https://doi.org/10.1016/j.cpr.2025.102615

Ellenberger, H. F. (1970). *The discovery of the unconscious: The history and evolution of dynamic psychiartry*. Basic Books.

Fausto, D. Y., Leitão, A. E., Silveira, J., Martins, J. B. B., Dominski, F. H., & Guimarães, A. C. A. (2023). An umbrella systematic review of the effect of physical exercise on mental health of women in menopause. *Menopause*, *30*(2), 225. https://doi.org/10.1097/GME.0000000000002105

Felder, L. (2026). *Inviting nature into the room: A conversation with clinical psychology* [Doctoral Thesis]. University of Southampton.

Fernee, C. R., Gabrielsen, L. E., Andersen, A. J. W., & Mesel, T. (2017). Unpacking the Black Box of Wilderness Therapy: A Realist Synthesis. *Qualitative Health Research*, *27*(1), 114–129. https://doi.org/10.1177/1049732316655776

Franceschi, L., Small, N., Goldsby, T., Goldsby, M., Padamada, S., Ziegler, M. G., & Mills, P. J. (2024). The Groundswell Community Surf Therapy Intervention for At-Risk Women and Changes in Body Acceptance, Resilience, and Emotional Regulation. *Global Advances in Integrative Medicine and Health*, *13*, 27536130241278970. https://doi.org/10.1177/27536130241278970

Gascon, M., Zijlema, W., Vert, C., White, M. P., & Nieuwenhuijsen, M. J. (2017). Outdoor blue spaces, human health and well-being: A systematic review of quantitative studies. *International Journal of Hygiene and Environmental Health*, *220*(8), 1207–1221. https://doi.org/10.1016/j.ijheh.2017.08.004

Gaskell, C., Simmonds-Buckley, M., Kellett, S., Stockton, C., Somerville, E., Rogerson, E., & Delgadillo, J. (2023). The Effectiveness of Psychological Interventions Delivered in Routine Practice: Systematic Review and Meta-analysis. *Administration and Policy in Mental Health*, *50*(1), 43–57. https://doi.org/10.1007/s10488-022-01225-y

Gobster, P. H., Schultz, C. L., Kruger, L. E., & Henderson, J. R. (2022). Forest Therapy Trails: A Conceptual Framework and Scoping Review of Research. *Forests*, *13*(10), 1613. https://doi.org/10.3390/f13101613

Grajek, M., Krupa-Kotara, K., Białek-Dratwa, A., Sobczyk, K., Grot, M., Kowalski, O., & Staśkiewicz, W. (2022). Nutrition and mental health: A review of current knowledge about the impact of diet on mental health. *Frontiers in Nutrition*, *9*. https://doi.org/10.3389/fnut.2022.943998

Gray, A. (2013). *An introduction to the therapeutic frame*. Routledge.

Hagerup, A., Wijk, H., Lindahl, G., & Olausson, S. (2024). It looks like nature—A phenomenological study of the built environment in psychotherapy from psychologists' and psychiatrists' perspective. *International Journal of Qualitative*

*Studies on Health and Well-Being*, *19*(1), 2408812. https://doi.org/10.1080/17482631.2024.2408812

Harandi, T. F., Taghinasab, M. M., & Nayeri, T. D. (2017). The correlation of social support with mental health: A meta-analysis. *Electronic Physician*, *9*(9), 5212–5222. https://doi.org/10.19082/5212

Harper, N. J., & Dobud, W. W. (2024). What Is Outdoor Therapy? A New Name for an Old Therapeutic Practice. *OBM Integrative and Complementary Medicine*, *09*(04), 1–15. https://doi.org/10.21926/obm.icm.2404065

Harper, N. J., Fernee, C. R., & Gabrielsen, L. E. (2021). Nature's Role in Outdoor Therapies: An Umbrella Review. *International Journal of Environmental Research and Public Health*, *18*(10), Article 10. https://doi.org/10.3390/ijerph18105117

Hay, P. (2013). A systematic review of evidence for psychological treatments in eating disorders: 2005–2012. *International Journal of Eating Disorders*, *46*(5), 462–469. https://doi.org/10.1002/eat.22103

*History | Surfers Healing*. (n.d.). Retrieved 28 March 2026, from https://www.surfershealing.org/node/3

International Surf Therapy Organization. (2019). *International Surf Therapy Organization—About*. https://intlsurftherapy.org/, https://intlsurftherapy.org/

Iqbal, N., Nkire, N., Nwachukwu, I., Young, C., & Russell, V. (2012). Home-based treatment and psychiatric admission rates: Experience of an adult community mental health service in Ireland. *International Journal of Psychiatry in Clinical Practice*, *16*(4), 300–306. https://doi.org/10.3109/13651501.2012.687450

James, G., Kidd, K., Cooley, S., & Fenton, K. (2021). The Feasibility of Outdoor Psychology Sessions in an Adult Mental Health Inpatient Rehabilitation Unit: Service User and

Psychologist Perspectives. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.769590

James, S., Abate, D., Abate, K. H., Abay, S. M., Abbafati, C., Abbasi, N., Abbastabar, H., Abd-Allah, F., Abdela, J., Abdelalim, A., Abdollahpour, I., Abdulkader, R. S., Abebe, Z., Abera, S. F., Abil, O. Z., Abraha, H. N., Abu-Raddad, L. J., Abu-Rmeileh, N. M. E., Accrombessi, M. M. K., … Murray, C. J. L. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: A systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, *392*(10159), 1789–1858. https://doi.org/10.1016/S0140-6736(18)32279-7

Jannoun, L., Munby, M., Catalan, J., & Gelder, M. (1980). A home-based treatment program for agoraphobia: Replication and controlled evaluation. *Behavior Therapy*, *11*(3), 294–305. https://doi.org/10.1016/S0005-7894(80)80047-5

Jelalian, E., Mehlenbeck, R., Lloyd-Richardson, E. E., Birmaher, V., & Wing, R. R. (2006). 'Adventure therapy' combined with cognitive-behavioral treatment for overweight adolescents. *International Journal of Obesity*, *30*(1), 31–39. https://doi.org/10.1038/sj.ijo.0803069

Jericho, B., Luo, A., & Berle, D. (2022). Trauma-focused psychotherapies for post-traumatic stress disorder: A systematic review and network meta-analysis. *Acta Psychiatrica Scandinavica*, *145*(2), 132–155. https://doi.org/10.1111/acps.13366

Jiménez, J. D., Guillén-Guzmán, E., Oliva, V., Ballesteros-Urpi, A., & Pardo-Hernandez, H. (2022). Theoretical approaches to the engagement with patients in case-management programmes and assertive outreach teams: A systematic review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *29*(5), 647–658. https://doi.org/10.1111/jpm.12831

Jordan, M., & Marshall, H. (2010). Taking counselling and psychotherapy outside: Destruction or enrichment of the therapeutic frame? *European Journal of Psychotherapy & Counselling*, *12*(4), 345–359. https://doi.org/10.1080/13642537.2010.530105

Joschko, L., Pálsdóttir, A. M., Grahn, P., & Hinse, M. (2023). Nature-Based Therapy in Individuals with Mental Health Disorders, with a Focus on Mental Well-Being and Connectedness to Nature—A Pilot Study. *International Journal of Environmental Research and Public Health*, *20*(3), 2167. https://doi.org/10.3390/ijerph20032167

Juggernauth, P. (2025). *The Experience of Clinical Psychologists Enacting Compassionate Leadership in Health and Social Care Settings* [Doctoral, University of Hertfordshire]. https://uhra.herts.ac.uk/id/eprint/26133/

Kaleta, B., Campbell, S., O'Keeffe, J., & Burke, J. (2025). Nature-based interventions: A systematic review of reviews. *Frontiers in Psychology*, *16*. https://doi.org/10.3389/fpsyg.2025.1625294

Kendrick, T., Burns, T., Garland, C., Greenwood, N., & Smith, P. (2000). Are specialist mental health services being targeted on the most needy patients? The effects of setting up special services in general practice. *The British Journal of General Practice*, *50*(451), 121–126.

Knowles, N., Ladwa, A., Price, L., Wright, K., Gillison, F., Harrison, J., & Anderson, R. (2026). Explaining how, why, for whom and when surf therapy improves mental health and wellbeing in adults: A realist synthesis. *Advances in Mental Health*, *0*(0), 1–27. https://doi.org/10.1080/18387357.2026.2644914

Koziel, N., Vigod, S., Price, J., Leung, J., & Hensel, J. (2022). Walking Psychotherapy As a Health Promotion Strategy to Improve Mental and Physical Health for Patients and Therapists: Clinical Open-Label Feasibility Trial. *Canadian Journal of Psychiatry.*

*Revue Canadienne de Psychiatrie*, *67*(2), 153–155. https://doi.org/10.1177/07067437211039194

Lane, D., & Reed, P. (2023). The nature space. A reflexive thematic analysis of therapists' experiences of 1:1 nature-based counselling and psychotherapy with children and young people: Exploring perspectives on the influence of nature within the therapeutic process. *Counselling and Psychotherapy Research*, *23*(2), 432–445. https://doi.org/10.1002/capr.12531

Lavender, T., & Hope, R. (2007). New Ways of Working for Applied Psychologists. *Clinical Psychology Forum*, *1*(169), 39–43. https://doi.org/10.53841/bpscpf.2007.1.169.39

Leichsenring, F., Abbass, A., Heim, N., Keefe, J. R., Kisely, S., Luyten, P., Rabung, S., & Steinert, C. (2023). The status of psychodynamic psychotherapy as an empirically supported treatment for common mental disorders – an umbrella review based on updated criteria. *World Psychiatry*, *22*(2), 286–304. https://doi.org/10.1002/wps.21104

Leichsenring, F., Steinert, C., Rabung, S., & Ioannidis, J. P. A. (2022). The efficacy of psychotherapies and pharmacotherapies for mental disorders in adults: An umbrella review and meta-analytic evaluation of recent meta-analyses. *World Psychiatry*, *21*(1), 133–145. https://doi.org/10.1002/wps.20941

Leonard, A., Tairi ,Tatiana, & and Blampied, N. M. (2024). Tai Wātea/Waves of freedom: An evaluation of a surf therapy programme for improving psychosocial functioning in young men at high risk of adverse life outcomes. *Journal of Adventure Education and Outdoor Learning*, *24*(3), 488–508. https://doi.org/10.1080/14729679.2022.2153370

Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological therapies for post-traumatic stress disorder in adults: Systematic review and meta-

analysis. *European Journal of Psychotraumatology*, *11*(1), 1729633. https://doi.org/10.1080/20008198.2020.1729633

Linardon, J., Messer, M., Reid, R., Bolger, T., & Andersson, G. (2025). Absolute and relative rates of treatment non-initiation, dropout, and attrition in internet-based and face-to-face cognitive-behavioral therapy: A meta-analysis of randomized controlled trials. *Cognitive Behaviour Therapy*, 1–14. https://doi.org/10.1080/16506073.2025.2542364

Mahindru, A., Patil, P., & Agrawal, V. (2023). Role of Physical Activity on Mental Health and Well-Being: A Review. *Cureus*, *15*(1), e33475. https://doi.org/10.7759/cureus.33475

Marquez, D. X., Aguiñaga, S., Vásquez, P. M., Conroy, D. E., Erickson, K. I., Hillman, C., Stillman, C. M., Ballard, R. M., Sheppard, B. B., Petruzzello, S. J., King, A. C., & Powell, K. E. (2020). A systematic review of physical activity and quality of life and well-being. *Translational Behavioral Medicine*, *10*(5), 1098–1109. https://doi.org/10.1093/tbm/ibz198

Marshall, J., Kamuskay, S., Samai, M. M., Marah, I., Tonkara, F., Conteh, J., Keita, S., Jalloh, O., Missalie, M., Bangura, M., Messeh-Leone, O., Leone, M., Ferrier, B., & Martindale, R. (2021). A Mixed Methods Exploration of Surf Therapy Piloted for Youth Well-Being in Post-Conflict Sierra Leone. *International Journal of Environmental Research and Public Health*, *18*(12), 6267. https://doi.org/10.3390/ijerph18126267

Mason, B. (1993). Towards positions of safe uncertainty. *Human Systems*, *3–4*(4), 189–200.

Meuwese, D., van der Voort, N., Dijkstra, K., Krabbendam, L., & Maas, J. (2021). The Value of Nature During Psychotherapy: A Qualitative Study of Client Experiences. *Frontiers in Psychology*, *12*, 765177. https://doi.org/10.3389/fpsyg.2021.765177

Mitchell, S. B., Chapman, B., Hayes, R., Bonnici, H., Banks, H., Mareva, S., & Hardwick, R. (2024). Nature-based approaches: A mixed methods study of facilitators and barriers to implementation in CAMHS. *BMC Health Services Research*, *24*(1), 1369. https://doi.org/10.1186/s12913-024-11541-8

Morgan, P. (2010). 'Get Up. Stand Up.' Riding to resilience on a surfboard. *Child & Family Social Work*, *15*(1), 56–65. https://doi.org/10.1111/j.1365-2206.2009.00637.x

Morrey, T., Larkin, M., & Rolfe, A. (2020). What claims are made about clients and therapists' experiences of psychotherapy environments in empirical research? A systematic mixed-studies review and narrative synthesis. *Counselling and Psychotherapy Research*, *20*(4), 666–679. https://doi.org/10.1002/capr.12336

Mulder, C. L., Jochems, E., & Kortrijk, H. E. (2014). The motivation paradox: Higher psychosocial problem levels in severely mentally ill patients are associated with less motivation for treatment. *Social Psychiatry and Psychiatric Epidemiology*, *49*(4), 541–548. https://doi.org/10.1007/s00127-013-0779-7

Mulder, C. L., Ruud, T., Bahler, M., Kroon, H., & Priebe, S. (2014). The availability and quality across Europe of outpatient care for difficult-to-engage patients with severe mental illness: A survey among experts. *International Journal of Social Psychiatry*, *60*(3), 304–310. https://doi.org/10.1177/0020764013485941

Munder, T., Flückiger, C., Leichsenring, F., Abbass, A. A., Hilsenroth, M. J., Luyten, P., Rabung, S., Steinert, C., & Wampold, B. E. (2018). Is psychotherapy effective? A re-analysis of treatments for depression. *Epidemiology and Psychiatric Sciences*, *28*(3), 268–274. https://doi.org/10.1017/S2045796018000355

Naor, L., & Mayseless, O. (2021a). The therapeutic process in nature-based therapies from the perspectives of facilitators: A qualitative inquiry. *Ecopsychology*, *13*(4), 284–293.

Naor, L., & Mayseless, O. (2021b). Therapeutic factors in nature-based therapies: Unraveling the therapeutic benefits of integrating nature in psychotherapy. *Psychotherapy*, *58*(4), 576–590. https://doi.org/10.1037/pst0000396

NICE guideline. (2022). *Depression in adults: Treatment and management*. National Institute for Health and Care Excellence.

O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*, *44*(7), 558–568. https://doi.org/10.1007/s00127-008-0476-0

O'Keeffe, B., & Russell, V. (2019). Home treatment services for acute mental disorders: An all-Ireland survey. *Irish Journal of Psychological Medicine*, *36*(1), 7–17. https://doi.org/10.1017/ipm.2017.83

Patwary, M. M., Dzhambov, A., Disha, A. S., Bardhan, M., Haque, M. Z., Rahman, M. A., Tareq, M. F., Browning, M. H. E. M., Larson, L. R., Alam, M. A., Labib, S. M., Shuvo, F. K., & Parkinson, C. (2022). Exposure to nature during the COVID-19 pandemic and the associated effect on mental health: A systematic review with meta-analysis. *The Lancet Planetary Health*, *6*, S20. https://doi.org/10.1016/S2542-5196(22)00282-0

Pellizzer, M. L., Zhou, Y., de Valle, M. K., Linardon, J., & Wade, T. D. (2026). A Timely Update: An Umbrella Review and Meta-Meta-Analysis of Psychotherapy for Non-Underweight Eating Disorders. *International Journal of Eating Disorders*, *59*(1), 3–15. https://doi.org/10.1002/eat.24567

Pressly, P. K., & Heesacker, M. (2001). The Physical Environment and Counseling: A Review of Theory and Research. *Journal of Counseling & Development*, *79*(2), 148–160. https://doi.org/10.1002/j.1556-6676.2001.tb01954.x

Punzi, E., & Singer, C. (2018). ‘Any room won’t do.’ Clinical psychologists’ understanding of the consulting room. An interview study. *Psychodynamic Practice*, *24*(4), 319–333. https://doi.org/10.1080/14753634.2018.1526107

Rahmati, M., Lee, S., Yon, D. K., Lee, S. W., Udeh, R., McEvoy, M., Oh, H., Butler, L., Keyes, H., Barnett, Y., Koyanagi, A., Shin, J. I., & Smith, L. (2024). Physical activity and prevention of mental health complications: An umbrella review. *Neuroscience & Biobehavioral Reviews*, *160*, 105641. https://doi.org/10.1016/j.neubiorev.2024.105641

Revell, S., Duncan, E., & Cooper, M. (2014). Helpful aspects of outdoor therapy experiences: An online preliminary investigation. *Counselling and Psychotherapy Research*, *14*(4), 281–287. https://doi.org/10.1080/14733145.2013.818159

Revell, S., & McLeod, J. (2016). Experiences of therapists who integrate walk and talk into their professional practice. *Counselling and Psychotherapy Research*, *16*(1), 35–43. https://doi.org/10.1002/capr.12042

Rishbeth, C. (2022). *Included outside: Engaging people living with disabilities in nature*. Natural England.

Roe, D., Yanos, P. T., & Lysaker, P. H. (2006). Overcoming Barriers to Increase the Contribution of Clinical Psychologists to Work With Persons With Severe Mental Illness. *Clinical Psychology: Science and Practice*, *13*(4), 376–383. https://doi.org/10.1111/j.1468-2850.2006.00051.x

Rogers, S. (2014). The Moving Psychoanalytic Frame: Ethical Challenges for Community Practitioners. *International Journal of Applied Psychoanalytic Studies*, *11*(2), 151–162. (96311032). https://doi.org/10.1002/aps.1403

Roseborough, D. J., McLeod, J. T., & Wright, F. I. (2016). Attrition in Psychotherapy: A Survival Analysis. *Research on Social Work Practice*, *26*(7), 803–815. https://doi.org/10.1177/1049731515569073

Sarkisian, G. V., Curtis, C., & Rogers, C. M. (2020). Emerging hope: Outcomes of a one-day surf therapy program with youth at-promise. *Global Journal of Community Psychology Practice*, *11*(2).

Schubert, S., Buus, N., Monrouxe, L. V., & Hunt, C. (2023). The development of professional identity in clinical psychologists: A scoping review. *Medical Education*, *57*(7), 612–626. https://doi.org/10.1111/medu.15082

Scott, D., & Happell, B. (2011). The high prevalence of poor physical health and unhealthy lifestyle behaviours in individuals with severe mental illness. *Issues in Mental Health Nursing*, *32*(9), 589–597.

Shedler, J. (2022). That Was Then, This is Now: Psychoanalytic Psychotherapy for the Rest of us. *Contemporary Psychoanalysis*, *58*(2–3), 405–437. https://doi.org/10.1080/00107530.2022.2149038

Sidenius, U., Stigsdotter, U. K., Varning Poulsen, D., & Bondas, T. (2017). "I look at my own forest and fields in a different way": The lived experience of nature-based therapy in a therapy garden when suffering from stress-related illness. *International Journal of Qualitative Studies on Health and Well-Being*, *12*(1), 1324700. https://doi.org/10.1080/17482631.2017.1324700

Singh, B., Bennett, H., Miatke, A., Dumuid, D., Curtis, R., Ferguson, T., Brinsley, J., Szeto, K., Eglitis, E., Zhou, M., Simpson, C. E. M., Petersen, J. M., Firth, J., & Maher, C. A. (2026). Systematic Umbrella Review and Meta-Meta-Analysis: Effectiveness of Physical Activity in Improving Depression and Anxiety in Children and Adolescents.

*Journal of the American Academy of Child & Adolescent Psychiatry*, *65*(2), 171–186. https://doi.org/10.1016/j.jaac.2025.04.007

*Special Interest Group for Addressing Climate and Environmental Emergency | SIG | PSI*. (n.d.). Retrieved 16 April 2026, from https://www.psychologicalsociety.ie/groups/Special-Interest-Group-for-Addressing-Climate-and-Environmental-Emergency

Stein, L. I., & Test, M. A. (1980). Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, *37*(4), 392–397. https://doi.org/10.1001/archpsyc.1980.01780170034003

Stevens, A., & Truong, S. (2024). Exploring Therapeutic Nature-Based Programs for Individuals Who Have Experienced Trauma: A Scoping Review. *Therapeutic Recreation Journal*, *58*(2). https://doi.org/10.18666/TRJ-2024-V58-I2-12175

Stigsdotter, U. K., Corazon, S. S., Sidenius, U., Nyed, P. K., Larsen, H. B., & Fjorback, L. O. (2018). Efficacy of nature-based therapy for individuals with stress-related illnesses: Randomised controlled trial. *The British Journal of Psychiatry: The Journal of Mental Science*, *213*(1), 404–411. https://doi.org/10.1192/bjp.2018.2

Tambyah, R., Olcoń, K., Allan, J., Destry, P., & Astell-Burt, T. (2022). Mental health clinicians' perceptions of nature-based interventions within community mental health services: Evidence from Australia. *BMC Health Services Research*, *22*, 841. https://doi.org/10.1186/s12913-022-08223-8

Tan, G. X. D., Hartanto, A., Eun, Z. K. Y., Hu, M., Hsu, K. J., & Majeed, N. M. (2026). Effectiveness of Cognitive and Behavioral Interventions in the Treatment of Schizophrenia: An Umbrella Review of Meta-Analyses. *Journal of Clinical Medicine*, *15*(1), 187. https://doi.org/10.3390/jcm15010187

Ulrich, R. S. (1991). Effects of interior design on wellness: Theory and recent scientific research. *Journal of Health Care Interior Design: Proceedings from the... Symposium on Health Care Interior Design. Symposium on Health Care Interior Design*, *3*, 97–109.

Van Citters, A. D., & Bartels, S. J. (2004). A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach Services for Older Adults. *Psychiatric Services*, *55*(11), 1237–1249. https://doi.org/10.1176/appi.ps.55.11.1237

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

Warnick, E. M., Gonzalez, A., Robin Weersing, V., Scahill, L., & Woolston, J. (2012). Defining dropout from youth psychotherapy: How definitions shape the prevalence and predictors of attrition. *Child and Adolescent Mental Health*, *17*(2), 76–85. https://doi.org/10.1111/j.1475-3588.2011.00606.x

White, M. P., Alcock, I., Grellier, J., Wheeler, B. W., Hartig, T., Warber, S. L., Bone, A., Depledge, M. H., & Fleming, L. E. (2019). Spending at least 120 minutes a week in nature is associated with good health and wellbeing. *Scientific Reports*, *9*(1), 7730. https://doi.org/10.1038/s41598-019-44097-3

Wilkie, L., Fisher, Z., & Kemp, A. H. (2022). The 'Rippling' Waves of Wellbeing: A Mixed Methods Evaluation of a Surf-Therapy Intervention on Patients with Acquired Brain Injury. *Sustainability*, *14*(15), Article 15. https://doi.org/10.3390/su14159605

Wilson, L. (2025). *Psychologists as Approved Clinicians: Exploring Professional Views and Experiences of the Role in Relation to Power and Professional Identity*. https://uel-repository.worktribe.com/output/503767/psychologists-as-approved-clinicians-exploring-professional-views-and-experiences-of-the-role-in-relation-to-power-and-professional-identity

Wilson, S. J., & Lipsey, M. W. (2000). Wilderness challenge programs for delinquent youth: A meta-analysis of outcome evaluations. *Evaluation and Program Planning*, *23*(1), 1–12. https://doi.org/10.1016/S0149-7189(99)00040-3

Windle, E., Tee, H., Sabitova, A., Jovanovic, N., Priebe, S., & Carr, C. (2020). Association of Patient Treatment Preference With Dropout and Clinical Outcomes in Adult Psychosocial Mental Health Interventions: A Systematic Review and Meta-analysis. *JAMA Psychiatry*, *77*(3), 294–302. https://doi.org/10.1001/jamapsychiatry.2019.3750

Wood, C. J., Morton, G., Rossiter, K., Baumber, B., & Bragg, R. E. (2024). A qualitative study of the barriers to commissioning social and therapeutic horticulture in mental health care. *BMC Public Health*, *24*(1), 1197. https://doi.org/10.1186/s12889-024-18621-8

Yang, J. A., Garis, J., Jackson, C., & McClure, R. (2009). Providing Psychotherapy to Older Adults in Home: Benefits, Challenges, and Decision-Making Guidelines. *Clinical Gerontologist*, *32*(4), 333–346. https://doi.org/10.1080/07317110902896356

Yang, Y., Kim, H., Kang, M., Baik, H., Choi, Y., Jang, E.-J., Chang, E.-J., Yun, S., Park, M., Park, E., Yun, H., Lee, T.-J., Kwon, Y.-H., Hong, K.-P., Lee, A.-R., Jung, S., Ahn, T.-H., Jin, H.-Y., & Choi, K.-H. (2023). The effectiveness of nature-based therapy for community psychological distress and well-being during COVID-19: A multi-site trial. *Scientific Reports*, *13*(1), 22370. https://doi.org/10.1038/s41598-023-49702-0

# Psychological components of surf therapy interventions: A scoping review

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## Abstract

Surf therapy is used with a wide range of populations and reasons which shows promise in improving wellbeing and appealing to a difficult to engage groups. Besides surfing being a core component, many interventions include additional elements informed by psychological theory such as psychoeducation or group therapy but there is a little consistency in their use, justification, or understanding of their contribution to intervention outcomes. This research review aims to examine the existing literature on the use of psychological components of surf therapy interventions. A scoping review design was used to identify, categorise and synthesise research on surf therapy interventions where additional psychological components were used. A synthesis and overview of the use of psychological components within surf therapy interventions is presented. Our findings show there is generally poor reporting in research on the details of psychological components incorporates such as, how they are delivered, by whom, and using what theoretical underpinning. Some research has moved towards including theory of change and connecting intervention elements with outcomes, helping understand the purpose and use of additional psychological components. The area of surf therapy would benefit from more detailed reporting of interventions to support the development of more comprehensive theories of change, which would include an understanding of the purpose of additional psychological components, and several frameworks are suggested to support this.


*Keywords:* Surf therapy, Mental health, Clinical psychology

## Introduction

Time spent in nature is linked to positive health and mental health outcomes (Bratman et al., 2015; Wang et al., 2025). As a result, spending time in nature is increasingly being prescribed as a treatment to improve wellness (Kondo et al., 2020). This has led some mental health practitioners to combine therapeutic interventions with nature-based activities in order to maximise therapeutic benefits, with a growing number of activities available (e.g. Kaleta et al., 2025). These nature-based interventions show promise in treating mental health conditions such as depression (Rosa et al., 2023) and anxiety (Jessen et al., 2025). Nature-based interventions that utilise rivers, lakes, and seas are termed ‘blue care’, and there is some evidence supporting the efficacy of these approaches for health, mental health, levels of physical activity and psycho-social wellbeing (Britton, Kindermann, Domegan, et al., 2020; Gascon et al., 2017). As well as the benefits of being in nature, many of these interventions incorporate an element of physical activity, which has been shown to positively benefit the cognitive and mental health of both children and adults (Lubans et al., 2016; Ward, 2014).

Surf therapy combines elements of blue care nature-based activities, along with physical exercise and therapeutic interventions (Benninger et al., 2020; Clapham et al., 2020). Surf therapy is a form of therapeutic intervention where groups or individuals are taught to, or given the opportunity to, surf in the ocean, with the goal of improving psychological, psychosocial, and health outcomes. The practice of surfing in some form is thousands of years old, while the first journal article related to surf therapy appeared in 2010 (Morgan, 2010; Warshaw, 2017). Surf therapy has been defined as: “The use of surfing as a vehicle for delivering intentional, inclusive, population-specific, and evidenced-based therapeutic structures to promote psychological, physical, and psychosocial well-being.” (International Surf Therapy Organization (ISTO), 2019). Research shows that surf therapy has been carried out effectively, in countries across the world, with a wide range of populations: adults,

children, people with disabilities and with a variety of presenting issues or solely for the purpose of improving overall well-being. Surf therapy has shown some advantage over regular exercise interventions (Benninger et al., 2020; Walter et al., 2023). The positives of surfing, such as physical activity, learning a new skill, time spent outdoors, are ubiquitous to any surf therapy intervention (Morgan, 2010), while surf therapy is often supplemented with additional psychosocial elements such as psychoeducation, group therapy, or the incorporation of psychoeducation into the surfing lessons (Benninger et al., 2020). These elements vary widely between interventions, and more research is needed to increase the level of evidence in the area (Carneiro et al., 2024).

Overall, the area of surf therapy interventions is largely under researched, particularly within the context of psychological therapeutic support. Currently, there is one broad review of surf therapy interventions carried out in 2020 by Benninger et al. This scoping review looked at the efficacy of surf therapy interventions, in order to evaluate the potential benefits of these interventions, as well as inform and guide future research in the area. Benninger et al. (2020) highlighted that most of the included studies used some additional element such as supportive coaching or group processing as well as the surf therapy, but Benninger et al. (2020) did not examine in detail these additional components, possibly because journal articles frequently did not include details regarding them. Benninger et al. (2020) broadly divided surf therapy into two frameworks: surf therapy as an exercise / health intervention, and surf therapy as a psychosocial intervention. In the latter case, additional elements focused on supporting psychological and social functioning. In their recommendations they highlight the importance of considering whether surf therapy is a stand-alone intervention or uses additional elements. Despite this, no research has looked in detail at what these additional elements include and the impact they may have on the outcomes of surf therapy across the literature.

Two other reviews of the area focus on more specific populations, including adults with mental health conditions and military veterans (Carneiro et al., 2024; González-Devesa et al., 2025). The former review found only three studies met their criteria, all of which had additional psychological components (Carneiro et al., 2024). The latter had seven included studies, four of which offered additional components to the surf intervention (three yoga and one group discussion) (González-Devesa et al., 2025). However, the additional components were not examined in detail in the review (González-Devesa et al., 2025). The heterogeneity in how interventions are designed and delivered, and how intervention components are reported, makes meaningful interpretations difficult.

A survey of 33 ISTO-affiliated surf therapy programmes found that most providers note several elements beyond surfing as integral to the therapeutic structure. These include provision of a physical and emotional safe space, socialisation-based activities, psychoeducational activities, coping skills training and facilitated discussions. A minority also endorsed "supplemental therapeutic structures" without providing further detail (Brennan et al., 2024, p. 247). These data were from providers rather than participants, so it is unclear whether these elements are seen as integral by participants of surf therapy. The lack of reported detail is common in the surf therapy literature (Benninger et al., 2020). This leads to issues of replicability and an understanding of how surf therapy works. Approaches such as programme theory could support the future effective evaluation and practical implications from surf therapy interventions. Programme theory is a method frequently employed to help explain causative links between intervention elements and outcomes using the theory of change to help understand pathways through which an intervention acts (Bauman et al., 2002; Rogers, 2008). The psychosocial intervention elements of surf therapy may be important components for facilitating positive therapeutic outcomes, but to the best of our knowledge

there is no research comparing surf therapy with and without additional psychosocial elements.

Marshall et al., (2019) in an examination of programme theory (Bauman et al., 2002) within a surf project for children and adults identified a number of pathways which may lead to improved mental health outcomes. In Marshall et al., (2019)'s study the pathways are in two categories: "self-selected pacing and progression while surfing and creation of emotional and physical safe space at the beach" (Marshall et al., 2019, p. 6).

The ISTO's guidance on research, which lays out ethical and assessment criteria, may be beneficial in standardising surf therapy and surf therapy research as it would allow for more controlled examination of surf therapy as an intervention (ISTO, 2023). Surf therapy projects continue to incorporate psychological elements to their interventions; this may be because practitioners of surf therapy see these elements as helpful or may not see the intervention as complete without them. As long as surf therapy projects continue to incorporate other components besides surfing, these will need to be detailed and examined to understand what and how they may contribute to the intervention.

**The Current Review**

For the current review, surf therapy with additional psychologically informed components, delivered alongside or during surf therapy interventions will be considered. Interventions which utilise solely surfing and learning to surf as an intervention have been excluded. This scoping review will bring together research which relates to psychologically-informed components of surf therapy interventions to provide insight on how surf therapy interventions are informed by psychological therapies and modalities.

To ensure a comprehensive review of the literature the research questions reflect a wide range of aspects among surf therapy interventions which included psychosocial elements:

- What does current research say about the practice of surf therapy interventions and what – and to what extent - is input from psychological theory and practice used?
- What modalities inform the psychosocial elements of surf therapy interventions?
- What are the characteristics of the additional psychosocial elements and how are they being implemented?
- Which populations and diagnoses are these surf therapy interventions currently used to treat?

## Methodology

From Benninger et al.'s (2020) review it is clear there is a broad range of intervention approaches as well as populations to be found within surf therapy research. For that reason, it was decided a scoping review would be the most appropriate methodology for understanding the current range of psychological components included in surf therapy interventions. The aim of scoping reviews is to examine the variety and nature of research in an area where it is unclear what range of materials and results might be available. Scoping reviews also identify research gaps in existing literature to help understand the overall state of research activity in a given area (Arksey & O'Malley, 2005).

PRISMA-ScR guidelines were followed, see Figure 1 (Tricco et al., 2018). It is anticipated that the results of this scoping review will inform the development of further research related to surf therapy. The scoping review was registered on the Open Science Framework (Fawsitt et al., 2025).

The primary objectives of this review were to understand both the forms of delivery (who, what, and how) and the theoretical underpinnings (why) of the psychological components of surf therapy interventions.

### Identifying Relevant Studies

#### *Context*

Included studies were not limited to specific geographical locations or cultural or gender factors, and although the first surf therapy study we are aware of, was published in 2010, no date restrictions were implemented. Location was not restricted and artificial surfing environments were not excluded if they met the other inclusion criteria.

### *Types of Participants*

Participants were not limited by age, mental health status, or disability status. As the focus of this review is on the methods employed by surf therapy interventions, the participant criteria were kept broad to not unnecessarily exclude potentially relevant interventions.

### *Types of Studies*

Qualitative, quantitative, and mixed methods studies were all included. Both short- and long-term studies were included and no minimum or maximum intervention length was set. Studies were limited to those published in English. Grey literature was also included.

### *Search strategy*

Databases searched included Scopus, CINAHL, Embase, Web of Science, Cochrane, Psycinfo, Pubmed and EBSCO. The first thousand results from Google Scholar were also considered. These metadatabases were selected based on appropriateness of topic, preliminary searches, and previous studies in the area (Benninger et al., 2020; Carneiro et al., 2024).

A search strategy was iteratively derived in Scopus and then adapted for use in the remaining databases. Search terms combined two concepts, the first related to surf therapy and surfing-based interventions, and the second related to psychological interventions. Wildcards were used where appropriate, to broaden search findings. Table 1 contains a sample search string used for Psycinfo but see Appendix 2 for a full list of search terms and search inputs. One paper was identified from the reference list of Benninger et al. (2020)

which did not use the term surf therapy, using instead ocean therapy. No papers in the reference list of this paper or citing this paper, which met inclusion criteria, were missed.

**Table 1**

*Sample search string*

Psycinfo

| |
|---|
| ( ( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ) ) AND ( ( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) ) |

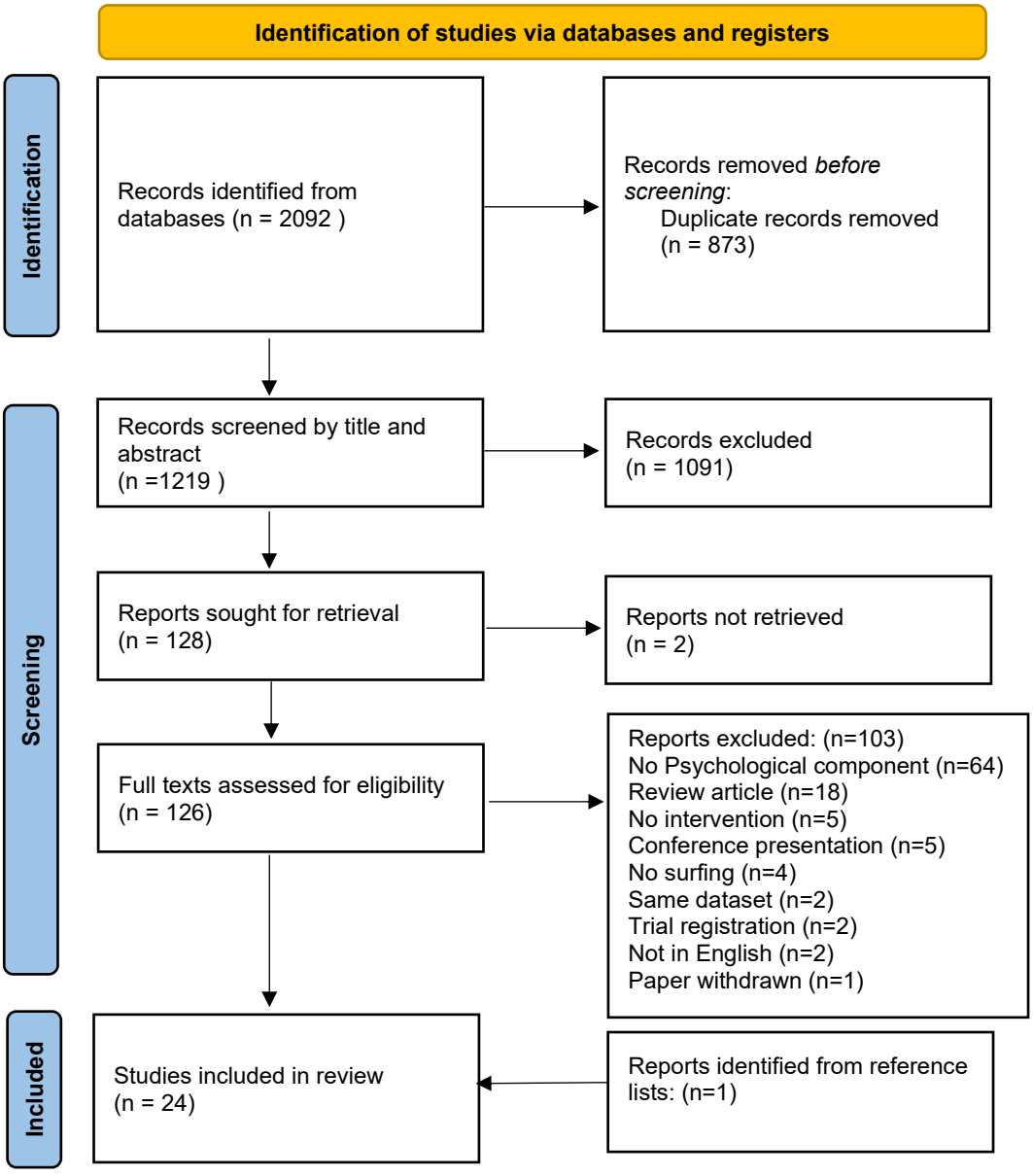
Searches were conducted on all databases on the 23rd of April 2025. Initial search results were merged in Rayyan and duplicates removed (Ouzzani et al., 2016). Two of the authors (FF and OJ) independently screened 10% of the title and abstracts before convening to discuss and resolve any differences in decisions. FF then reviewed the remaining title and abstracts and identified all studies that had the potential to meet the inclusion criteria. As some studies in surf therapy do not detail whether psychological elements are used in the intervention, all surf therapy interventions were progressed to full text review. Again, 10% of the full text articles were reviewed by two researchers (FF and OJ) with a meeting to

determine consensus and then FF reviewed the remaining full texts. Cohen's Kappa for the title and abstract screening was 0.45 and for the full text reviews was 0.92.

Twenty-four papers were included in the final results of this study. Two of these were theses submitted for masters and doctoral degrees, the rest were peer-reviewed journal articles. Two papers were excluded during full text review as they used the same dataset as other included papers. In one case a journal article was published based on the data originally published in a master's thesis (Leonard et al., 2024; Pretorius, 2020) so only the master's thesis was included as it provided more detail. In the other case, two masters' theses analysed the same intervention (Rolfe, 2021; Snelling, 2015) and one was therefore excluded. Data were extracted by FF. The extracted data was inserted into a bespoke Excel spreadsheet (appendix 3). The results are presented as a narrative synthesis appropriate for the heterogeneity of the research.

**Figure 1**

*Prisma flowchart*




## Results

Surf therapy is practiced globally, with included studies being carried out in Portugal, Australia, Germany, Brazil, USA, New Zealand, Sierra Leone, Liberia, South Africa, Wales, and Ireland. Since the cutoff date used by Benninger et al. in 2019, twenty surf therapy

studies meeting our more stringent criteria have been published, indicating a large increase in the number of studies examining surf therapy interventions. Benninger et al. (2019) identified eighteen studies published in the preceding years (2010-2019) with wider selection criteria. Only three of the studies included by Benninger et al. (2019) met our criteria and were included in this study. Table 2 summarises the main findings from the review.

**Table 2**

*Information regarding psychological components extracted*

| Citation | Facilitators | Nature of psychological intervention | Theoretical modality | Integrated or adjacent to surf therapy | Level of detail on psychological intervention provided |
|---|---|---|---|---|---|
| (Nada et al., 2025) | Three surf coaches and three psychologists | Session prior to surf therapy focused on group dynamics and session post surf therapy session with "a moment of finalisation with reflection on the achievements and establishments of commitments for the following week". Activities within surf therapy designed to promote target areas of social and emotional development. | None identified | Adjacent and integrated | One sentence saying surf therapy combined with therapeutic intervention |
| (Drake et al., 2021) | "Mentors" | Psychoeducation and skills group prior to surfing. Each week had a different theme | Behavioural activation, CBT, therapeutic mentorship | Adjacent | Named theoretical modalities and curriculum of goals and psychoeducation for each week |
| (Olive et al., 2023) | Volunteers with surf experience and a day of professional training on surf coaching and mental health literacy | Psychoeducation on cognition emotion behaviour, group communication skills, problem solving skills, identifying and preventing patterns of emotion avoidance and maladaptive emotion driven behaviours, increasing present focus awareness (mindfulness of emotion) relationship building skills, also individual mentoring on communicating emotions, | Guided Discovery method of teaching, social cognitive theory and elements of CBT | Integrated | Full curriculum available |

| Citation | Facilitators | Nature of psychological intervention | Theoretical modality | Integrated or adjacent to surf therapy | Level of detail on psychological intervention provided |
|---|---|---|---|---|---|
| | | teamwork, skill building, problem solving skills | | | |
| (Hearn et al., 2025) | Surf instructors and therapists | Group therapy and CBT | CBT | Group therapy adjacent, CBT integrated. | Full curriculum and manual in preparation |
| (Conde et al., 2024) | Psychologists and surf instructors | Psychoeducation meditation visualisation | Psychoeducation | Adjacent | Table of psychoeducation topics provided and session by session breakdown |
| (Marshall, Ferrier, Martindale, et al., 2020) | Mental health clinicians and surf instructors | Psychoeducation and CBT provided before surf lesson each day | Cognitive Behaviour Therapy | Both, adjacent but it claims they're also integrated to the surf therapy | Waves of Wellness programme with full detail provided |
| (McKenzie et al., 2021) | Mental Health Clinicians also qualified surf instructors | 45 minute talks on physical and mental wellness, identifying healthy and unhealthy emotions, managing change, mindfulness, problem solving and asking for help, relationships, meaning making, and looking to the future | Unclear | Adjacent | Waves of Wellness programme with full detail provided |
| (Francesch i et al., 2024) | Surf coaches who underwent groundswell facilitator curriculum | Group therapy, emotional regulation | Somatic and Trauma Informed | Both | Full curriculum breakdown |
| (Leonard et al., 2024) | Unclear | One to one counselling, one to one youth worker support, group work informed by cultural practices and, role modelling | Community Based Adventure Therapy (CB-AT), Trauma informed | Both | Discussion topics named and connected with surfing, more detail on website |
| (Marshall et al., 2021) | Individuals who attended a two week training programme run by the wave alliance | Learning activities (designed to support emotional regulation, goal setting, mindfulness, positive socializing, and respite), the safe space, caring coaches, and positive socializing | Unclear | Adjacent | Safe space sessions held but no detail on how each of the psychological intervention elements delivered |
| (Marshall l, Ferrier, | Mental Health Clinicians also | CBT, goal setting, emotion monitoring/ regulation, | CBT but also safe | Unclear | Waves for Change |

| Citation | Facilitators | Nature of psychological intervention | Theoretical modality | Integrated or adjacent to surf therapy | Level of detail on psychological intervention provided |
|---|---|---|---|---|---|
| Ward, et al., 2020) | qualified surf instructors | breathing and meditation techniques. Link to programme curriculum https://jsfd.org/wp-content/uploads/2020/11/w4c-curricculum-overview.pdf | spaces, social support, mind/body therapy | | curriculum available online |
| (Beranbaum et al., 2024) | Non-specialist workers who have received training in surf therapy, trauma informed care, waer safety | Psychoeducation - Emotion regulation skills | Unclear | Unclear | Waves for Change curriculum available online |
| (van der Merwe & Yarrow, 2020) | "Surf mentors" youth in the area who have completed a surf coach and mentor learnership at waves for change | Adapted 16 week coping skills curriculum, meditation, coping skills including trust, communication, breathing. | Unclear | Adjacent | Waves for Change curriculum available online – this was adapted for the population but detail on how not provided |
| (Snelling, 2015) | "Surf mentors" youth in the area who have completed a surf coach and mentor learnership at waves for change | Psychoeducation and skills based. Unit titles include : respecting ourselves and others, protecting ourselves and others, communicating with others and listening, reconnecting with our feelings and the feelings of others, understanding feelings and coping with them, understanding who we are building strengths and setting goals, empath understanding and promoting mental and physical health, understanding health and unhealthy spaces in our community, helping others and building the community | Curriculum designed by a child therapist and draws from CBT and humanistic therapy. | Adjacent | Waves for Change curriculum available online |
| (Wilkie et al., 2022) | 2 members of neurorehabilitation service and two qualified surf instructors, and volunteers | Goal setting including surfing, and psychosocial goals i.e. Connecting more with peers. Encouraged to bring concepts such as mindfulness as well. | Unclear | Integrated | Described how clinicians connected surfing with psychology |
| (Gibbs et al., 2022) | 3 members of neurorehabilitation service and two | Informal goal setting and progress monitoring comprised an integral component of the | Unclear | Integrated | Detail on the goal setting provided |

| Citation | Facilitators | Nature of psychological intervention | Theoretical modality | Integrated or adjacent to surf therapy | Level of detail on psychological intervention provided |
|---|---|---|---|---|---|
| | qualified surf instructors, and volunteers | intervention. Clinical team members at the CNS worked with participants to identify initial informal goals prior to engaging within the intervention. These goals typically reflected individual reasons for taking part and often reflected psycho-social outcomes and opportunities, including socialising with new people, and learning about the experiences of other brain injury survivors. During each week, goals tailored to the needs and requirements of each participant were revisited and participants were encouraged to reflect on their progress and outline actions that they wanted to achieve for that day. Sessions were carefully designed to bring clients out of their comfort zone and help them: make room for difficult experiences/feelings; focus on positive experiences such as the feeling of being in the water; bringing awareness to the present moment, and the experience of belonging to a group. Meanwhile, informal goal setting was included to facilitate achievement and the broadening of skills. | | | |
| (Pereira, 2020) | Eleven Multi disciplinary Team members, three specialised in mental health, psychologists and a psychology masters student, four surf instructors, four volunteers for youth at risk | Group sharing, group dynamic exercises to promote theme of the week, frequently socio emotional skills such as non-violent communication, empathy, self-confidence, sharing and reflection post session. | Unclear | Adjacent | Overview of topics covered - Some materials only available in Portuguese |

| Citation | Facilitators | Nature of psychological intervention | Theoretical modality | Integrated or adjacent to surf therapy | Level of detail on psychological intervention provided |
|---|---|---|---|---|---|
| (Matos et al., 2017) | Camp coordinator, psychologist, two specialised technicians, psychology and sociology areas, three surf instructors, two training agents trained in lifesaving. | Activities to promote social and emotional skills, group cohesion activities, group reflection exercises | Unclear | Unclear | Topic outlines but very little detail on content |
| (Sarkisian et al., 2020) | Surf instructors and each session facilitated by the program director who is a licensed therapist | Three talking circles with reflections on the day and theme of the day. | Unclear | Adjacent | Themes named but no detail on level of guidance or facilitation |
| (Gomes et al., 2020) | Technical team consisting of surf coach, psychologist, 1 or 2 volunteers | Bi-monthly workshops on a range of themes, parent and community involvement and psychoeducation, crisis support, rewards for positive behaviours, individual strengths based plan developed with the psychologist | Multiple educational models | Adjacent | Individual plans developed by psychologist. |
| (Cavanaugh, 2010) | Occupational therapist, physical therapist, teachers university student volunteers | Social skills training | Unclear | Adjacent | Basded on the SCORE skills (Vernon et al., 1996), detail provided in original paper. |
| (Santos et al., 2020) | Physical Education teachers | Life skills taught implicitly and explicitly including: perseverance, teamwork, emotional control, focus, leadership, and decision making | Unknown | Integrated | Full curriculum and lesson plans provided |
| (Britton, Kinderman n, & Carlin, 2020) | Unclear | Body mapping supplementary to surf therapy | Unknown | Adjacent | Full detail on body mapping provided |
| (Rogers et al., 2014) | Occupational therapists and surf instructors | Reflective groups between and after surfing sessions | Unclear | Adjacent | Full curriculum provided |

**Research Methodologies**

The research studies mostly used quantitative data and psychometric measures as their outcomes, with ten studies using exclusively this approach. Seven studies used primarily qualitative approaches including interviews with participants, trainers, and parents. Finally, seven studies used mixed methods.

**Populations and Diagnoses**

Fourteen of the included studies were with children exclusively, and five had both children and adults – the latter were typically interventions aimed at adolescents and young adults together. Only five studies included adults exclusively. Two of the adult studies focused on individuals with brain injuries, one with women who had previously reported abuse or trauma, one with adults with a diagnosis of anxiety or depression, and one with United States military veterans. In the studies with child participants, one required a diagnosis of depression, one study had a mix of participants with neurodevelopmental conditions and/or mental health diagnoses, three required diagnoses of Autism Spectrum Disorder (ASD), one had some participants with unspecified learning difficulties, and one had children from socioeconomically deprived backgrounds. Of the studies that combined adults and children, one required participants to not be in employment or full-time education, one required referral from "youth serving organisations" that provide support for foster care and mental healthcare, the other three studies did not name any specific requirements for participation.

**Facilitators**

Surf therapy was always facilitated by individuals who were surf instructors or had some training in surf instruction, but the interventions also often had trainers with mental health training, or from mental health backgrounds. In seven of the studies, the facilitators were volunteers or surf instructors who underwent some mental health training as part of the

preparation for the intervention. The papers that included trained volunteers did not give detail on the specifics of the training volunteers went through although some mentioned how long the training took which ranged from a single day of training in mental health literacy, e.g. Olive et al. (2023), or longer training such as the two week training by Marshall et al. (2021). In thirteen of the interventions the facilitators included professionals with a mental health background, such as occupational therapists, psychologists and psychotherapists. One study provided mental health training to surf coaches facilitating, one study had physical education teachers, and two studies were unclear in the qualifications of the facilitators.

**Modality and Format**

Of the nine studies that mentioned a theoretical modality, the breakdown of approaches was as follows; two studies named just CBT, while four more combined CBT with other approaches - one with behavioural activation and therapeutic mentorship, one with guided discovery and social cognitive theory, one with safe spaces, social support and mind/body therapy and one with humanistic therapy. Three of the studies that included their theoretical modality did not mention CBT; one named only trauma informed approaches, one mentioned community-based adventure therapy combined with a trauma informed approach and one reported using Priest's experiential learning and judgement paradigm and experiential learning cycles, and supported on the circle of courage model, and the principles of re-education (Gomes et al., 2020). CBT was the most common approach mentioned and typically involved psychoeducation and skills.

The included studies had two general approaches to utilising psychological knowledge in the surf therapy interventions. The approaches included either (1) having it adjacent or separate to the surf therapy, or (2) incorporating it into the surfing or the surfing training/knowledge. When the elements were adjacent to the surfing it was frequently psychoeducation or groups delivered on land immediately before or after the surfing. Some

studies used both, with delivery both on land and in the sea during the surfing activity. The most common method was having the psychological element separately, with twelve studies using this approach. Five studies used both adjacent and integrated approaches and finally four studies used the psychological elements only during the surfing. Unfortunately, it was unclear in three studies what approach was used as no further detail was provided on specific intervention activities.

**Qualitative Results**

Thirteen of the included studies presented analysis of qualitative data including interviews, focus groups, and responses to open-ended questionnaire questions, with participants and facilitators as well as accounts from the researchers. One study, Sarkisian et al., (2020), used a novel approach, a projective drawing task with participants. This task asked participants to draw and write a sentence about their drawing and then coded these outputs into themes. Likewise, (Britton, Kindermann, & Carlin, 2020) used a 'body mapping' exercise to supplement traditional interviews. The body mapping exercise allowed the researchers to engage the young people who participated in an exercise to explore their physical experience of the surfing and helped connect changes in physical states, such as a participant who had been feeling physically anxious describing a change to feeling 'buzzing' and excited.

Nada et al., (2025) highlighted the challenge of parsing possible causative factors in interpreting the results of surf therapy interventions. The multiple elements - the 'blue space', the supportive social context, the exercise, and the structured psychological components - as well as the interaction between them may all play a role. Several studies did not theoretically link the qualitative results to the psychological components of the interventions, although it was clear from accounts from participants that they identified positive changes (Drake et al., 2021; Nada et al., 2025).

Themes across the studies were largely positive, related to connection to nature, growth, and social benefits. Social elements were frequently mentioned, including social functioning and valuing social aspects of the groups (Drake et al., 2021; Gibbs et al., 2022; Marshall et al., 2021; Marshall, Ferrier, Martindale, et al., 2020; Marshall, Ferrier, Ward, et al., 2020; McKenzie et al., 2021; Nada et al., 2025; van der Merwe & Yarrow, 2020). Improvements in psychosocial functioning in both personal and school settings appeared repeatedly (Conde et al., 2024; Gibbs et al., 2022; Marshall et al., 2021; Marshall, Ferrier, Ward, et al., 2020; McKenzie et al., 2021; Nada et al., 2025; van der Merwe & Yarrow, 2020; Wilkie et al., 2022). A relatively common theme was mastery and mindset shifts to feel more capable (Drake et al., 2021; Marshall, Ferrier, Martindale, et al., 2020; McKenzie et al., 2021). This was connected with the learning of a new skill and overcoming anxiety related to same. Connection with nature also featured in the themes (Gibbs et al., 2022; Wilkie et al., 2022).

Elements from the psychological intervention components of the surf therapy interventions were mentioned infrequently. In their study Marshall, Ferrier, Martindale, et al., (2020) included a range of themes related to “mental health by stealth” (Marshall, Ferrier, Martindale, et al., 2020, p. 239). Key areas identified within these were “(a) removal of judgement, (b) participant selected pacing and (c) participatory facilitation”. The authors suggest these criteria were what allowed for good engagement with the young people (Marshall, Ferrier, Martindale, et al., 2020, p. 241). Participants also reported being better able to engage in the coping strategies and psychoeducation due to the peer support provided by the group. They divided the programme theory components into (1) surfing benefits and (2) mental health by stealth. This is the clearest division of results regarding the surfing intervention as separate from the psychological elements, while both elements complement each other.

A common element in most of the studies was the aim of creating a safe space for participants to share experiences, goals, and feelings (Drake et al., 2021; Marshall et al., 2021; Marshall, Ferrier, Martindale, et al., 2020; Marshall, Ferrier, Ward, et al., 2020). This approach was frequently used with at-risk youth to help develop psychological openness and acclimatise individuals, who may have difficulty sharing, to this experience. The participants in two studies described the non-judgemental space as helping individuals engage in challenging activities without fear of judgement (Marshall, Ferrier, Martindale, et al., 2020; McKenzie et al., 2021). Psychological safety helped participants with mental health difficulties and those with brain injuries in two studies where participants reported valuing the normalisation of their unique experiences (McKenzie et al., 2021; Wilkie et al., 2022).

Psychological safety allowed participants to engage in the psychological elements such as coping skills while the surfing gave participants a real space to try these out (Marshall, Ferrier, Martindale, et al., 2020; McKenzie et al., 2021). This practice helped participants learn how to take these lessons into the real world, having already practised the skills in a real setting. Using a 'ripple effects mapping approach' (a style of qualitative workshop-based data collection approach designed to identify long term changes as a result of an intervention (Chazdon et al., 2017), Wilkie et al. (2022) found that participants experienced an increased interest in some of the psychological elements of the intervention such as mindfulness, possibly because they were connected to the activity, making them more practical.

Participants believed that the sensory environment also played an important role in helping make the psychoeducation more effective "The sensory experiences at WOW (Waves of Wellness) helped participants to: (a) ground themselves within difficult discussions, (b) explore different approaches to mindful practice to find what strategies best worked for them and (c) offered potential direct pathways to improved well-being" (Marshall, Ferrier,

Martindale, et al., 2020, p. 243). Participants also noted that they were able to be fully immersed in the surfing which helped provide them respite after particularly heavy discussions, helping them to cope better with discussing difficult topics.

Although Marshall et al., (2021) did not provide qualitative results explicitly related to the psychological interventions, they did categorise what they believed were likely mechanisms for the benefits identified in the qualitative data. For example, they reported qualitative impacts of improved socializing, reduction in certain behaviours, improving academic performance and an improved mindset were all attributed in part to the coping skills and the safe space created by the intervention. Other benefits were attributed to the surfing component and peer support.

Gibbs et al. (2022) found that due to clinicians being involved in delivery, clinicians were able to reinforce the adoption of healthy coping mechanisms or understandings. For example, in managing and accepting difficult emotions, as participants learned to accept what they could not control while surfing, clinicians could make the link between accepting difficult emotions and situations outside of participants' control. Cavanaugh, (2010) used a mixed methods approach including qualitative elements, as only parents and instructors had the opportunity to participate, it is unclear what the participants (young people with a diagnosis of ASD) thought of the social skills intervention being combined with the surf camp. Any improvements in socialisation reported by parents and instructors cannot be definitively attributed to either as a result.

**Quantitative Results**

Quantitative measures were very varied, see table of results in appendix 3 for full list of included measures. Commonly included measures were the Strengths and Difficulties Questionnaire (SDQ) and the Youth Outcome Questionnaire – self report version (Goodman, 1997; Ridge et al., 2009). Results showed improvement in the included measures in all but

one study. Snelling (2015) did not find significant improvements in measures of psychosocial functioning but they noted poor fidelity, with participants only receiving approximately half of the planned intervention. Outcome improvements were also not always sustained at follow ups, where follow ups were included (McKenzie et al., 2021; Olive et al., 2023). Only four studies included follow up measures at a range of post intervention timeframes, ranging from one to three months. Two out of four of these studies showed sustained improvements at follow up (Gomes et al., 2020; Sarkisian et al., 2020). One of the longest running interventions, Gomes et al., (2020), found a reduction in general difficulties as measured by the SDQ at two and three years, with a dose increase in effectiveness. It is not clear from their paper whether they followed up with all participants at these points, and the majority of participants attended just one year, but a small percentage attended up to five years of the intervention. However, Gomes et al., (2020) included a wide range of additional and separate intervention elements, including parent psychoeducation workshops and a behavioural reward programme for the young people participating, so it is unclear again how much change if any can be attributed to the surf therapy elements.

Finally, one of the purported strengths of surf therapy as an intervention is the ability to reach groups who may typically have difficulty being recruited to or engaging with more traditional interventions. While several of the included papers mentioned surf therapy as useful in engaging hard to reach populations and some included dropout rates (Snelling, 2015), only a few examined this as a research question. Pereira (2020) described surf therapy as a low stigma approach and noted their dropout rate was very low when compared to interventions delivered in mental health services. Olive et al., (2023) found that 100% of participants who attended at least one surf therapy session would strongly recommend it to others, demonstrating a high level of acceptability. Leonard et al., (2024) showed that the attrition rate in their study (17% including pre-programme attrition) was significantly lower

than would be predicted for the population, at risk young men, and that this is a positive predictor for long term outcomes (McMurran & Theodosi, 2007). Others did not appear to attempt to measure this directly. Hearn et al., (2025) found lower dropout rates when compared to the general literature and not a control group. Other studies such as Franceschi et al. (2024) noted the strong attendance rate of their participants. Only one study reported difficulty with attendance and this was in a challenging environment and not compared to any more traditional mental health interventions, so inferences cannot be drawn (Marshall et al., 2021).

## Discussion

The purpose of this review was to examine the nature and delivery of additional psychosocial components of surf therapy interventions. Important findings were that there was inadequate reporting of theoretical modalities underpinning the psychological components of the interventions. Details on what these components comprised of and that the pathways effecting change in interventions are not adequately mapped in the existing literature. Furthermore, the review found that non-professionals could deliver a beneficial intervention, and that there was a wide range of approaches, allowing for adaptations to population needs.

Our finding of a lack of reporting on the theoretical underpinnings of, and purpose of the psychological elements, as well as their causative impact on outcomes, are similar to what has been found for the literature on adventure-based therapies, which shows a lack of detail on programme structure, theory, and a link with causal mechanisms (Harper et al., 2021). With few exceptions, the included papers did not explore the effects of the additional psychosocial components on participants as separate from the surfing element and frequently did not have a clear rationale for their inclusion or how they were matched to the population they were used with. As noted by Brennan et al. (2024), current research does not provide

clear pathways for specific changes brought on by surf therapy. Similar to our findings, a special issue on surf therapy in the Global Journal of Community Psychology Practice, notes the lack of understanding of the effective pathways in surf therapy (Walter et al., 2020). Surf therapy programmes may be largely successful, but further theoretical underpinning is needed to help explain how change is achieved. Through this, core processes can be identified in order to achieve desired outcomes and provide a framework for the further development and optimisation of surf therapy programmes. Walter et al. (2020) suggest that the use of both process and outcome evaluation are needed to provide insight. For evaluation, Walter et al. (2020) suggests comparison groups with traditional therapies as well as randomised controlled trials. By comparing groups with and without specific elements of the interventions (psychosocial intervention without surfing elements, surfing intervention without psychosocial elements and the combination of surfing and psychosocial intervention) researchers could better understand what causes an effect, if any.

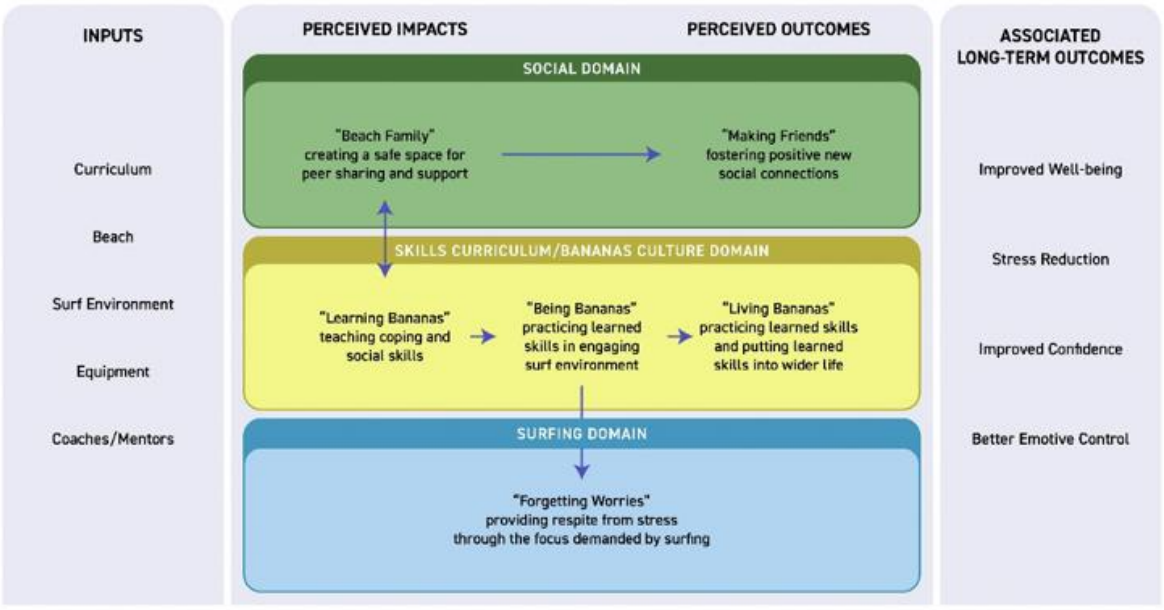
With a wide range of approaches used in the included studies, there is scope for ensuring match between population need, and intervention adaptation. It may be beneficial to develop a clear formulation of target symptoms or behaviours with pathways for change. Approaches such as intervention mapping may be useful for interventions in developing a clear plan for the target behaviour / measurable symptom, whether it can be influenced by an intervention connected to surf therapy, and how it would be influenced (Bartholomew et al., 1998; van Agteren et al., 2021). Approaches like using goal setting for children with disabilities (van der Merwe & Yarrow, 2020) or providing children at risk of engaging in criminal behaviours an alternative culture to engage in (e.g. Marshall, Ferrier, Ward, et al., 2020) appear appropriate and internally consistent, and future interventions should ensure a thorough rationale for the additional psychosocial elements of their surf therapy interventions.

Findings around attrition and outreach success are limited. As we did not examine studies that did not include psychological components, those not included papers may have focused more on measuring outreach and acceptability. Future research should ensure that all of the potential strengths of surf therapy interventions are measured.

Some of the included studies have used programme theory to examine their specific interventions and understand how surf therapy and the additional components influence change in participants (Marshall, Ferrier, Martindale, et al., 2020; Marshall, Ferrier, Ward, et al., 2020). This helps connect what an intervention achieves to the components of the intervention. As such, programme theory or a similar approach is needed to help understand current approaches in surf therapy where interventions are vague on the channels of action which affect change. Two included studies worked to help parse out a complex intervention and its outputs using this approach (Marshall, Ferrier, Martindale, et al., 2020; Marshall, Ferrier, Ward, et al., 2020). The interview schedule used by Marshall, Ferrier, Ward, et al., (2020) in their study explicitly asked about the non-surfing elements of the interventions, giving participants space to discuss how they found the socialising and the psychoeducation components. This also allowed for the authors to make sense of the ways these components contributed to outcomes (See figure 2). “Being bananas” is a term used by the intervention delivery to help the younger participants connect with the psychological lessons and broader cultural messages of the psychological components of the intervention (Marshall, Ferrier, Ward, et al., 2020).

**Figure 2**

*Programme theory*




*Note:* Reprinted from ""I feel happy when I surf because it takes stress from my mind": An Initial Exploration of Program Theory within Waves for Change Surf Therapy in Post-Conflict Liberia" by J, Marshall, B. Ferrier. P.B. Ward. and R. Martindale. 2020, Journal of Sport for Development, Volume 9 (1), page 7. Copyright 2020 by the Journal of Sport for Development. Reprinted with permission.

Not only do interventions need to be well thought out, but for the future development of these interventions and our theoretical understanding of them in the research, the interventions need clearer reporting. The lack of detail provided by the researchers presents challenges to the reproducibility of the research and may reflect a lack of coherence in the delivery of surf therapy interventions. The lack of detail in how the psychological elements especially were delivered, by whom, and using what model make it difficult for the field to develop and evaluate itself. Frameworks such as the template for intervention description and replication (TIDieR) checklist may provide a guide for future studies to include enough detail to allow for replication (Hoffmann et al., 2014). The practicalities of some of the surf

interventions included may not lend themselves to this form of checklist, while others such as the intervention used by Gomes et al. (2020) which had some participants engage in the intervention in different forms over five years, may be difficult to quantify. Surf therapy provides a unique way of engaging typically hard-to-reach participants in a psychological intervention and has potential to better serve these communities. At the same time, it is crucial that this is not done haphazardly and that the learning from each iteration can be brought forward to improve surf therapy as an area going forward.

One advantage of surf therapy was the ability for non-professionals to deliver the therapeutic intervention. Some interventions were able to scale up using participants who had completed the surf therapy intervention to then deliver surf therapy (e.g. Gomes et al., 2020) or training trainers who then launch surf therapy in new locations (e.g. Marshall et al., 2021). However, the content of the training for those delivering surf therapy was not made clear and it would be beneficial for future interventions to include this, or to evaluate the training programmes separately in order to improve surf therapy interventions and the fidelity to them (Kirkpatrick & Kirkpatrick, 2006). Another approach is to have specific elements of the interventions delivered by mental health professionals, such as the psychoeducation or group exercises prior to and after surfing, with surf instructors delivering the surfing elements.

One of the potential strengths of surf therapy purported by several of the included studies is its ability to appeal to hard-to-reach populations and make therapeutic interventions more acceptable to those who may have difficulty staying engaged with traditional interventions. Very few of the identified studies measured this although many made the claim, but some noted their attendance and dropout rates compared favourably to traditional therapeutic interventions (Franceschi et al., 2024; Hearn et al., 2025; Olive et al., 2023; Pereira, 2020). This is an important issue to examine in future surf therapy interventions as several of the targeted populations - such as adolescents with mental health issues

(approximately 23%) and those at risk of the criminal justice system have high dropout rates in traditional mental health services (Hammett et al., 1998; Rohden et al., 2017).

**Conclusion**

Although the ISTO definition of surf therapy is surfing as a "vehicle" (ISTO, 2019), it is often unclear what this vehicle is carrying. The surf therapy interventions included utilised some form of psychological intervention alongside the surf therapy; at times the psychological intervention aimed to enhance the benefits of surfing, and other times the surfing aimed to enhance the benefits of psychological intervention.

Similar to Carneiro et al. (2024) we found that while surf therapy is often combined with other elements, these are poorly defined. Carneiro et al. (2024) also suggest the focus should be refined as to whether either or both of the surfing or the additional elements are seen as crucial. We suggest that if the predictions and outcomes of each element are clearly defined it will support better identification of the crucial components. Using approaches such as programme theory to build an understanding of mediators in the relationship between intervention is best practice in programme development (Olive et al., 2020; Rogers, 2008; Skivington et al., 2021). If a strength of surf therapy is making psychological interventions more palatable to hard-to-reach groups as suggested by Walter et al. (2023), then it is important a way to demonstrate and measure this is devised.

Specific modalities may also lend themselves to being incorporated into surf therapy. Cognitive behaviour therapy was the most commonly cited theoretical modality underpinning the interventions, but other adventure therapies such as sailing have had success integrating Acceptance Commitment Therapy (Donisi et al., 2024). A clear programme theory could allow for more deliberate choice of theoretical integration into the surf therapy intervention.

Future research could also work to evaluate training programmes for those delivering surf therapy, especially when becoming a mentor is frequently seen as part of the intervention

such as the Waves for Change programme which evaluated its training programme (Rolfe, 2021).

## References

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Bartholomew, L. K., Parcel, G. S., & Kok, G. (1998). Intervention Mapping: A Process for Developing Theory and Evidence-Based Health Education Programs. *Health Education & Behavior*, *25*(5), 545–563. https://doi.org/10.1177/109019819802500502

Bauman, A. E., Sallis, J. F., Dzewaltowski, D. A., & Owen, N. (2002). Toward a better understanding of the influences on physical activity: The role of determinants, correlates, causal variables, mediators, moderators, and confounders. *American Journal of Preventive Medicine*, *23*(2), 5–14.

Benninger, E., Curtis, C., Sarkisian, G. V., Rogers, C. M., Bender, K., & Comer, M. (2020). Surf therapy: A scoping review of the qualitative and quantitative research evidence. *Glob. J. Community Psychol. Pract*, *11*, 1–26.

Beranbaum, S., Kouri, N. A., Van der Merwe, N., & D'Andrea, W. (2024). The impact of surf therapy on risk-taking and interpersonal closeness among violence-exposed youth. *Global Journal of Community Psychology Practice*, *15*(2).

Bratman, G. N., Daily, G. C., Levy, B. J., & Gross, J. J. (2015). The benefits of nature experience: Improved affect and cognition. *Landscape and Urban Planning*, *138*, 41–50.

Brennan, M., Stain, H. J., & Marshall, J. (2024). Mapping the landscape: Surf therapy program delivery. *Journal of Outdoor and Environmental Education*. https://doi.org/10.1007/s42322-023-00152-2

Britton, E., Kindermann, G., & Carlin, C. (2020). Surfing and the senses: Using body mapping to understand the embodied and therapeutic experiences of young surfers with autism. *Global Journal of Community Psychology Practice*, *11*(2).

Britton, E., Kindermann, G., Domegan, C., & Carlin, C. (2020). Blue care: A systematic review of blue space interventions for health and wellbeing. *Health Promotion International*, *35*(1), 50–69. https://doi.org/10.1093/heapro/day103

Carneiro, L., Clemente, F. M., Claudino, J. G., Ferreira, J., Ramirez-Campillo, R., & Afonso, J. (2024). Surf therapy for people with mental health disorders: A systematic review of randomized and non-randomized controlled trials. *BMC Complementary Medicine and Therapies*, *24*, 376. https://doi.org/10.1186/s12906-024-04674-0

Cavanaugh, L. K. (2010). *An exploration of the effectiveness of a surf camp curriculum on social competence, social skills, and self-concept changes of children with autism spectrum disorder*. Texas Woman's University.

Chazdon, S., Emery, M., Hansen, D., Higgins, L., & Sero, R. (2017). *A field guide to ripple effects mapping*. University of Minnesota Libraries Publishing.

Clapham, E. D., Lamont, L. S., Shim, M., Lateef, S., & Armitano, C. N. (2020). Effectiveness of surf therapy for children with disabilities. *Disability and Health Journal*, *13*(1), 100828. https://doi.org/10.1016/j.dhjo.2019.100828

Conde, E. F. Q., Sauerbronn, M. C., da Silva Cerqueira, C., & Nepomuceno, L. B. (2024). Effects of Surf Therapy on Mental Health During the Coronavirus Disease Pandemic: A Brief Experience Report. *Alternative Therapies in Health and Medicine*, *30*(11), 6–10.

Donisi, V., Poli, S., Berti, L., Gobbin, F., Giusto, G., Capurso, M., Gagliani, M., Campo, A., Presti, G., Deledda, G., Harris, R., & Rimondini, M. (2024). Combining acceptance and commitment therapy with adventure therapy to face vulnerability: Examples and

insights from a sailing experience. *Journal of Contextual Behavioral Science*, *32*, 100759. https://doi.org/10.1016/j.jcbs.2024.100759

Drake, C. J., Keith, M., Dober, M. R., Evans, S., & Olive, L. S. (2021). A qualitative investigation into the perceived therapeutic benefits and barriers of a surf therapy intervention for youth mental health. *Complementary Therapies in Medicine*, *59*, 102713. https://doi.org/10.1016/j.ctim.2021.102713

Fawsitt, F., Larkin, F., & Dr Mike Murphy. (2025). *A scoping review of the psychological components of surf therapy interventions*. OSF Registries. https://doi.org/10.17605/OSF.IO/ZXQS7

Franceschi, L., Small, N., Goldsby, T., Goldsby, M., Padamada, S., Ziegler, M. G., & Mills, P. J. (2024). The Groundswell Community Surf Therapy Intervention for At-Risk Women and Changes in Body Acceptance, Resilience, and Emotional Regulation. *Global Advances in Integrative Medicine and Health*, *13*, 27536130241278970. https://doi.org/10.1177/27536130241278970

Gascon, M., Zijlema, W., Vert, C., White, M. P., & Nieuwenhuijsen, M. J. (2017). Outdoor blue spaces, human health and well-being: A systematic review of quantitative studies. *International Journal of Hygiene and Environmental Health*, *220*(8), 1207–1221. https://doi.org/10.1016/j.ijheh.2017.08.004

Gibbs, K., Wilkie, L., Jarman, J., Barker-Smith, A., Kemp, A. H., & Fisher, Z. (2022). Riding the wave into wellbeing: A qualitative evaluation of surf therapy for individuals living with acquired brain injury. *PLOS ONE*, *17*(4), e0266388. https://doi.org/10.1371/journal.pone.0266388

Gomes, P., Fazenda, N., Gomez-Baya, D., Rauktis, M. E., & Provost, G. (2020). Surf.Art in Portugal: Daring, Accomplishing and Transforming Portuguese Youth and Their

Communities. *Global Journal of Community Psychology Practice*, *11*(2). https://doi.org/10.17161/gjcpp.v11i2.20677

González-Devesa, D., Vilanova-Pereira, M., Araújo-Solou, B., & Ayán-Pérez, C. (2025). Effectiveness of surfing on psychological health in military members: A systematic review. *BMJ Military Health*, *171*(e1), e9–e13. https://doi.org/10.1136/military-2024-002856

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, *38*(5), 581–586. https://doi.org/10.1111/j.1469-7610.1997.tb01545.x

Hammett, T. M., Gaiter, J. L., & Crawford, C. (1998). Reaching Seriously At-Risk Populations: Health Interventions in Criminal Justice Settings. *Health Education & Behavior*, *25*(1), 99–120. https://doi.org/10.1177/109019819802500108

Hearn, B., Biscaldi, M., Rauh, R., & Fleischhaker, C. (2025). Feasibility and effectiveness of a group therapy combining physical activity, surf therapy and cognitive behavioral therapy to treat adolescents with depressive disorders: A pilot study. *Frontiers in Psychology*, *16*. https://doi.org/10.3389/fpsyg.2025.1426844

Hoffmann, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., Altman, D. G., Barbour, V., Macdonald, H., Johnston, M., Lamb, S. E., Dixon-Woods, M., McCulloch, P., Wyatt, J. C., Chan, A.-W., & Michie, S. (2014). Better reporting of interventions: Template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, *348*, g1687. https://doi.org/10.1136/bmj.g1687

International Surf Therapy Organisation. (2023, July 26). *ISTO Evaluation Framework*. https://intlsurftherapy.org/isto-evaluation-framework/

International Surf Therapy Organization. (2019). *International Surf Therapy Organization—About*. https://intlsurftherapy.org/, https://intlsurftherapy.org/

Jessen, N. H., Løvschall, C., Skejø, S. D., Madsen, L. S. S., Corazon, S. S., Maribo, T., & Poulsen, D. V. (2025). Effect of nature-based health interventions for individuals diagnosed with anxiety, depression and/or experiencing stress—A systematic review and meta-analysis. *BMJ Open*, *15*(7), e098598. https://doi.org/10.1136/bmjopen-2024-098598

Kaleta, B., Campbell, S., O'Keeffe, J., & Burke, J. (2025). Nature-based interventions: A systematic review of reviews. *Frontiers in Psychology*, *16*. https://doi.org/10.3389/fpsyg.2025.1625294

Kirkpatrick, D., & Kirkpatrick, J. (2006). *Evaluating Training Programs: The Four Levels*. Berrett-Koehler Publishers.

Kondo, M. C., Oyekanmi, K. O., Gibson, A., South, E. C., Bocarro, J., & Hipp, J. A. (2020). Nature Prescriptions for Health: A Review of Evidence and Research Opportunities. *International Journal of Environmental Research and Public Health*, *17*(12), 4213. https://doi.org/10.3390/ijerph17124213

Leonard, A., Tairi ,Tatiana, & and Blampied, N. M. (2024). Tai Wātea/Waves of freedom: An evaluation of a surf therapy programme for improving psychosocial functioning in young men at high risk of adverse life outcomes. *Journal of Adventure Education and Outdoor Learning*, *24*(3), 488–508. https://doi.org/10.1080/14729679.2022.2153370

Lubans, D., Richards, J., Hillman, C., Faulkner, G., Beauchamp, M., Nilsson, M., Kelly, P., Smith, J., Raine, L., & Biddle, S. (2016). Physical Activity for Cognitive and Mental Health in Youth: A Systematic Review of Mechanisms. *Pediatrics*, *138*(3), e20161642. https://doi.org/10.1542/peds.2016-1642

Marshall, J., Ferrier, B., Martindale, R., & Ward, P. B. (2020). A grounded theory exploration of programme theory within Waves of Wellness surf therapy intervention. *Psychology & Health*, *0*(0), 1–23. https://doi.org/10.1080/08870446.2023.2214590

Marshall, J., Ferrier, B., Ward, P. B., & Martindale, R. (2020). I feel happy when I surf because it takes stress from my mind": An Initial Exploration of Program Theory within Waves for Change Surf Therapy in Post-Conflict Liberia. *Journal of Sport for Development*, *9*(1), 1–17.

Marshall, J., Kamuskay, S., Samai, M. M., Marah, I., Tonkara, F., Conteh, J., Keita, S., Jalloh, O., Missalie, M., Bangura, M., Messeh-Leone, O., Leone, M., Ferrier, B., & Martindale, R. (2021). A Mixed Methods Exploration of Surf Therapy Piloted for Youth Well-Being in Post-Conflict Sierra Leone. *International Journal of Environmental Research and Public Health*, *18*(12), 6267. https://doi.org/10.3390/ijerph18126267

Marshall, J., Kelly, P., & Niven, A. (2019). "When I Go There, I Feel Like I Can Be Myself." Exploring Programme Theory within the Wave Project Surf Therapy Intervention. *International Journal of Environmental Research and Public Health*, *16*(12). https://doi.org/10.3390/ijerph16122159

Matos, M. G., Santos, A. C., Fauvelet, C., Marta, F., Evangelista, E. S., Ferreira, J., Moita, M., Conibear, T., & Mattila, M. (2017). Surfing for social integration: Mental health and well-being promotion through surf therapy among institutionalized young people. *HSOA Journal of Community Medicine & Public Health Care*, *4*(1), 1–6. https://doi.org/10.24966/CMPH-1978/100026

McKenzie, R. J., Chambers, T. P., Nicholson-Perry, K., Pilgrim, J., & Ward, P. B. (2021). "Feels Good to Get Wet": The Unique Affordances of Surf Therapy Among Australian Youth. *Frontiers in Psychology*, *12*, 721238. https://doi.org/10.3389/fpsyg.2021.721238

McMurran, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased reconviction over no treatment? *Psychology, Crime & Law*, *13*(4), 333–343.

Morgan, P. (2010). ‘Get Up. Stand Up.’ Riding to resilience on a surfboard. *Child & Family Social Work*, *15*(1), 56–65. https://doi.org/10.1111/j.1365-2206.2009.00637.x

Nada, C., Rios, C., Miguel, I., Cailliau, B., Arbués, D., & Silva Dias, T. (2025). ‘When I enter the ocean, I forget about all my problems’: Improving young people’s well-being and education through surf therapy. *Leisure Studies*, 1–17. https://doi.org/10.1080/02614367.2025.2486091

Olive, L., Dober, M., Mazza, C., Turner, A., Mohebbi, M., Berk, M., & Telford, R. (2023). Surf therapy for improving child and adolescent mental health: A pilot randomised control trial. *Psychology of Sport and Exercise*, *65*, 102349. https://doi.org/10.1016/j.psychsport.2022.102349

Olive, L., Parker, R., Dober, M., Drake, C., Keith, M., & Telford, R. (2020). Intervention mapping: Using theory and evidence to inform the ocean mind surf therapy program for improving youth mental health. *Global Journal of Community Psychology Practice*, *11*(2), 1–21.

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—A web and mobile app for systematic reviews. *Systematic Reviews*, *5*(1), 210. https://doi.org/10.1186/s13643-016-0384-4

Pereira, A. I. (2020). Effectiveness of a combined surf and psychological preventive intervention with children and adolescents in residential childcare: A randomized controlled trial. *Revista de Psicología Clínica Con Niños y Adolescentes*, *7*(2). https://doi.org/10.21134/rpcna.2020.07.2.3

Pretorius, A. (2020). *Tai Wātea/Waves of Freedom: An evaluation of a surf therapy programme for high-risk males residing in New Zealand: A thesis presented in partial fulfilment of the requirements for the degree of Master of Health Science in Psychology at Massey University, New Zealand*. Massey University.

Ridge, N. W., Warren, J. S., Burlingame, G. M., Wells, M. G., & Tumblin, K. M. (2009). Reliability and validity of the youth outcome questionnaire self-report. *Journal of Clinical Psychology*, *65*(10), 1115–1126. https://doi.org/10.1002/jclp.20620

Rogers, C. M., Mallinson, T., & Peppers, D. (2014). High-Intensity Sports for Posttraumatic Stress Disorder and Depression: Feasibility Study of Ocean Therapy With Veterans of Operation Enduring Freedom and Operation Iraqi Freedom. *The American Journal of Occupational Therapy*, *68*(4), 395–404. https://doi.org/10.5014/ajot.2014.011221

Rogers, P. J. (2008). Using Programme Theory to Evaluate Complicated and Complex Aspects of Interventions. *Evaluation*, *14*(1), 29–48. https://doi.org/10.1177/1356389007084674

Rohden, A. I., Benchaya, M. C., Camargo, R. S., Moreira, T. de C., Barros, H. M. T., & Ferigolo, M. (2017). Dropout Prevalence and Associated Factors in Randomized Clinical Trials of Adolescents Treated for Depression: Systematic Review and Meta-analysis. *Clinical Therapeutics*, *39*(5), 971-992.e4. https://doi.org/10.1016/j.clinthera.2017.03.017

Rolfe, E. (2021). *A formative evaluation of the development and implementation of the waves for change coach training programme*. http://hdl.handle.net/11427/33142

Rosa, C. D., Chaves, T. S., Collado, S., Larson, L. R., & Profice, C. C. (2023). The Effect of Nature-Based Adventure Interventions on Depression: A Systematic Review. *Environment and Behavior*, *55*(3), 140–174. https://doi.org/10.1177/00139165231174615

Santos, F., Bean, C., Azevedo, N., Cardoso, A., Pereira, P., & Cruz, H. (2020). Moving From an Implicit to an Explicit Approach of Life Skills Development and Transfer: The Case of Surfing in Schools. *Sage Open*, *10*(2), 2158244020933316. https://doi.org/10.1177/2158244020933316

Sarkisian, G. V., Curtis, C., & Rogers, C. M. (2020). Emerging hope: Outcomes of a one-day surf therapy program with youth at-promise. *Global Journal of Community Psychology Practice*, *11*(2).

Skivington, K., Matthews, L., Simpson, S. A., Craig, P., Baird, J., Blazeby, J. M., Boyd, K. A., Craig, N., French, D. P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M., & Moore, L. (2021). A new framework for developing and evaluating complex interventions: Update of Medical Research Council guidance. *BMJ*, *374*, n2061. https://doi.org/10.1136/bmj.n2061

Snelling, M. (2015). *Breaking cycles of violence, one wave at a time: A formative evaluation of the Waves for Change Surf Therapy programme* [University of Cape Town]. OpenUCT. http://hdl.handle.net/11427/20657

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., … Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*, *169*(7), 467–473. https://doi.org/10.7326/M18-0850

van Agteren, J., Iasiello, M., Ali, K., Fassnacht, D. B., Furber, G., Woodyatt, L., Howard, A., & Kyrios, M. (2021). Using the Intervention Mapping Approach to Develop a Mental Health Intervention: A Case Study on Improving the Reporting Standards for Developing Psychological Interventions. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.648678

van der Merwe, N., & Yarrow, P. (2020). More than surfing: Inclusive surf therapy informed by the voices of South African children with autism spectrum disorder. *Global Journal of Community Psychology Practice*, *11*(2).

Vernon, S., Schumaker, J. B., & Deshler, D. D. (1996). *The SCORE skills: Social skills for cooperative groups*. Edge Enterprises.

Walter, K. H., Otis, N. P., Ray, T. N., Glassman, L. H., Beltran, J. L., Kobayashi Elliott, K. T., & Michalewicz-Kragh, B. (2023). A randomized controlled trial of surf and hike therapy for U.S. active duty service members with major depressive disorder. *BMC Psychiatry*, *23*(1), 109. https://doi.org/10.1186/s12888-022-04452-7

Walter, K. H., Sarkisian, G. V., Martinez, G., & Ward, P. B. (2020). Surf Therapy Practice, Research, and Coalition Building: Future Directions. *Global Journal of Community Psychology Practice*, *11*(2). https://doi.org/10.17161/gjcpp.v11i2.20682

Wang, X., Feng, B., & Wang, J. (2025). Green spaces, blue spaces and human health: An updated umbrella review of epidemiological meta-analyses. *Frontiers in Public Health*, *13*. https://doi.org/10.3389/fpubh.2025.1505292

Ward, S. R., Anne Tiedemann, Catherine Sherrington, Jackie Curtis, Philip B. (2014, March 31). Physical Activity Interventions for People With Mental Illness: A Systematic Review and Meta-Analysis. *Psychiatrist.Com*. https://www.psychiatrist.com/jcp/physical-activity-interventions-mental-illness-systematic/

Warshaw, M. (2017). *A Brief History of Surfing*. Chronicle Books.

Wilkie, L., Fisher, Z., & Kemp, A. H. (2022). The 'Rippling' Waves of Wellbeing: A Mixed Methods Evaluation of a Surf-Therapy Intervention on Patients with Acquired Brain Injury. *Sustainability*, *14*(15), Article 15. https://doi.org/10.3390/su14159605

# Leaving the clinic room: Clinical psychologists experiences and perceptions of working outside of the clinic room

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## Abstract

Clinical psychologists are expected to be adaptable and have a wide range of interventions at their disposal. There has been growth in the use of psychological interventions outside of traditional clinic spaces arising from to an increased interest in nature and a need to adapt interventions since the Covid-19 pandemic (Cooley et al., 2023). With this increase in interest and use, it is important we understand the experiences and perceptions of clinical psychologists of leaving the clinic room. Seventeen clinical psychologists practicing in Ireland took part in semi-structured interviews to explore their experiences and perspectives of conducting interventions outside of the clinic room. Data was analysed using reflexive thematic analysis. Four main themes were identified: "*What!?, leave the sanctity of my clinic space?" Traditional spaces as safe, "We've KPIs to hit" Organisational pressure, Enhancing therapy* and *Wherever you are, you're still a psychologist*. Clinical psychologists were aware of the potential benefits and opportunities to enhance therapeutic interventions by leaving the clinic room but the potential of risk as well as organisational barriers frequently prevented them from engaging in such interventions. Working outside of the clinic room is an adaptation to practice that may be important to further support in practicing clinical psychologists through training and support networks.


*Keywords*: Talking therapy, Nature therapy, Walk and talk, Assertive outreach

**Leaving the clinic room: Clinical psychologists' experiences and perceptions of working outside of the clinic room**

Although the clinic room is where clinical psychologists spend most of their time (Carr, 2012), there are several reasons they may deliver psychological therapies in other environments. There is a significant portion of service users with severe mental illness who may struggle attending traditional therapies, and alternative approaches can be beneficial in encouraging engagement. Approaches such as assertive outreach use models of engagement that involve meeting service users in the community (Berghmans et al., 2024). These community settings are often third places, a term for social and common areas including public spaces, cafes, etc (Jeffres et al., 2009). Assertive outreach and related approaches are often used to target groups who are difficult to reach, such as older adults (Yang et al., 2006), indigenous groups who may be apprehensive of traditional approaches (Elgharbawy & Bove, 2025), those with substance use issues (Penzenstadler et al., 2019), and with unhoused people (Fisk et al., 1999). Furthermore, the rise of interventions which include exposure to nature or other physical activities has begun to challenge traditional ways of working (Cooley et al., 2020, 2023; James et al., 2021; Naor & Mayseless, 2021a). The current paper will consider these various contexts for psychotherapeutic work, which collectively represent a move away from traditional clinical spaces, i.e. therapy rooms.

Assertive outreach is an approach adopted by mental health teams which typically involves meeting service users more frequently and outside of the mental health clinic, typically in the community and service user's home (Berghmans et al., 2024). In the treatment of those with severe mental illness, assertive outreach shows promise in reducing disengagement (O'Brien et al., 2009) and is associated with fewer inpatient stays and better outcomes in difficult to engage populations (Moledina et al., 2021). Clinical psychologists play a vital role in assertive outreach teams (Division of Clinical Psychology, 2013), but little

research has examined what their direct involvement with service users on these teams involves, and how leaving the clinic may impact psychological therapy with clients. When using assertive outreach approaches, clinicians can find themselves needing to be flexible and conducting therapy in community settings, service user homes or gardens, walkways and more (Berghmans et al., 2025; Division of Clinical Psychology, 2013). There is little research on psychotherapy in people's homes, and the existing limited research typically focuses on older adults (Demmerle et al., 2023; J. A. Yang et al., 2009). Research suggests that clinical psychologists working on assertive outreach teams can feel de-skilled, as their training does not prepare them for the range of work and work environments this approach requires (Pipon-Young et al., 2010).

Outside of assertive outreach teams, it is not clear in Ireland how often clinical psychologists deliver therapy in spaces other than clinic rooms, but in the United Kingdon (UK) approaches like walk and talk therapy have increased significantly due to the Covid-19 pandemic (Cooley et al., 2023). Clinical psychologists have also begun to use outdoor spaces to address challenges in specific settings such as reducing exposure to infectious diseases in inpatient settings (James et al., 2021) but also to enhance therapeutic interventions (Cooley et al., 2020). Practitioners using outdoor settings have several levels of engagement with nature, from passive which simply entails carrying out therapy in nature, to more active, where activities and nature are brought into the therapeutic activity (Cooley et al., 2020).

Leaving the clinic room may have advantages. Spending time in nature has been found to positively impact mental health (Callaghan et al., 2021; Trøstrup et al., 2019; Wang et al., 2025). These findings may be particularly relevant for those with mental health conditions (Kondo et al., 2020; Shrestha et al., 2025; Troughton et al., 2024). Approaches such as outdoor therapies can attempt to take advantage of the positive effects of nature to improve outcomes in those with mental health conditions. They may be an accessible and

effective addition to mental health treatments, but research on them remains inconclusive (Harper et al., 2021).

When delivering therapy outdoors, some have theorised there are additional benefits associated with nature, such as reducing power dynamics, and nature's potential as a therapeutic tool in itself (Naor & Mayseless, 2021b; Troughton et al., 2024). Delivering talking therapy outdoors is a growing area of research interest (Cooley et al., 2020; Naor & Mayseless, 2021a). The British Psychological Society provides guidance on carrying out walking therapy in outdoor spaces (Cooley & Robertson, 2020) and the integration of nature into talking therapies is an area of ongoing development (Naor & Mayseless, 2021a). A variety of terms have been used for these approaches, such as nature-based interventions (Shrestha et al., 2025), outdoor therapies (Harper et al., 2021), ecotherapy (Rueff & Reese, 2023) among others. These names are poorly delineated and often used interchangeably (Revell et al., 2014), encompassing a broad range of activities such as spending time in nature, nature-based activities, and carrying out therapy in a natural environment.

Previous reviews of outreach-based interventions have grouped working in nature and working in the community as outreach interventions, as they are both ways to connect to service users outside of the clinic space (Elgharbawy & Bove, 2025). A study on the perceptions of nature-based interventions with management in health organisations in the UK found that they also tend to group these interventions together as being 'out of the office' (Cooley et al., 2022). Although these interventions tend to be grouped separately in research, clinical psychologists are expected to be adaptive and integrative and use the most appropriate intervention for the client they have. Therefore, we have grouped the use of activities, nature, and community working together to explore psychologists' perceptions and experiences of working outside of traditional clinic spaces.

Clinical psychologists in Ireland possess a specialist qualification in clinical psychology and they typically work in primary, secondary, or tertiary care systems and with a range of populations including, adults, children, those with disabilities, and those with physical health conditions (McDonagh et al., 2024). Clinical psychologists are encouraged to be reflective scientist practitioners and to adopt a wide range of intervention approaches and to adapt to the needs of service users (McDonagh et al., 2024). However, it is unclear what their attitudes and perspectives might be with regard to delivering psychological therapy outside of the clinic room as no research has focused on the use of therapy outside of the clinic room with clinical psychologists in Ireland. Psychotherapists who carry out therapy outdoors describe it changing the therapeutic relationship, with potential for positive impacts (Moore & Mahmood, 2025). Therefore, this study sought to address this research gap by exploring the views of clinical psychologists in Ireland about conducting psychological therapy outside of traditional spaces. More specifically, the research explored the following questions below.

**Research questions**

- What are clinical psychologists' experiences of conducting therapy outside of traditional therapy spaces?
- What are clinical psychologists' views about conducting therapy outside of traditional therapy spaces?
- What knowledge do clinical psychologists have about the evidence base related to conducting therapy outside of traditional therapy spaces?

## Methodology

**Participants**

Practicing clinical psychologists were recruited in Ireland through professional organisations and social media using purposive and snowball sampling. The recruitment flyer

was necessarily non-specific by asking psychologists to participate in a study about current clinical practices, as we wanted a range of participants who were both interested/invested and not interested/invested in non-traditional therapy (see Appendix 5). Therefore, the flyer did not mention alternative approaches, outdoor therapy, or assertive outreach. The flyer was distributed by the Psychological Society of Ireland Division of Clinical Psychology to members and professional social media sites.

Eleven participants were female and six were male. Participants were an average of 46 years old and qualified an average of 14 years (ranging from 32 years to less than five). Only one participant worked primarily outside of the clinic, and a second has previously delivered an adventure camp with therapeutic elements. One participant had previous experience on an assertive outreach team. Eight participants worked primarily with children, seven with adults (one primarily inpatient), and one with older adults. Four participants worked privately with the other twelve working in the health service or publicly funded organisations. Due to the relatively small number of clinical psychologists working in Ireland, participant numbers are not paired with demographic information to reduce identifiability.

**Design**

A qualitative design was deemed most appropriate to address the research questions, in order to explore the wide range of practices, experiences and perspectives of Clinical Psychologists working in Ireland. A semi-structured interview format was chosen to allow for a wide array of experiences and perspectives to be prompted and allowing the interviewer to explore these, without limiting participants in their responses. Interviews were chosen as the most appropriate method for learning about the experiences and perspectives of participants, unfettered from group dynamics (DiCicco-Bloom & Crabtree, 2006). An interview schedule (Appendix 6) was developed based on the literature and discussions between the authors. An

additional question was added after the third interview in order to explore participant's experiences from their perspectives as clients, where applicable (clinical psychologists who had taken part in alternative approaches such as walk and talk or activity-based interventions). This was based on several of the earlier participants disclosing their experiences of therapeutic intervention and activities outside of traditional therapy spaces. While this means this question was missing from the first three interviews, we did not exclude them due to the loss of valuable data this would have incurred.

**Analytic Approach**

Due to the exploratory nature of the research, reflexive thematic analysis (RTA) was chosen as the most appropriate method of analysis (Braun & Clarke, 2019, 2021). RTA allows researchers to develop themes across cases, in the analysis of a larger heterogeneous sample. Although all our participants were clinical psychologists, their areas of practice and expertise varied widely. RTA is also suitable when a goal is to develop results that have implications for practice (Braun & Clarke, 2022). Both an inductive and deductive approach were used where appropriate: inductive in order to best develop practice implications from data, and deductive where appropriate theories could be applied as a lens to best understand the data. Data was analysed more at the semantic level than latent and primarily experiential in the sense that we aimed to understand and capture perspectives and understandings of our participants, but critical where there was conflict or contradictions within accounts. Finally, we adopted a critical realist ontological approach, meaning that participant accounts are considered socially influenced perspectives on what is real for them (Braun & Clarke, 2022).

Braun and Clarke's six-phase approach to RTA was used (Braun & Clarke, 2022). This was primarily carried out by FF, and as recommended by Braun and Clarke, (2022) the personal pronoun I is used hereafter and refers to FF. The first phase began with data familiarisation. Interviews were conducted and recorded using video recording software on

Microsoft (MS) Teams, and when correcting the transcription I was able to rewatch them many times to be able to situate the text in the tone and gestures of the participants. Transcription was done automatically within MS Teams using the transcription function and was checked against the recordings multiple times to ensure accuracy, including during the initial coding phase. I kept a journal of trends that I noticed and reflections throughout all phases of the analysis.

During the second phase, generating initial codes, Nvivo 14 was used to aid in this process. Interviews were coded in order and the first two interviews were revisited once initial coding was completed on all data to consolidate similar codes, where appropriate. A sample of the coding is presented in Appendix 7. Some participant experiences were later judged to be outside the scope of this research, this was discussed among the research team and it was agreed they would be included at the initial coding phase and removed afterwards. During the third phase, generating initial themes, I began creating initial candidate themes. This was an iterative process with themes and subthemes being created and merged in order to create a coherent narrative of the experiences and perspectives of participants. Phase four, developing and reviewing themes, involved discussions within the research team that helped the refinement of themes. For example, the theme *Wherever you are, you're still a psychologist*, was originally several themes and captured ideas around training requirements, supports that participants felt they required, and guides to practice. This was consolidated into a single theme capturing the fact that all of these components are part of the role of psychologists, and this is just doing them in a different way. Managing the dual criteria for judging categories (Patton, 1990) was challenging with some themes and subthemes. The fifth phase, refining, defining and naming themes was carried out with the consideration of creating a clear narrative from the data in order to best answer our research questions. The sixth and final phase involved the creation of the report and the final tasks of the

interpretation were completed. This involved determining the order of the themes and revisiting names and descriptions for clarity. These phases were not linear but recursive, with revisiting of each of these phases happening throughout.

**Reflexivity**

FF, the lead author is a white, male, middle class person working within a medicalised healthcare setting, on teams where the lead is typically the psychiatric consultant. Working within this setting, where coercive elements (such as involuntary admission) can be used, and a lack of mental illness is privileged, shapes my worldview in several ways. The moral injury of being part of these systems can cause a pushback into wanting to do things differently such as assertive outreach, although this is not free from ethical implications (Claassen & Priebe, 2007). Besides the ideological elements of the Irish healthcare system, the service realities also influence my positioning. With lengthy waiting lists and a lack of accessible mental healthcare, working within a system where those with the greatest mental health difficulties, those who are in social deprivation and those with disabilities, can all have difficulty accessing and engaging with services, it is challenging as a clinician to not want to do more to reach people. My positivity about these interventions, or at least the assertive outreach approaches, could be seen as paternalistic, not giving the opportunity for people to opt out – or it could be seen as adapting to the needs of service users who would otherwise not be able to engage.

Therefore, I was aware that I felt positively about these interventions and although worked to remain neutral when conducting interviews, many participants had questions about the research, such as what motivated it. During these times my own enthusiasm for such interventions may have come across to participants and in cases this occurred early on in the interview, may have influenced participants to respond in a more favourable manner. However, participants primarily posed questions on the reasoning for the research, after the

interview. One participant wanted to discuss this further before the interview in order to understand the rationale for the research. Most clinicians were up front about negative aspects such as risk and the increased resources and time needed for these approaches and I worked to be open to these. While analysing the data I had to be mindful not to project my own want to make these approaches work and see them as an easily transferred model to positively impact all mental health services. This came up especially when asking participants around suitability. I had to reflect that participants' experiences were not mine and their concerns and fears regarding practice were legitimate and worked to be curious around these.

## Results and Discussion

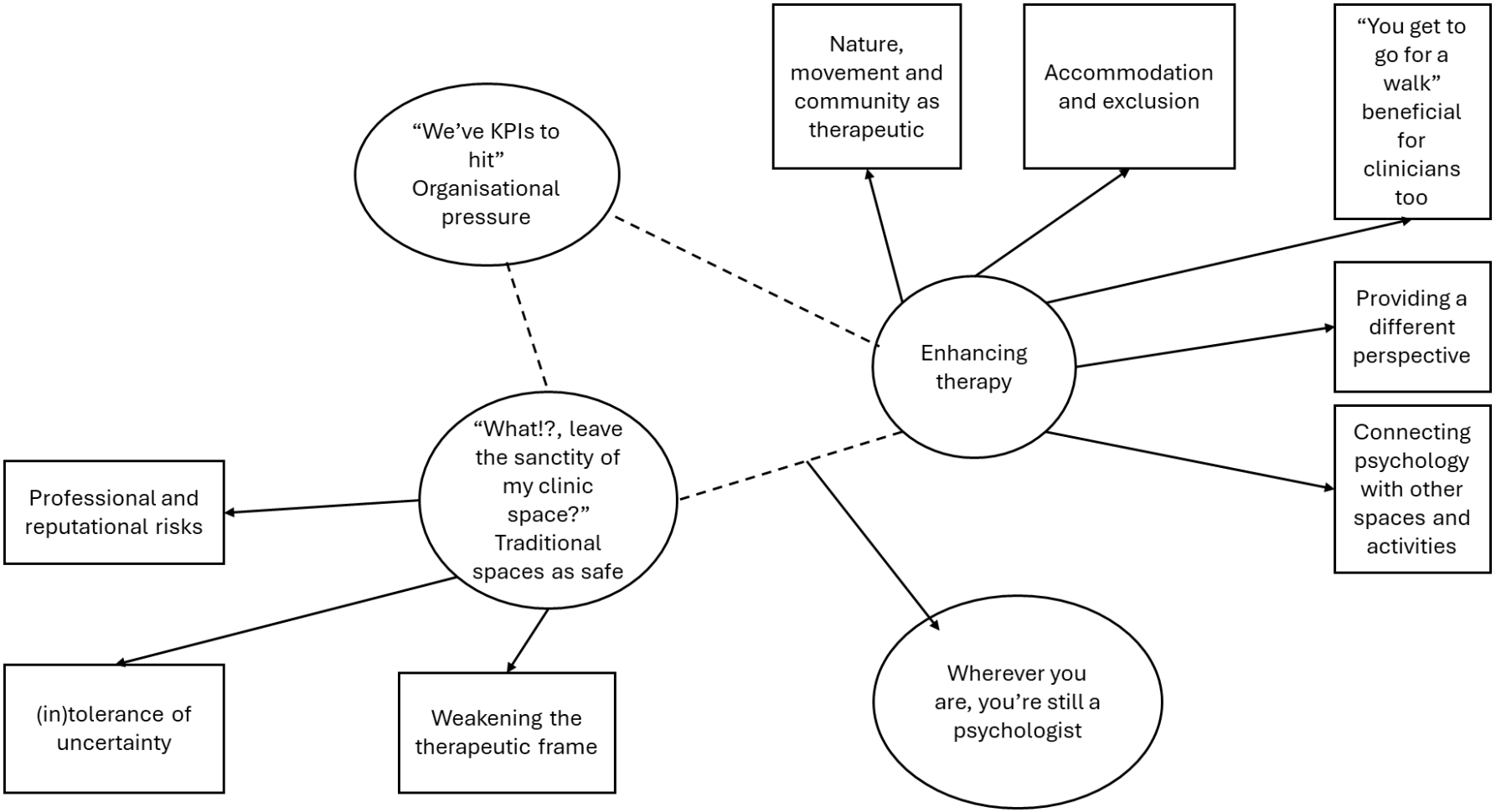
Participants spoke about using alternative approaches in delivering interventions outside of the clinic, in people's homes, gardens, third places including nature, as well as interventions which included activities not traditionally part of psychological interventions. These included using climbing groups, upcycling groups, yoga, and adventure camps. The Reflexive Thematic Analysis resulted in four main themes and numerous subthemes, in relation to clinical psychologists' perceptions and experiences of leaving the clinic room. Although all participants had experience of working outside the clinic room to some extent, this may have only been individual cases.

The themes were *Enhancing therapy* – which captured the many ways clinicians believed therapy benefits from the non-therapeutic elements of the interventions, either enhancing or even allowing therapy to happen. *"What, leave the sanctity of my clinic space?" Traditional spaces as safe* captured the range of fears clinicians experienced at the thought of leaving the clinic room, or at early stages of doing so. Distinct from fears regarding these approaches, in *"We've KPIs to hit" Organisational pressure*, clinicians described the organisational pressures and barriers that inhibit these approaches being used and which contributed to clinicians' hesitancy. Finally, *Wherever you are, you're still a psychologist*

captured how all participants still framed venturing into these approaches through the lens of a clinical psychologist, using the same professional and therapeutic skills they would in a clinic room. The themes, and their related subthemes, will now be discussed and can be seen in figure 3 below,

**Figure 3:**

*Themes, subthemes, and the relationships between them.*



## Enhancing Therapy

Nature, other spaces, and activities were seen to have inherent benefits to them which could enhance therapy. These were broken down into more active aspects, such as connecting psychology with other spaces, and more passive benefits, such as the positive effect of time in nature and of doing an activity, as well as benefits to the therapy related to reducing hierarchy and gathering additional information in seeing each other differently. Some of these findings are similar to those found in a meta synthesis of therapists who work in nature (Cooley et al., 2020). Another impact described was making psychology more accessible to those who might otherwise have difficulty engaging in traditional approaches. Finally, clinician benefits were mentioned, which were seen as a way for clinicians to improve their wellbeing and therefore their work. Participants appeared to value each of these elements as making a meaningful contribution to their work and their clients.

### *Connecting psychology with other spaces and activities*

Clinicians saw ways to actively use other environments and activities to enhance therapy, frequently by connecting psychoeducation or psychological techniques to nature and making them more relevant to the moment, as seen in the quote from Participant 1's (P1) experience of a climbing group run in a mental health service below. These approaches allowed for psychological techniques to be used by clients immediately, demonstrating their effectiveness to clients. One participant recounted how they helped young people at an activity camp practice focusing on goals rather than challenges for motivation and the participant could then use the current activity as an example so that clients could immediately see the benefits of it. This was an extension of a common style of intervention used in exposure activities where exposure and achievement were readily linked by doing the activity (Abramowitz, 2013). The connection between psychological knowledge and the activity adding a layer of understanding for clients.

*"They* (clients) *like the parallels between things like the fight or flight response and adrenaline and all of that. They could, you know, relate it to the climbing part and then not like the negative cognitive beliefs and everything that came into play,* (clients) *were like,"I can't do it. I can't do it" and then being able to do it." P1*

Most clinicians also spoke about using the outdoors to enhance grounding techniques, while they were effective in clinics, they were perceived as having additional power when done outside. This was available as a backup for clinicians when traditional approaches were not sufficient. The implication was that being in other environments or engaged in activities helped to get clients out of their head and into their bodies. This was seen as a requirement for dealing with conditions like trauma especially.

*"Even the focusing work and so on, just getting out of your head and focusing on what your body is telling you, if anything or what answers are in your body?" P10*

*"If I'm struggling to help them ground in session then I would think about. OK, let's go outside" P1*

Sometimes the psychological knowledge and techniques were implicit, for example, suggesting psychologist and client take a walk as a way to help clients practice behavioural activation or participants being able to connect movement with perceived improvements in mood for clients. Participants used their psychological knowledge, informed by their formulation of the client, to make interventions such as behavioural activation, even if they did not make the link explicit, the impacts on clients were still present. This is a departure from traditional models of working where participants could use the environment and activity as ways of encouraging client factors, such as motivation and autonomy (Scheel, 2011).

*"Especially with people with low mood, I actually think getting them moving it might be the only it might be the most movement they have on a day, just the most basic level in terms of like behavioural activation. I think it gets people moving and I think even*

*the kind of happy hormones and things that that brings, you can kind of almost see people perking up within 10 minutes of going for a walk." P2*

Sometimes the connection between psychology and the location was more abstract, where metaphor was used to connect nature and a clients' experiences or a psychological lesson. In the example below, observing change in nature during the session, which would be more difficult during a clinic session, was seen as a way to help a client understand and accept change. This was only one of several metaphors used connecting nature with areas such as grief, choice and spirituality, which were all used to make psychological ideas more tangible for clients.

*"We will have been together during the winter, when everything was bare and empty and then as we progress in our therapy, we'll be able to highlight the, let's call it, the green shoots idea and then some are seeing things blooming, highlighting that we're going to have bad times coming and difficult times and that's normal. Hence the autumn and the winter again. But that actually the cycles do pass. So a lot of it would be, I would use a seasonal type reference point" P16*

It was suggested that the connections with nature and psychology would be taken forward beyond the therapeutic intervention. While interventions in the clinic room stay there and are in a way, no longer accessible to clients once they finish a session or therapy altogether, interventions held in nature are embedded into the client's memories of those places. These places can then become sources of strength and reinforcement of psychological growth for clients. Sometimes this is planned literally in sessions such as the comment below about a client whose sessions were held in the hospital garden:

*"*(spending time in the hospital garden was a) *little bit more sacred kind of association because that's somewhere that she would then go at other points during the week and kind of practise the skills or reflect or take time for her space for herself (…) she did*

*kind of seek it out and it'd be (...) her place to go to if she was distressed, to kind of help her regulate because it wasn't a very easy place to live." P8*

*"A lot of my clients would return to the routes that we would use that they've chosen that they may have never really used before therapy, but now they use as part of a healing journey. They actually go the physical walk to get there so the idea that this route means something when therapy's not even taking place." P16*

Some research has found practitioners who use these approaches described nature as a co-therapist and one participant in our study who used nature captures this perspective more explicitly (Harper & Dobud, 2021). P17's suggestion that nature throws up the perfect analogy, mirrors the way that while they were using metaphors in nature to teach clients psychological ideas and make sense of their experiences, simultaneously they were using nature to make sense of how they worked with clients, using their environment and context to connect with and support their clients. Their clients better understand psychological lessons through the lens of the natural world, and the participant made sense of how they work through attributing their ability to nature.

*"You know the natural environment just naturally throws up the perfect analogy. You know, it's like* (imitating talking to a client) *that sheep over there all on their own, you know, and you'd wonder, like, is that a very unhappy sheep on their own? Or maybe, you know, they just need to be on their own because they found their best bit of grass, and that's what they're chewing on now, you know those kinds of things just appear" P17*

As discussed later, changes in the therapeutic frame could be seen as negative but some participants described how a change in roles and locations could be used therapeutically. One clinician noted celebrating with a child client after they received an autism diagnosis they had wanted, with a slice of cake in a coffee shop, which they found

important as the young person did not have other supportive adults in their life who would be positive about the diagnosis. A change in the frame also aided participants' symbolic move towards an ending in therapy - moving from the clinic room into the 'real world' outside as a way to symbolically show a client they were ready to get back out there and live life.

> *"We got the crux of the work done, the therapeutic work that was difficult in a very safe, controlled environment in the office. But then we continued kind of almost like the relapse prevention work in the coffee shop. I thought that was nice and that was a nice kind of way to move towards an ending." P4*
>
> *"Celebrate it* (young person's autism diagnosis) *and get a coffee and it was a nice and sunny day and we were able to, the whole session was kind of spent focusing on that* (the celebrating) *and I don't know if you'd have had that same kind of celebratory moves in a clinic setting for an hour would it have held?" P2*

***Nature, movement, and community as therapeutic***

Just being in nature was seen as a positive by participants, with some referencing research supporting time in nature as a wellbeing intervention. The nature elements were treated as separate from the psychological components, distinct from the previous subtheme, and were considered a different form of therapeutic intervention in themselves. These were seen as adding on to the benefits of therapy as illustrated in the quote below by participant eight.

> *"Taking it* (therapy) *into a nature setting where possible would have kind of a double impact in some ways." P8*

The individual benefits named were frequently vague, with participants mentioning grounding and healing. Despite this, participants were definitive in their belief that time in nature is a positive. For P9 this almost took on mystical overtones and was communicated to clients, bringing the importance of nature into the therapeutic intervention.

*"We forget so often, nature heals us, contact with nature actually heals us" P9*

*"If you're out in nature like the just the whole bit of nature, you know, fresh air, kind of freedom, I suppose, from the constraints of a room, I think they would be really might be positive." P14*

*"The place with that we go is one of the few ancient Irish, kind of deciduous, it's the only one in Connemara and so to be in the presence of these ancient oak trees and you know the moss and knowing that the moss is only there because the air is so pure. (...) Just the being here. Even if we did nothing but stand in the one spot for the next four hours, it would be good for us, you know?" P17*

Similar to time in nature being seen as a positive, participating in activities was seen as a positive in and of itself, discrete from the psychological elements of the intervention. These were more frequently connecting with achievement, or novel experiences for clients. This was often seen as something that was missing for those with mental health difficulties that would not have been done if it was not connected with these interventions, an element that is lacking in traditional interventions.

*"The activities themselves sometimes are enough to help kids feel good about themselves because they might achieve or do something that they've never done before. We have lots of kids who, you know, have never jumped in off a pier into the sea" P17*

*"When I think about the rock-climbing piece like there was a very strong sense of community and shared interest and shared purpose and shared mastery." P1*

Interest or activity-based groups similarly were seen as having a positive impact beyond the psychological intervention. These unique elements of community, friendship, and shared experience were seen as somewhat distinct from those found in psychology-specific

groups that focused on areas such as social groups or emotion regulation. This is consistent with the social support and stress buffering models (Cohen & Wills, 1985).

> *"There's a lot of that kind of, I don't know, shared goodwill then that permeates the group and a lot of gentleness and kindness." P17*
>
> *"This might be their only opportunity to have made a friend and have had positive interactions with other kids and that the parents would have said, like, the amount of people who say, oh, like, they really made a good friend." P6*

These benefits were often framed against the challenges of working in clinic rooms which were often seen as borderline unsuitable for therapy by clinicians. Being able to take a break from the artificial environments which felt stale and unhospitable, even to clinicians.

> *"Being in the clinic room, especially one without natural light, can be like exhausting." P2*
>
> *"*(being in nature) *I suppose that it just naturally is more calming and maybe again, less threatening or intimidating." P7*

***Providing a different perspective***

A common finding in walk and talk therapy is an enhanced sense of mutuality within the therapeutic relationship (Cooley et al., 2020), some of that is captured within this sub-theme as well, but there were key additional elements. Participants spoke about sometimes seeing clients differently in both a practical sense, gathering more collateral information about their lives than they may have gotten in an assessment, and in a metaphorical sense, gaining insight into their clients' real experiences. Participants noted that they gained insight into many more areas of clients lives from seeing their homes. Other participants mentioned seeing them interact with the world where they may have gotten a better understanding of clients' lived experience, their mental health difficulties, or their interactions with others. This

additional lens provided insight into their clients that may have been more difficult to capture in an assessment.

> *"Even to see, oh my God, there's actually kind of two grandparents in the corner whose needs are huge, whereas they may might not even feature in an assessment that you do in the clinic." P5*

> *"I learned a lot more about what it was actually like for her to be in that situation rather than her describing it. I was like, God, she's terrified (...) I had a greater appreciation for her level of fear in that situation." P12*

Participants frequently mentioned material for therapeutic intervention came up due to being prompted by the environment. Being outside the clinic in their homes, gardens, or in nature encouraged clients to reveal parts of their lives they may not have thought to share in regular sessions. These helped participants gain insight into the lives that clients had led and even helped shape interventions. Participants described this as a richer form of interaction which would have been missed had they never left the clinic. P4 and P2's examples below illustrate this, with material that came organically from the surroundings providing material for intervention:

> *"*(Hearing birdsong with an older adult in the garden of a nursing home) *The patient that I was working with, the resident started reciting a poem. Hope is a thing with feathers (...) the whole poem was just about hope and, you know, hope is very fragile. But it's the same time. It stays. And there's great meaning in it. And that formed the basis then of the work we were doing in that session, but that would never have happened if we weren't sitting outside." P4*

> *""That's where whoever's body was found, I knew them through that."* (participant quoting client describing the death of a friend) *Do you know? And I don't know if he'd have brought it up if we weren't walking." P2*

*"The conversation isn't limited to the kind of clinically kind of questions that we might be inclined towards." P11*

Participants also described a shaking up of perspective in both clinician and client that allowed for progress to be made in therapy or in a clinician's formulation for a client. Each of these provided insight and information which would likely not have been attained if restricted purely to the clinic.

*"It can take someone out of the kind of repetitive narrative that they might be in." P1*

*"We got to meet the kids themselves in a setting where they were not actually distressed (which) feeds into the formulations back in the clinic." P7*

***Accommodation and exclusion***

These approaches were frequently framed as ways to overcome challenges in traditional approaches. For example, participants described working with clients who find face-to-face therapy difficult, who would not have engaged in traditional interventions with the belief that "*they would just say they weren't suitable*" P11. Some of the groups described as being likely to be excluded were neurodivergent people, men, those with concentration or regulation difficulties, and clients with a mistrust of the mental health system. This additional regulating factor of being outside and overcoming client barriers to attending services were all seen as important positive aspects of approaches outside of the clinic room. Although some of these accommodations could be made in the clinic, it was often not seen as enough.

*"Perhaps if we think about someone that might be neurodivergent coming into a clinic space, the lighting, having the people, the noises, even though, you know, we try so many things to help with that and to help regulate. Imagine if we could go to a place for them that felt calm and soothing. It'd be so different," P13*

*"Clients with neurodivergence actually as well who might find kind of that eye contact and that shared attention quite difficult. So I think that actually could be*

*particularly helpful for those. I think it could be a nice way to kind of build rapport. Without it being, I think I think a lot of clients actually fear therapy and they can be very anxious coming to see us." P8*

*"If you're neurodiverse, for example, it would definitely help if the interventions were more flexible to meet your needs. Doesn't mean you want to go surfing, but it might mean that the, you know, psychologist would take into consideration the bright lights, the noise, the kind of things that would kind of give you." P11*

The regulating impact of being in safer environments was seen as helping clients feel safe, open up, and even retain more information. This meant again that clients who did not have this available to them would be missing out on potentially important elements of therapeutic interventions or even excluding them from services. This accommodation was even seen as overcoming a client's previous negative experience with mental health services in the quote from P2.

*"Just having someone to talk to, to process stuff, to help him understand himself was amazing and he didn't have that before because he couldn't access it… He didn't like it. He didn't feel comfortable. He couldn't sit still. He didn't like the psychologist he'd met." P2*

*"I found that that some of the clients that I worked with therapeutically within the hostel would tell me things on those walks that they would never tell me in actual sessions." P9*

While clinicians often spoke fearfully about leaving the clinic room, they did also notice that clients were often fearful about entering the clinic room. Client fears were frequently associated with previous negative experiences with mental health services. For clients, participants felt that the clinic space could feel dangerous and this lack of safety was a barrier to the therapeutic work and for some clients to even showing up. In order to connect

these spaces with a feeling of safety, participants used assertive outreach approaches to get them to feel safe in the relationship before clients could feel safe in the room.

> *"Doesn't matter what the therapeutic approach is, if they're not safe, nothing is going to happen." P11*
>
> *"(Quoting hypothetical client) "I lost my grandmother in that building. I don't feel comfortable going back in there" So the idea of being somewhere else is straight away we had a massive uptake. So our 'did not attend'* (a term for a client not attending an appointment without notice)*, went from kind of 80% down to 1%." P16*
>
> *"I'd see him in his house and he was so at ease. Initially he was obviously nervous, but over time he was so at ease and then I would go with him. I used to accompany him sometimes when the nurse couldn't up to his psychiatry appointments and he would be sweating buckets." P2*

Participants believed that the ultimate result of this fear for many clients was they would not be able to attend services and they would effectively be excluded from treatments. P2 and P12 described how clients are expected to fit within services and not the other way around.

> *"In terms of assertive outreach, pragmatically, all those parts I think are so, so important especially for vulnerable client groups 'cause I just don't think you'd get these people if you didn't use alternative therapy. They'd just be missed." P2*
>
> *"Even though we're trying to get better, it's like 'client, you must come to us essentially and operate according to our laws'. In lots of ways, right there is a bit of that 'you come, we have a system you fit into the system or you don't', like that's it." P12*

*"People going to be discharged without getting a service with the belief system. Traditional model is they don't want to engage in the service (...) they do want to engage with psychology, but not in the way that we usually practise." P16*

There were levels of acceptability to this as well with participants mentioning addressing agoraphobia with clients in their homes more frequently than other approaches, similar to the almost-sanctioned ability for professionals to leave the clinic to deliver exposure treatments. Another group more likely to be visited at home or in third places were older adults, although only one participant worked exclusively with older adults, so it is unclear whether others held that view.

***"You get to go for a walk" beneficial for clinicians too***

Clinicians spoke about the personal and professional benefits they experienced from these approaches. These ranged from the benefit of shifting a stuck feeling, recognising the sedentary nature of psychology and that as P2 put it "*you get to go for a walk*" which helped with health as well as thinking, or simply feeling like this way of working matches who the participants felt they are as people. There was a recognition that the work done by clinical psychologists can be very demanding and that the benefits of alternative approaches can benefit the clinician, and the therapy.

*"I suppose, the job satisfaction with that that we feel like we're making a difference and sometimes in traditional therapies (...) we can feel stuck (...) So I suppose for our own joy and entertainment, but also I suppose to move forward with therapy where maybe the tradition isn't always working." P7*

For one participant, they noted that the way they work with their population (older adults) is more authentic to them, closer to how they would like to be treated, which they saw as an additional benefit for them in how they work. It allowed them to bring more of themselves to the work, similar to accounts from therapists offering walk and talk therapy by

Revell and McLeod, (2017) where therapists embodied in their work a deeply held belief in their way of working.

> *"The way I'm treating the people I work with is how I would want to be treated like I would see myself as quite a home bird, and someone who likes sitting in the garden (...) My own kind of personal way of being and how I am as a clinical psychologist." P4*

The benefits were not always where the participants got to go, but where they got to leave. The juxtaposition between participants' descriptions of clinic rooms as sterile and lifeless in contrast to the outdoors, which was frequently described as alive or more human, was striking. The contrast in working almost seemed to be between life and the absence of it. This may be contributed to by the majority of participants working in mental health services in the Irish health service, the Health Service Executive (HSE), where they often cannot personalise rooms or attempt to make them more alive.

> *"I just think that when you're outside, it just feels more hopeful if you have more moments of joy than you do in just a white sterile clinic room. It just feels more alive. You just feel like more human. And so I think they're the pieces that I think you can't capture in a clinic space as easy." P4*

Variety, freshness, and these more "real world" experiences were seen as increasing longevity in a challenging career area. Breaks from the clinic, feeling more joy, and getting to see real world change in individuals were all important to the participants.

> *"In terms of like managing burnout … Yes, it's hard work and you're giving (a lot) of yourself, but it's fun at the same time. And I do think being in different settings can just be a nice, just lift and a boost to the day." P6*

> *"Variety in your working week is a huge thing. I really, really, really do crave a bit of variety." P8*

*"I definitely see it as a change being as good as a rest." P16*

**"What!? Leave the sanctity of my clinic space?" Traditional spaces as safe**

Participants frequently described fears related to leaving the clinic room. These fears were primarily about what could go wrong and were broken down into three subthemes: *(In)tolerance of uncertainty, weakening the therapeutic frame,* and *professional and reputational risks*. These were all framed as the traditional approaches being safer ways to work.

***(In)tolerance of uncertainty***

Participants' accounts frequently focused on the risks of leaving the clinic room. Practical risks often centred around the physical safety of either the clinician or the client when not in the clinic. This was often centred around the unpredictability of the world outside of the safety and support of the clinic space. As P10 put it, outside the clinic is "an uncontrolled space". In contrast, the clinic space was considered safe as it was more predictable and there was frequently a team nearby, although even those working in private practice without a team still described the clinic as safer.

*"You can't control the environment and that's difficult." P4*

*"Being somewhere where there's other staff is important as well. Like, that's something I'm thinking about because the minute you leave your space, whatever, you're also leaving the support of the system around you in some ways" P12*

Interestingly all participants reported using alternative spaces for exposure work although it was also described as risky and fear-inducing to one participant, paralleling the process of fear and avoidance that exposure works to overcome. Participants who used these approaches for exposure spoke about it as being a necessity rather than a choice. As the below quote illustrates, the fears were more hypothesised than experienced, participant

reporting no adverse experiences but still demonstrating a level of fear regarding leaving the clinic.

> *"Even within even doing exposure work, I'm always sort of concerned, but it's because it's necessary for the therapy. I just sort of motor on ahead with it and I've never had, thankfully never had any negative sort of experiences, but I am mindful" P10*

A leading theory of fear that exposure work is designed to treat, mirrors several points made by clinicians, namely danger, unpredictability, and uncontrollability (Armfield, 2006). This sense of fear and uncertainty around the physical danger of these approaches was evident in many of the interviews, especially those of people who did not use these approaches frequently. This maps onto how avoidance frequently worsens fears, even innocuous activities appearing to take on more dangerous aspects. In contrast, participants who used these approaches frequently mentioned practicalities of managing risk, but not fears. They described specific events that may happen and contingency plans for how to deal with them. Clinicians without extensive experience of these approaches could not tolerate the uncertainty associated with them.

> *"You're taking someone out of that safe place and you're putting unpredictable things. And they're like, and that can even be something as small as going to a coffee shop like, you know, you we just don't know. Even to cross the road with someone and something happens like you're adding so much more risk to therapy the second you remove it from those four walls within a clinic space." P13*

> *"You feel you need support as a clinician to help with the person you're on your own (...) It hasn't happened, but it could happen. That would be a worry." P4*

Furthermore, as predicted by Armfield's theory (2006), clinicians often reassured themselves by focusing on changing their level of perceived control in the situation. This was

through a predicted belief in their own abilities or in their assessments of clients and activities. This confidence would remove the fear related to leaving the clinic room.

> *"They* (clinicians who use these approaches) *would need to, really, I suppose, trust in their own crisis management as well. You know, if something did go wrong" P13*

Even when clinicians had not had reason to use security measures they felt these provided some reassurance for them in their practice. This is similar to how individuals experiencing fear will attribute their feeling of safety to a safety behaviour or external factor.

> *"You're not going to have alarms in the community, we don't use them here anyway. But you know they're under the desk if we need them." P8*

The impact of unpredictability on the clinician's practice was also an issue, with participants expressing concerns regarding how well one can practice in strange environments due to being taken out of the moment by external stimuli. This sense of danger reportedly led to one participant being distracted during sessions, and potentially impacting their practice.

> *"I would definitely would have my own, at the times of, anxiety, different times in houses where I might be completely safe with the clients but I'm like, who's at the door? Is someone in the bedroom that you don't get in a clinic setting" P2*

For private clinicians, one participant mentioned how their fear is amplified by their insurance company drawing their attention to these risks and selling them protections against risk. Even though the participant had no negative experiences, they were fearful, and this fear was stoked by insurance companies. This participant even uses the word protect, highlighting the feeling of danger from these practices.

> *"I've never had, thankfully never had any negative sort of experiences* (leaving the clinic room for graded exposure)*, but I am mindful and ... They're* (insurance companies) *forever sending you drop mails about the legal implications of this and*

*the note taking and this and that and those firms is providing you with lots of sort of very expensive courses that you can do to learn how to protect yourself from risk and so on." P10*

***Weakening the therapeutic frame***

Besides these very practical fears, participants were fearful that leaving the clinic room would also mean leaving the therapeutic frame. The therapy frame is defined in several different ways but core elements are usually location, length of session, fee (if applicable), confidentiality, and the therapist using minimal self-disclosure (Langs, 2017). Participants had concerns primarily about the elements related to confidentiality and the blurring of boundaries, although some referenced the lack of containment due to the breakdown in frame and a worry about role dilution. P12 captured this fear well *"I'd worry about losing the role of myself as psychologist"*. Without the frame to rely on for support, participants worried about their ability to maintain boundaries in different places and modes of working. Participants' fear appeared to be about their own ability.

*"You're changing the relationship it can sometimes feel a little bit less boundaried when you're out of a like recognised therapeutic environment." P1*

*"If you end up doing these non-traditional spaces and whatever, like you risk contaminating that a bit, you risk it being a bit uncontained and you risk yourself feeling a bit uncontained," P12*

A level of discomfort in the participants, as opposed to in their clients, related to potential frame violations was discussed. No participants mentioned clients reporting these difficulties and a participant who reported this as a primary mode of working found that they needed to draw client attention to these challenges. Similarly, when the issue did arise it was the clinician, not the client who was uncomfortable with it. This suggests the clinicians felt the responsibility for maintaining the therapeutic frame. These often weren't abstract fears;

P4 gave an example where several of these issues emerged while meeting a client in a third place:

> *"She just said can we meet in a coffee shop instead, which we did, and I found that intervention really quite difficult because and whether it's the power and control piece, I don't know. But I just think you have to keep a really critical eye on your own practise sometimes and it on is this is this befriending? Are we just having a little chat here? Confidentiality wasn't great, there was other people around approaching her. She was she was a local woman who was well known" P4*
>
> *"...feel like it breached a bit of the privacy. Yeah, I don't think she felt that, but I just felt like it was more. I was uncomfortable not having that space." P12*

Participants' worries about the impact of the therapeutic frame were primarily that the therapeutic work would be negatively impacted - that they would not be able to maintain the same level of quality in their interventions. This was not seen as insurmountable, but an additional challenge.

> *"I think it's actually harder work for clinicians. I think it's like from yeah, when I think about it in terms of what we've just been talking about note keeping and sharing formulations and kind of keeping an eye on your own practise that it doesn't get too watered down. I think that's quite challenging as a clinician." P4*

There was very little mention from most of the participants of possible ways to address this besides being aware of the additional challenge. Creating the additional rules and boundaries outside of the clinic was seen as an extra layer of difficulty for most participants. In contrast, one participant who primarily works outside of traditional spaces laid out their way of addressing it. They described these challenges to the frame as something to be prepared for, rather than feared.

*"Confidentiality people would assume is the biggest issue. I would say it's not a huge issue because if somebody for example says they want to meet somewhere that's extremely busy, tables are very close to each other. I will highlight the risks of that environment… confidentiality people overhearing and if, for example, the person still chooses to go there, I will go there, but I'll highlight that we need to be quieter and I will highlight that actually we might keep some of the content for a more secluded space." P16*

To make sense of why participants felt unprepared to manage the possible influence on the therapeutic frame, it is helpful to consider Langs (2017), who explains that the frame needs to be set up clearly at the beginning of the therapy, and that this may be more straightforward for clinicians when they know what to expect within therapy. Without experience of working outside the clinic room, or guidelines, they may lack the confidence to establish a slightly different frame. As Jordan and Marshall (2010) discuss, working outside requires a different way of working and adopting a 'living frame' that is mobile and adaptable, and this was not a familiar concept for most participants.

***Professional and reputational risks***

As well as these practical and therapeutic risks, participants were also very concerned about perceptions and risks to their individual and professional reputations. P10 expressed a common concern, that there could be "a reduction in respect for clinical psychologists" from the perspective of clients, but also from other professions and management. These approaches were seen by many participants as less serious, and they frequently assumed others would believe the same.

*"Could it lead to reduction in respect for clinical psychologists because they seem to be like your sport organiser or something?... they might see it as a bit sort of like new-agey as opposed to science-based." P10*

*"It seems like you're going to be like, is this guy actually trained?" P12*

Clinicians also worried about the risk of being seen by the team to not be fulfilling the role of a psychologist or taking on the roles of others. Participants' worries seemed to be exacerbated by a perception that clinical psychology's identity is less defined than it was traditionally. Trying to define the professional identity of clinical psychologists may be negatively impacted by doing therapy in ways that are seen as less serious and could cause tension on teams.

*"Oh, that's peer supporty stuff, (...) and they* (the team) *jokingly say stay in your lane, was very much like, you know, don't veer out of your lane." P1*

*"We always think about, like, the chaise longue, you know, and the clipboard. That's like, even though that's not what really it is anymore." P13*

This judgement was not only external to clinical psychology but seen as coming from within the profession as well. While very few clients expressed any personally held negative views about these approaches, some feared being perceived negatively by other clinical psychologists, or the wider profession. This mirrors the sense of professional difference described by Revell et al. (2014) as being held by therapists who offer walk and talk therapy. There was a sense that other clinical psychologists would not take them seriously or see these approaches as being below the dignity of clinical psychology. This also extended to a fear of negative consequences being experienced by clinicians who would engage in them.

*"Psychologists might see it as a disadvantage where they're, I don't know, is it a bit of a challenge to your ego to be like, oh, I've done all this training in all of these super complex experts kind of assessment stuff and you're asking me to go for a walk outside or and, you know, have a cup of tea or something. It's like, I have certainly encountered psychologists who would feel that might be beneath them" P15*

*"It's kind of like you're afraid to step out of that* (traditional approaches) *because you're really afraid of challenging, and the risk is particularly in Ireland if you challenge that you may be ostracized." P13*

**"We've KPIs to hit" Organisational pressure**

Unlike the fear that ran through the previous theme, this theme was more related to participants' views of their services not being supportive of these kinds of approaches and the organisational and logistical pressures contributing to not using them. Participants saw these approaches as an increased demand on their own and the services' limited resources, and also felt there were organisational and structural barriers to them implementing them.

Participants recognised that these approaches frequently take more time, effort and planning per session with a client and that current pressures on most participants mean they do not feel supported in using them. Interestingly this was seen not just in public services, but in private practice where they said that it would cost them more time and there would be challenges regarding billing and legalities, whereas those in public services noted pressures on their time.

*"I think the reality is they would take more time." P8*

*"If I wanted to do like let's say something on the beach or if I want to do something up the mountain like that's two or three hours for one client, if not more. Then how do you pick up the, do you charge more?" P13*

This perception came not only from individuals' sense of responsibility to waitlists but also top down within organisations. Several participants noted frustration with a sense of compromising therapy due to the organisational demands and expectations they felt.

*"It's not encouraged or supported for you to do that. It's kind of like you just get on and see who's on your wait list and keep going and keep going and keep going." P1*

Inherent in participant perspectives was that these approaches were not the most cost-effective use of time. Participants almost exclusively pointed to the increased amount of time required, while one clinician who used these approaches regularly argued they had seen the potential benefit. The participant recognises that in the short term these approaches take more time but, for those in the health services at least, they may be beneficial in the long term.

> *"One particular client I'm thinking they were eighty days a year in the approved centre and that was reduced down to one day a year. So, from a financial cost it's huge. For me, that's a very valuable walk." P17*

Other practicalities determined by the logistical factors were the facilities available being unsuitable for activities, or their location being inconvenient for them, with one participant noting the change in clinic location had changed the interventions available to them. Intervention choice was therefore driven not by what was best for clients, but what was available.

> *"*(using trauma informed yoga) *In the chair or encouraging them to stand up and doing some moves rather than like a full, like lying down yoga mat, probably also to do with the size of my room. It doesn't really facilitate that." P1*

> *"*(in previous setting) *we could have got a bit of garden and done something, whereas now (….) there's no space for that," P5*

Similarly, some clinicians benefited from their clinic locations and were able to use them to opportunistically enhance interventions. These did not always change the core of the intervention but were able to enhance the interventions as discussed above.

> *"we're very lucky* (nature rich environment) *is very near us here. We've done that actually with our DBT group as well with the introductory mindfulness sessions we once took that outside during the summer, we met in the* (nature rich environment) *instead." P8*

The specific organisational landscape of the service provided barriers and opportunities to adopting these approaches as well. Some participants noted a desire for specific policy to know whether they could and how to implement these approaches within their organisation safely, while one participant had an example of a good policy in their organisation which facilitated their use of them. This key organisational support was framed as either facilitating or blocking these practices.

> *"You don't want to just start off doing something by yourself because you need kind of like approval and there needs to be long working procedures or protocols around doing these things. So they probably have to come a little bit more from top than the bottom up to actually start implementing them." P2*
>
> *"it's a question of permission from management or the powers that be, you know. I guess that's why those policies and procedures are developed here is because people we're meeting hurdles and roadblocks and it was like, OK, well let's if we write it up and figure out a kind of a problem solving or troubleshooting approach to it and that'll help to kind of free up the ability or our space to do this." P15*

These findings fit well with previous research done with professionals delivering therapies outdoors (Cooley et al., 2020) where organisational barriers played a large role. Efforts to involve organisations in the development of these practices may help clinicians and organisations enhance practice safely (Cooley et al., 2022).

**Wherever you are, you're still a psychologist**

Participants spoke about what they found helpful in in their experiences of leaving the clinic room. Perhaps unsurprisingly, the competencies and attributes that were highlighted as being necessary are those of clinical psychologists in any setting. As P12 said, *"I have this like picture of like, cool psychologists using these kinds of interventions"*. P12 may believe those who use these approaches are "cool psychologists", but their role is still psychologists.

The competency areas that came up were assessment, intervention, evaluation, reflection, supervision, and continued professional development, competencies cited as core to clinical psychologists (Ahern et al., 2026; Carr, 2012; McDonagh et al., 2024). Formulation was the only one of these not mentioned by name in relation to the decision to leave the clinic room but a focus on the appropriateness of specific locations and activities for clients was the same in practice. For example, one participant who ran an adventure therapy style camp used it to help young people with activities designed to address issues around confidence, anxiety, and self-esteem. As mentioned in the theme *Enhancing therapy* above, using the environment to help clients regulate when they are judged to be too anxious to engage in traditional therapy was also a way of using a client formulation to inform an intervention.

Participants stressed the importance of assessment and particularly risk assessment (as discussed in the *(In)tolerance of uncertainty* in adopting these approaches, understanding that suggesting an inappropriate activity for someone could be unhelpful or even harmful. Key points were ensuring that activity and location are matched to the client's wants and needs, and importantly to avoid harm.

> *"People can maybe suggest activities that a person should do or get involved in, without maybe thinking about how that might impact them. So like you know, like going to a yoga class where the yoga teacher comes over and starts manipulating your body." P1*

Participants focused on the decision to use these approaches being deliberate and informed by assessment. As P12 said "*I wouldn't do it willy nilly. It would be for a reason".* Making sure they understand the purpose of the specific intervention for that specific client was important. As one participant put it, there are important questions to ask yourself as a clinician. While formulation was only mentioned in three interviews and never in relation to

planning interventions, participant descriptions of the rationale required for implementing these interventions was like that of a formulation, as illustrated below.

*"Why am I doing these activities? What is the point? What am I trying to achieve?" P6*

Participants also stressed not defaulting to any specific approach for specific diagnoses or even for individual clients but tailoring it to the client's needs at the time. Participants who did describe defaulting to an approach defaulted primarily to clinic-based interventions because they were familiar to them or because they lacked confidence in other approaches, often due to a lack of exposure to them during training or from other psychologists in their networks. P16 illustrated that they choose their approach based on the client need, although their primary approach is outside of clinics.

*"There are some people, for example, who every so often want to go into the clinic space because they've got very, very deep stuff that they really want to talk about. But they certainly don't want anyone to see them getting upset in public." P16*

Beyond individual assessment, clinicians also spoke about the suitability of these approaches for those with specific diagnoses but there was little agreement between participants. Many participants mentioned that the only group they believed would not be suitable would be those with psychosis or severe mental illness, while the only participant working in long-term inpatient disagreed.

*"People with psychosis, active psychosis, you know. They're hard to really match with any kind of environment that's traditional, so you know, things like kind of nature and stuff like that feels like very appropriate." P11*

This also meant not applying these approaches as a one size fits all but ensuring the nature of engagement was also tailored to a client, necessitating a strong assessment.

Knowing about the clients' interests and using those to tailor the intervention to be more engaging for them was an important consideration.

*"They come from a farming background so like to try and kind of make connections with that person we will go into the polytunnel" P11*

*"(client) absolutely adored, having like the hair done and the makeup and having the nails polished. So our therapy session used to be based actually in like the little spa room ... So when I go in weekly, my job used to be to paint the fingernails. So that's how we would get the therapy done." P13*

These approaches were expected to be evaluated and reflected upon similar to any intervention a clinical psychologist might carry out. One participant had worked to evaluate an outdoor intervention run by occupational therapists in their service; in this case the psychologist was more of a consultant to the intervention but their competency in evaluation still contributed. Participants also regularly spoke about revisiting the rationale for your choices as a clinician similar to how this is necessary in traditional practices.

*"Are there different outcome measures if you do it in this way?" P10*

*"You've got to be monitoring it and you know, doing whatever changes need to happen and you know, always come back to look at, well, are we going where we need to go here, do what modifications do we need to make, is this going well? Is it not going well?" P6*

Reflection and supervision were both frequently mentioned with almost all participants. Similar to any psychological practice, participants believed that it would be unprofessional to practice without supervision, and wanted tailored supervision to these approaches from professionals familiar with them.

*"I think strong supervision afterwards, after everyone debriefs, strong supervision, but firstly to be prepared going into it, you know, ... Did I mess up? You know? If so,*

*how, how might I learn from that? How can I improve that the next time, you know?" P9*

Continuing professional development was also spoken about, with almost all participants expressing an eagerness to learn from those who used these approaches rather than trying to figure them out on their own. Participants wanted to feel confident in the approach and were aware of the impact a lack of confidence might have. These approaches were not something participants wanted to try without a level of training and support.

*"You have to get top-down support peer support and find links and to other people doing similar things just to enable you to do it." P11*

*"It would be interesting to have a more formal input about this and like how to do it because people talk about that like, oh, just go for a walk with a client (...) and I'm like that feels very like big. You know, what is that? That's so cool but you need to have people who have done it before." P12*

Although almost all participants had experience of leaving the clinic room, and all the participants described the importance of doing so responsibility and deliberately, all but two participants did not know of any research or guidelines in the area. Of the two participants, one of whom worked in an organisation which provided guidance, and the other had a special interest in the area. Participants almost all expressed an interest in receiving information or training related to these areas, suggesting there is a lack of guidance from professional organisations and within training programmes on these approaches, despite a potential wide usage.

**Conclusion**

Self-determination theory may help make sense of these results within existing psychological theory (Deci & Ryan, 1985). Self-determination theory is a theory of motivation used to explain individual functioning behaviour and outcomes and may be useful

in understanding how clinical psychologists may adopt the approaches. Self-determination theory has previously been used more generally in organisational psychology to understand workplace behaviours (Hagger & McAnally Star, 2026). It uses the satisfaction of three basic psychological needs to predict motivation, namely: autonomy, competency and relatedness. In terms of our results, autonomy relates to how psychologists make the decision whether to use these approaches or not. When making the decision clinicians consider their understanding of their goals for treating clients and how these approaches may help them achieve them, as well as the benefits to themselves, and if they can choose to do these under organisational pressures. To exercise autonomy they also may need to feel free from the *professional and reputational risks* discussed. Competency relates to the theme *"What!?, leave the sanctity of my clinic space?" Traditional spaces as safe w*hich captures the lack of confidence that many of our participants experienced. Finally, our participants who were interested in these approaches all stressed wanting to be connected with other psychologists who use these approaches as well as having support from others in implementing them. In order for clinical psychologists to be motivated to implement these approaches, each of these criteria must be met.

The results of this study show that clinical psychologists leave their clinics for a wide range of reasons, and their experiences of these activities are informative in our understanding of the practice of clinical psychology. Overall, clinical psychologists experienced leaving the clinic room as an anxiety-inducing prospect, while simultaneously finding it appealing in a number of ways. They were concerned with remaining professional within this and not losing their role as clinical psychologists. These perspectives were situated within external challenges presented by the organisational and logistical barriers that complicated actual opportunities for practice even further.

## References

Abramowitz, J. S. (2013). The Practice of Exposure Therapy: Relevance of Cognitive-Behavioral Theory and Extinction Theory. *Behavior Therapy, The Theory-Practice Gap in Cognitive-Behavior Therapy*, *44*(4), 548–558. https://doi.org/10.1016/j.beth.2013.03.003

Ahern, E., Crawley, L., Arnal, L., Creaven, A.-M., & Rogers, E. M. (2026). The Next Generation of Psychologists: An Irish Perspective on Competency Development in Research and Clinical Practice. In G. J. Rich, E. Nordmann, H. R. Searight, M. R. Mampane, J. Reece, & A. Padilla Lopez (Eds), *Teaching Psychology Globally* (pp. 323–335). Springer Nature Switzerland. https://doi.org/10.1007/978-3-032-09977-8_23

Armfield, J. M. (2006). Cognitive vulnerability: A model of the etiology of fear. *Clinical Psychology Review*, *26*(6), 746–768. https://doi.org/10.1016/j.cpr.2006.03.007

Berghmans, E., Vliegen, N., Destoop, M., & Luyten, P. (2024). Engagement strategies in an assertive outreach context: A mixed-methods systematic review. *Journal of Mental Health*, 1–13. https://doi.org/10.1080/09638237.2024.2390363

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I *not* use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide*. Sage.

Callaghan, A., McCombe, G., Harrold, A., McMeel, C., Mills, G., Moore-Cherry, N., & Cullen, W. (2021). The impact of green spaces on mental health in urban settings: A scoping review. *Journal of Mental Health*, *30*(2), 179–193. https://doi.org/10.1080/09638237.2020.1755027

Carr, A. (2012). *Clinical psychology: An introduction* (1. publ). Routledge.

Claassen, D., & Priebe, S. (2007). Ethical aspects of assertive outreach. *Psychiatry, Ethical, Legal and Social Aspects of Psychiatry*, *6*(2), 45–48. https://doi.org/10.1016/j.mppsy.2006.11.007

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin*, *98*(2), 310–357. https://doi.org/10.1037/0033-2909.98.2.310

Cooley, S., Jones, C. R., Kurtz, A., & Robertson, N. (2020). 'Into the Wild': A meta-synthesis of talking therapy in natural outdoor spaces. *Clinical Psychology Review*, *77*, 101841.

Cooley, S., Jones, C. R., Moss, D., & Robertson, N. (2022). Organizational perspectives on outdoor talking therapy: Towards a position of 'environmental safe uncertainty'. *The British Journal of Clinical Psychology*, *61*(1), 132–156. https://doi.org/10.1111/bjc.12315

Cooley, S., & Robertson, N. (2020). *The use of talking therapy outdoors*.

Cooley, S., Taylor, E., Ceslikauskaite, K., & Robertson, N. (2023). Outdoor therapy: Maverick or mainstream? A survey of clinical psychologists. *Clinical Psychology Forum*, *1*(370), 21–31. https://doi.org/10.53841/bpscpf.2023.1.370.21

*DCP Briefing Paper No 21: Clinical Psychologists and Assertive Outreach: Cover* (p. bpsrep.2013.rep37). (2013). British Psychological Society. https://doi.org/10.53841/bpsrep.2013.rep37

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic Motivation and Self-Determination in Human Behavior*. Springer US. https://doi.org/10.1007/978-1-4899-2271-7

Demmerle, C., Gellert, P., & Kessler, E.-M. (2023). Psychotherapists' experiences providing at-home psychotherapy for home-living older adults with long-term care needs and depression. *Journal of Counseling Psychology*, *70*(4), 403–414. https://doi.org/10.1037/cou0000663

DiCicco-Bloom, B., & Crabtree, B. F. (2006). The qualitative research interview. *Medical Education*, *40*(4), 314–321. https://doi.org/10.1111/j.1365-2929.2006.02418.x

Elgharbawy, H., & Bove, C. (2025). Beyond the office: The role of clinical outreach services in counselling with Indigenous youth and families. *Clinical Psychology Review*, *120*, 102615. https://doi.org/10.1016/j.cpr.2025.102615

Fisk, D., Rakfeldt, J., Heffernan, K., & Rowe, M. (1999). Outreach Workers' Experiences in a Homeless Outreach Project: Issues of Boundaries, Ethics and Staff Safety. *Psychiatric Quarterly*, *70*(3), 231–246. https://doi.org/10.1023/A:1022003226967

Hagger, M. S., & McAnally Star, K. (2026). Self-Determination Theory and Workplace Outcomes: A Meta-Analysis. *Stress and Health*, *42*(1), e70151. https://doi.org/10.1002/smi.70151

Harper, N. J., & Dobud, W. W. (Eds). (2021). *Outdoor therapies: Introduction to practices, possibilities, and critical perspectives*. Routledge.

Harper, N. J., Fernee, C. R., & Gabrielsen, L. E. (2021). Nature's Role in Outdoor Therapies: An Umbrella Review. *International Journal of Environmental Research and Public Health*, *18*(10), Article 10. https://doi.org/10.3390/ijerph18105117

James, G., Kidd, K., Cooley, S., & Fenton, K. (2021). The Feasibility of Outdoor Psychology Sessions in an Adult Mental Health Inpatient Rehabilitation Unit: Service User and Psychologist Perspectives. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.769590

Jeffres, L. W., Bracken, C. C., Jian, G., & Casey, M. F. (2009). The Impact of Third Places on Community Quality of Life. *Applied Research in Quality of Life*, *4*(4), 333–345. https://doi.org/10.1007/s11482-009-9084-8

Jordan, M., & Marshall, H. (2010). Taking counselling and psychotherapy outside: Destruction or enrichment of the therapeutic frame? *European Journal of Psychotherapy & Counselling*, *12*(4), 345–359. https://doi.org/10.1080/13642537.2010.530105

Kondo, M. C., Oyekanmi, K. O., Gibson, A., South, E. C., Bocarro, J., & Hipp, J. A. (2020). Nature Prescriptions for Health: A Review of Evidence and Research Opportunities. *International Journal of Environmental Research and Public Health*, *17*(12), 4213. https://doi.org/10.3390/ijerph17124213

Langs, R. (2017). *Fundamentals of adaptive psychotherapy and counselling: An introduction to theory and practice*. Bloomsbury Publishing.

McDonagh, C., Fleming, M., Kehoe, A., & Leader, J. F. (2024). Psychology in Ireland. In *The Handbook of International Psychology* (pp. 441–446). Routledge.

Moledina, A., Magwood, O., Agbata, E., Hung, J.-H., Saad, A., Thavorn, K., Salvalaggio, G., Bloch, G., Ponka, D., Aubry, T., Kendall, C., & Pottie, K. (2021). A comprehensive review of prioritised interventions to improve the health and wellbeing of persons with lived experience of homelessness. *Campbell Systematic Reviews*, *17*(2), cl2.1154. https://doi.org/10.1002/cl2.1154

Moore, E., & Mahmood, F. (2025). Talk With Me Outside: Therapists' Experiences of the Therapeutic Relationship in Natural Outdoor Settings. *Counselling and Psychotherapy Research*, *25*(3), e70039. https://doi.org/10.1002/capr.70039

Naor, L., & Mayseless, O. (2021a). The Art of Working With Nature in Nature-Based Therapies. *Journal of Experiential Education*, *44*(2), 184–202. https://doi.org/10.1177/1053825920933639

Naor, L., & Mayseless, O. (2021b). Therapeutic factors in nature-based therapies: Unraveling the therapeutic benefits of integrating nature in psychotherapy. *Psychotherapy*, *58*(4), 576–590. https://doi.org/10.1037/pst0000396

O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*, *44*(7), 558–568. https://doi.org/10.1007/s00127-008-0476-0

Patton, M. Q. (1990). *Qualitative evaluation and research methods, 2nd ed* (p. 532). Sage Publications, Inc.

Penzenstadler, L., Soares, C., Anci, E., Molodynski, A., & Khazaal, Y. (2019). Effect of Assertive Community Treatment for Patients with Substance Use Disorder: A Systematic Review. *European Addiction Research*, *25*(2), 56–67. https://doi.org/10.1159/000496742

Pipon-Young, L., Cupitt, C., & Callanan, M. (2010). Experiences of clinical psychologists in Assertive Outreach teams: A Delphi survey. *Clinical Psychology Forum*, *1*(212), 17–21. https://doi.org/10.53841/bpscpf.2010.1.212.17

Revell, S., Duncan, E., & Cooper, M. (2014). Helpful aspects of outdoor therapy experiences: An online preliminary investigation. *Counselling and Psychotherapy Research*, *14*(4), 281–287. https://doi.org/10.1080/14733145.2013.818159

Revell, S., & McLeod, J. (2017). Therapists' experience of walk and talk therapy: A descriptive phenomenological study. *European Journal of Psychotherapy & Counselling*, *19*(3), 267–289. https://doi.org/10.1080/13642537.2017.1348377

Rueff, M., & Reese, G. (2023). Depression and anxiety: A systematic review on comparing ecotherapy with cognitive behavioral therapy. *Journal of Environmental Psychology*, *90*, 102097. https://doi.org/10.1016/j.jenvp.2023.102097

Scheel, M. J. (2011). Client Common Factors Represented by Client Motivation and Autonomy. *The Counseling Psychologist*, *39*(2), 276–285. https://doi.org/10.1177/0011000010375309

Shrestha, T., Voon Yi Chi, C., Cassarino, M., Foley, S., & Di Blasi, Z. (2025). Factors influencing the effectiveness of nature-based interventions (NBIs) aimed at improving mental health and wellbeing: An umbrella review. *Environment International*, *196*, 109217. https://doi.org/10.1016/j.envint.2024.109217

Trøstrup, C. H., Christiansen, A. B., Stølen, K. S., Nielsen, P. K., & Stelter, R. (2019). The effect of nature exposure on the mental health of patients: A systematic review. *Quality of Life Research*, *28*(7), 1695–1703. https://doi.org/10.1007/s11136-019-02125-9

Troughton, A., Chin, M., & Amankwaa, I. (2024). Nature as a therapeutic place and tool for enhancing service users' engagement in mental health services: A comprehensive synthesis of evidence. *Health and Place*, *89*. Scopus. https://doi.org/10.1016/j.healthplace.2024.103344

Wang, X., Feng, B., & Wang, J. (2025). Green spaces, blue spaces and human health: An updated umbrella review of epidemiological meta-analyses. *Frontiers in Public Health*, *13*. https://doi.org/10.3389/fpubh.2025.1505292

Yang, J. A., Garis, J., Jackson, C., & McClure, R. (2009). Providing Psychotherapy to Older Adults in Home: Benefits, Challenges, and Decision-Making Guidelines. *Clinical Gerontologist*, *32*(4), 333–346. https://doi.org/10.1080/07317110902896356

Yang, J. A., Garis, J., & McClure, R. (2006). Clinical Mental Health Outreach to Older Adults: Serving the Hard-to-Serve. *Clinical Gerontologist*, *29*(2), 71–79. https://doi.org/10.1300/J018v29n02_08

# Chapter 4: Discussion

The overall aim of this thesis was to contribute to the limited evidence base on how clinical psychology can be used outside of clinic rooms as an effective intervention for mental health conditions, as well as a way to enhance other therapeutic activities. This aim was achieved by the completion of two studies. Study one, a scoping review, focused on the psychological components within surf therapy and found a wide variety of psychological theories and methods of intervention delivery are used to supplement surf therapy and concluded that these have the potential to enhance surf therapy interventions. It highlighted that future research should provide more detail on these elements and be clear about their role in the interventions. Study two employed a qualitative model to explore clinical psychologists' perceptions of leaving the clinic room. Results indicate that hold mixed perspectives: they saw the potential positives, and detailed their fears and the organisational roadblocks, all while trying to maintain the role of a clinical psychologist.

The results of the surf therapy scoping review showed that while aspects of psychological theory and therapy are beneficial, further research is needed to compare if and how this is more effective than an exercise-based surf therapy intervention alone. Vital to this work is programme theory, which systematically details the mechanisms of change within interventions (Marshall, Ferrier, Martindale, et al., 2020). Programme theory provides a way of connecting intervention inputs and outputs using theoretical pathways and mediators (Bauman et al., 2002). As Marshall et al. (2020) demonstrates, programme theory was useful in interpreting how the separate components of surfing and psychological knowledge used within a surf therapy intervention link to different qualitative outcomes within their study. Programme theory has also begun to be used to understand the wider surf therapy literature, such as in Knowles et al.'s (2026) recent review on surf therapy in adults. To further develop the area of surf therapy, future research should provide more detail on what additional

components are incorporated into the interventions, including aspects such as facilitator training, content of any psychological therapy components, and theories and concepts utilised. A lack of programme theory was evident in the papers reviewed in Study one, which varied widely in the level of detail provided about the content of the psychological elements incorporated into the interventions, and how these may have accounted for change. Programme theory and adherence to intervention reporting frameworks (e.g. TIDIER (Hoffmann et al., 2014) CONSORT (Hopewell et al., 2025); TREND (Des Jarlais et al., 2004) may be useful to advance this field. Without rigorous reporting and examination, it will be difficult for psychologically-informed surf therapy to develop an evidence base that justifies its use in treating those with mental health conditions or enhancing wellness.

Programme theory is not the only programme development theory that has been applied to surf therapy (Olive et al., 2020). Intervention mapping has been used effectively as a framework for the development, implementation and evaluation of a surf therapy intervention by Olive et al. (2020). Intervention mapping is an evidence-based decision making, and participatory research approach (Eldredge et al., 2016). Olive et al. (2020) used this in order to understand how the components of the intervention address the participatorily-identified needs of a target population (Bartholomew et al., 2006). They used stages that included needs assessment, formulation of change objectives, selection of theory-based methods and practical strategies, intervention development, adoption and implementation plan, and evaluation planning. This led to a comprehensive breakdown of the inputs and outputs of the intervention and how each element of the intervention could positively impact the participants' formulated needs. This research was then followed up with comprehensive evaluation approaches measuring qualitative and quantitative results, with a randomised controlled trial design (Drake et al., 2021; Olive et al., 2023). Alternative approaches such as the Medical Research Council (MRC) guidance on developing complex

interventions may also be useful, based on the complexity of surf therapy and the wide range of target populations. The MRC guidance allows for effective evaluation and revision of existing or identified interventions; as most surf therapy in established interventions are not formally evaluated by research, this approach may better meet the research needs of the area (Brennan et al., 2024).

Based on the findings of the scoping review, it is possible to hypothesise about what the mechanisms of change may be in these psychologically-informed surf therapies. Common factors in talking therapy are highly predictive of outcome and some of these are found in surf therapy. The more general common factors across therapeutic approaches include the therapeutic alliance, positive regard, the therapist, genuineness, cultural adaptation, and expectations (Wampold, 2015). Within surf therapy the use of therapeutic groups and safe spaces may support the cultivation of positive regard and genuineness. Use of groups was seen in a number of studies in the review (e.g. Drake et al., 2021; Marshall et al., 2021; Marshall, Ferrier, Martindale, et al., 2020; Marshall, Ferrier, Ward, et al., 2020). Bringing in elements of psychoeducation may help to shape participant expectations, as was evident in a number of studies (e.g. Beranbaum et al., 2024; Conde et al., 2024; Drake et al., 2021; Gomes et al., 2020; Marshall, Ferrier, Martindale, et al., 2020; Olive et al., 2023; Snelling, 2015). Other elements that are frequently part of surf therapy are the therapeutic alliance and cultural adaptation. Within surf therapy this has been used as well. For example, Leonard et al. (2024) adapted their intervention to meet the cultural needs of the participants, incorporating cultural work, and having speakers from the local community to talk about the unique challenges faced by the young, primarily Māori, male participants. Research into the experience of surf therapy volunteers suggests they may experience a version of the therapeutic alliance (Potts & May, 2024), as the experiences of these volunteer mentors and their accounts of participant experience mirrored some of the therapeutic elements inherent in the therapeutic relationship.

This expands on Drake et al. (2021) comparing the nature of the relationship between mentors and participants to that of unconditional positive regard from Carl Rogers (1974). Each of these common factors in surf therapy may contribute to positive outcomes in the same way they do in psychological therapies (Wampold, 2015). This issue is not unique to surf therapy, with theories of change within psychotherapies still elusive (Cuijpers et al., 2026).

However, these mechanisms of change are merely hypotheses, and further research is important to start to document and chart the active ingredients in psychologically-informed surf therapy. Beyond common factors, it may be that there are additional elements unique to nature-based approaches that facilitate change. Naor and Mayseless (2021) propose elements unique to nature-based interventions, all of which are present in surf therapy: the natural environment (no included study used artificial settings), the role of nature influencing the process, and challenge. The challenge element may be common across all surf therapy interventions regardless of the presence of additional psychological components, but the presence of professionals trained to support participants in setting realistic goals and reflecting on progress may enhance it further (Knowles et al., 2026). Challenge may be particularly important in surf therapy, as many of the qualitative results emphasised the experience of participants related to mastery and mindset shifts. A scoping review of adventure therapies by Dobud and Harper (2018) suggests that specific ingredients in adventure therapies specific to the activity may be less relevant than the common factors between them. Their review included studies that directly compared adventure therapies to traditional therapies and saw no major advantages, although they included adventure therapies that incorporated psychological components. They did not evaluate attrition in participants or whether adventure therapies were more attractive to clients, and called for client-focused future research to help evaluate these outcomes (Dobud & Harper, 2018).

A Delphi Consensus study amongst practitioners and researchers to identify active ingredients in these interventions would be a useful exercise to develop a formal tool to guide intervention design, delivery, and evaluation. This would be building on work by Brennan et al. (2024) which looked at how surf therapy programmes are currently delivered, and using this information to understand how they work and how they can be improved. Surf therapy has the potential to become relatively manualised, which would allow for more systematic comparison and evaluation of surf therapy programmes. Guidance such as that of the World Health Organization (2024) on the implementation of psychological interventions may prove useful in the development of more surf therapy interventions, and clinical psychologists as scientific evidence-based practitioners could be well placed to contribute to this.

Although surf therapy may still be a black box in some ways, efforts by researchers such as Marshall et al. (2020) and Knowles et al. (2026) help us understand how the benefits of surf therapy interventions may transpire. Our research builds on this further with the focus on the psychological components, and may allow those designing future interventions to incorporate those that are most effective and appropriate for their population. Knowles et al.'s (2026) review of adult surf therapy interventions examines potential mechanisms and pathways for change in surf therapy. Although they included studies where surfing was used as a stand-alone intervention, they propose additional elements such as groups and components from therapeutic modalities could be used for specific populations or presentations. This is helpful in developing a more comprehensive theory of surf therapy, and it remains to be seen if this will be the same for surf therapy with other populations.

The area of surf therapy for children and adolescents may require a separate realist review in order to develop a theory of change and understand what, why, for whom and when surf therapy is appropriate (Palm & Hochmuth, 2020). The majority of our included studies were with children and adolescents, although even within this group the identified needs were

diverse, some at risk of antisocial behaviour, some with disabilities, neurodevelopmental conditions, or mental health diagnoses. Developing a theory of change similar to what Marshall et al. (2020) have done in individual interventions, and Knowles et al. (2026) have done across adult interventions, is crucial to the development of the area of surf therapy across age ranges and presentations.

There is still a large gap in knowledge regarding surf therapy, as most surf therapy interventions do not publish research regarding their practice or outcomes (Brennan et al., 2024). The International Surf Therapy Organisation (ISTO) is carrying out important work by encouraging not only the evaluation of, but also the publication of research by surf therapy programmes using its evaluation framework (ISTO, 2023). This outlines the recommendations with specific scales and measures, as well as reporting guidelines; notably it does not include any recommendation on reporting programme details except for the sample. These guidelines include a sample report from Marshall (2014) that includes all the details of the intervention. Similarly, the Waves for Change organisation promotes effective evaluation and supports a more structured approach to delivering surf therapy for children and adolescents using their "take 5" approach to coaching (Beranbaum et al., 2024; *Waves for Change*, n.d.). The ISTO may benefit from updating their reporting guidelines in line with frameworks like TiDIER (Hoffmann et al., 2014).

A key claim made repeatedly by researchers is that surf therapy interventions access hard-to-reach populations (Benninger et al., 2020). However, this has not been formally demonstrated in research to a convincing degree. Some research has shown there may be an increased willingness among hard-to-reach populations to engage in traditional interventions after completing unconventional interventions such as adventure therapy, suggesting the presence of a gateway therapy effect (Bettmann et al., 2019, 2023). Bettmann et al. (2023) found that participants in an adventure therapy intervention were significantly more likely to

seek psychological support a year after the therapy than just before the intervention and suggest this may be due to reducing stigma and allowing participants to experience increased disclosure in a safe space (Bettmann et al., 2023). This evidence is limited to veterans, who have traditionally been difficult to engage in mental health interventions, but suggests that these approaches may not just have potential as being more attractive to people, but may also increase openness to other interventions. Both of these effects are worth investigating in the future to help reach difficult to engage clients and groups.

Approaches such as codesign may make surf therapy more appealing to difficult to reach populations as research suggests engaging a community can increase uptake (Lamb et al., 2015; Larkin et al., 2015; Shahnaz et al., 2025). Within surf therapy interventions, evaluating the facilitators and barriers to engagement is important and work by Marshall et al. (2024) using a Delphi design model shows engagement with a difficult to reach population (emergency workers) can be helpful in improving surf therapy intervention uptake. Research on measuring engagement in mental health interventions stresses the importance of operationalising engagement, measuring all dimensions of engagement, and engagement over time (Bijkerk et al., 2023). Future research with surf therapy could benefit from not only using design approaches to make it more appealing such as community engagement, but also considering how the level of success is measured.

Knowledge of psychological elements informing surf therapy is important for another reason, ensuring adequate training and the use of mental health professionals in the delivery of surf therapy interventions would allow for maximum benefit from these components. A review by Knowles et al. (2026) suggests that when certain components such as groups are not facilitated there is potential for negative experiences, further highlighting the need for training in surf therapy, and reporting of training within surf therapy research. Knowles et al. (2026) also highlight the importance of trained facilitators, with potential negative outcomes

from a lack of guidance during surf therapy, such as negative social interactions or inappropriate levels of challenge during the activity. Again, managing the dynamics of common psychotherapeutic factors is important: supervision for the facilitators of surf therapy interventions may be necessary and appropriate to ensure safe practice. This highlights the fact that psychological therapies should not be utilised without the required professional supports which make them effective and safe, such as clinical supervision, and adequate training in delivery and risk management, for example. None of the studies reviewed documented the training for those delivering interventions. Clinical psychologists have a potential role here in training and supervising para-professionals who may deliver less intensive psychological interventions of this kind.

Although Knowles et al. (2026) highlight that more advanced psychological elements could be included in interventions for populations with mental health difficulties, the literature in our scoping review suggests that a wide range of participants without mental health diagnoses appear to benefit from these more holistic and psychologically-informed interventions. A study utilising this adventure therapy plus the Acceptance Commitment Therapy (ACT) model with sailing, aimed to support those with a chronic disease and provides a model for how these elements can be effectively integrated to support service users in a novel way (Donisi et al., 2024). Similarly, Cognitive Behaviour Therapy and mindfulness have both successfully been combined with adventure therapy approaches for groups without mental health diagnoses (Jelalian et al., 2006; Kirwin et al., 2019). Psychologically-informed surf therapy may be useful for both clinical and community groups and further research is needed to ascertain what works for whom, and in which contexts. Realist evaluation by those adopting surf therapies will also be helpful to track the ways in which implemented interventions support those populations, looking inside the black box as it were.

While Study one reviewed the role of psychological therapy in a nature-based intervention, Study two complemented this by seeking the views of clinical psychologists on how they perceive their role in this regard. The results of Study two provide interesting insights into the areas of clinical psychology practice outside of the therapy room, and how these relate to professional identity, self-determination, and self-efficacy. As described in the study, self-determination theory can help make sense of these results within existing psychological theory (Deci & Ryan, 1985). Self-determination theory has previously been useful in understanding risk of burnout in psychologists (Labrecque et al., 2024). Reduced autonomy is a risk factor in burnout for psychologists; in our sample autonomy could be improved by the provision of organisational support to reduce organisational barriers, and facilitators such as clear guidance to help clinical psychologists engage in the treatments they believe are useful and effective. Relatedness could be supported through the support of any team the psychologist is working on, as well as a community of practice and supervision. Finally, training could help build clinicians' feelings of competence. Meeting these three psychological needs as part of self-determination theory would help support psychologists develop optimum forms of motivations, contributing to job satisfaction and reducing burnout (Labrecque et al., 2024).

The results are consistent with those from research with psychologists who use nature-based therapy, especially the themes related to risk and tolerance of uncertainty, the use of nature in therapy, and organisational barriers to implementing these approaches (Felder, 2026). As the sample in our study included mostly clinicians who do not routinely work outdoors or outside the clinic room, it is interesting that so many similar elements arose. Our participants recognised the therapeutic potential and importance of nature despite limited experience and expressed a desire for guidance and training related to this. There is a gap in the availability of guidance on how to use nature in talking therapies and existing guidance

from the British Psychological Society (BPS) could be further promoted and developed (Cooley & Robertson, 2020).

Similar to the findings on the use of therapies outdoors, our participants recognised the importance of conducting therapy in the community, noting that difficult to engage clients would effectively be excluded without it (Division of Clinical Psychology, 2008). Interestingly, none of the participants reported working on an assertive outreach team, although almost all had reported delivering psychological therapies in client homes or third spaces. Future research on the prevalence of these practices in clinical psychologists could inform the necessity of guidance regarding these practices. As the current research, as well as research on conducting therapy in homes and nature, has shown, there are additional challenges, but also additional opportunities (Bettis et al., 2020; Catty et al., 2002; Cooley et al., 2020; Naor & Mayseless, 2021b, 2021a). Although we do not know the prevalence, based on our sample it is likely not an uncommon practice for clinical psychologists to work to accommodate individuals who find engaging with traditional therapy difficult. It may be beneficial for training programmes in Ireland to evaluate whether this is a gap in their teaching practices in order to best prepare trainees for the realities of the role of a clinical psychologist (Ahern et al., 2026; Carr, 2012).

Training and knowledge may be extremely important in facilitating the confident adoption of these practices based on research suggesting that clinical psychologists' professional identity development is negatively impacted by a lack of professional confidence (Schubert et al., 2023). Our participants recognised this as part of their concerns regarding *Professional and reputational risks,* where they worried that these approaches are not taken seriously by other professionals or the clinical psychology field as a whole. This may fall under professional identity threat, where there is change to roles or blurring of lines between professions: when this happens individuals may experience threat to their professional

identity (McNeil et al., 2013). This is particularly prominent on multidisciplinary teams, where some roles may be seen to be more value than others (McNeil et al., 2013). Addressing this may be considerably more difficult in an Irish setting where the biomedical model dominates and professional uncertainty leads to clinical psychologists defaulting to the dominant culture, and not necessarily the best treatment for the client (Cooley et al., 2020; Schubert et al., 2023). What may facilitate clinical psychologists in taking risks in advocating for and using these approaches are the psychological needs identified by self-determination theory(Deci & Ryan, 1985). Autonomy to make the choice to deliver the treatment they believe is best in the way they believe is best, relatedness, support from the team in delivering these approaches, and the competence to do so through training and support.

There were some commonalities among participants working with specific populations. The participants who worked with adolescents noted that groups not focused on psychology were more successful at helping young people to have positive social experiences. There may be a potential gateway effect similar to Bettmann et al. (2023) whereby young people are more open to traditional therapies after experiencing less traditional experiences, potentially due to having had a positive or destigmatising experience (Bellairs-Walsh et al., 2025). The psychologist working with older adults worked largely in clients' residences (home or nursing home) which is more typical of those working with older adults. Participants who had experience with difficult to engage groups, including a homeless service and those with a mild intellectual disability, worked with them in the community. This is likely out of necessity in order to engage these groups. Those who had worked in nature frequently took the opportunity to bring nature into the therapy - they were adaptive to the environment and client, similar to research from Cooley et al. (2020).

In designing guidelines for working in alternative environments, identifying what the needs of the target group are and basing interventions on a psychological formulation may be

more helpful than a generic approach. For example, guidelines for working with people with self-esteem difficulties might include helping them to focus on building self-esteem through bringing their attention to their achievements and to building mastery, whichever activity may be employed to do so (e.g. surfing, hiking, climbing). For clients with anxiety, a focus on mindfulness and acceptance elements may be most beneficial from a non-traditional therapy. For individuals with depression, drawing their attention to the mood-boosting impact of the activity may be most effective in gaining most benefit. Clients who have experienced trauma may benefit most from the opportunity to share in a safe space before the reprieve of surfing or another activity. In each of these cases, clinicians need a strong formulation to inform their choice of interventions. Realist evaluation which focuses on 'what works for whom and in what circumstances?', e.g. through qualitative interviews with recipients, is key to understanding how to tailor novel interventions in this way (Palm & Hochmuth, 2020).

An interesting connection between the two studies in this thesis is the use of metaphor in the natural environment. In Study one, we found part of the psychoeducational elements of interventions is frequently to connect the lessons being taught about wellbeing, acceptance, change, etc. to the experience of surfing and being in the sea. Similarly, our participants in Study two who used nature as a setting for therapy frequently reported the use of metaphor to effectively support psychological learning (McMullen & Tay, 2023). This is common in nature-based approaches (Joschko et al., 2023) and training in the use of these forms of metaphor may be helpful in the development of training programmes for interventions outside of the therapy room (Rucińska & Fondelli, 2022). This contributes to the literature which already makes the case for the use of metaphor in therapeutic approaches (Malkomsen et al., 2022; Rucińska & Fondelli, 2022; Yu et al., 2022).

Although our scoping review did not find any direct evaluation of surf therapy interventions as more acceptable to participants than traditional approaches, some have

suggested surf therapy as more acceptable due to it being an activity, and potentially opening up people to further interventions (Bettmann et al., 2023; Knowles et al., 2026). Our findings in interviews with clinical psychologists support this idea. The theme *exclusion and accommodation* which explored participant beliefs that some populations would have found traditional approaches challenging, or simply not engaged in them, mirrors this argument. Although research on assertive outreach supports the use of community spaces as improving engagement (Berghmans et al., 2024), this is an under-researched area within nature-based therapies.

**Limitations and future research**

The scope of Study one was limited to surf therapy interventions and the psychological additions to these, allowing for a focused review of the area that can help inform further research and interventions. Limiting the scope to surf therapy interventions may have missed similar or transferable psychological components from other ocean-based and adventure-based interventions which may be useful in the design of future interventions. A next step for future research may be the recruiting of subject matter experts in these areas to collaborate in the development of guidelines and supplementary interventions for surf therapy interventions, and potentially adventure therapy interventions more broadly. This intervention could then be trialled with an appropriate population and combined with our understanding of the mechanisms of surf therapy to investigate the unique contributions that psychological elements may add to the intervention, or compared with an intervention without these components (Knowles et al., 2026; Marshall et al., 2020).

The scope of Study two was limited to clinical psychologists but not limited in the populations and services they work with. This presented interesting differences between approaches and highlighted elements that may be more common to the work with specific populations. Future research could look at work with individual groups; some research has

already shown that working therapeutically with older adults in their homes comes with challenges and advantages, but a psychologist who specialises in work with older adults also saw them for walks and in community spaces. Similarly, most participants working with young people saw the advantages of non-psychology focused groups and there may be worthwhile data to be gathered about their experiences specifically.

Our focus on qualitative data for Study two allowed for a rich exploration of the experiences of clinical psychologists. Future research could use quantitative methods to evaluate how widely used these practices are by clinical psychologists and using our results, prompt targeted questions to help to evaluate them. Finding out whether these practices are more common with certain demographics, presentations, private versus public services, or individual differences between clinicians, would be helpful to understand the contextual facilitators and barriers to these approaches, similar to (Cooley et al., 2023). This would help to inform the need for guidelines, supports, and trainings for practitioners working in Ireland. If this is a common practice, an evaluation of training programme curricula would allow for the identification of training gaps and needs and the opportunity for the creation of a continuing professional development programme to address this. Finally, targeted research with those who carry out these methods would be useful to develop, similar to Cooley et al. (2020), which also covers other commonly-used approaches such as home-based working, working in community settings, and incorporating activities into psychological interventions.

**Implications for clinical practice**

The implications of the scoping review are that clinical psychologists may have a role in the design and implementation of interventions such as surf therapy, helping to develop a formulation for the participant presentation and how additional elements such as safe spaces, psychoeducation, and the integration of psychological elements to surfing may be beneficial. In addition, contributing to the evidence base through both practice-based evidence and more

formal evaluations would be beneficial in the design and evaluation of these programmes (World Health Organization, 2024).

For Study two there was a lot of fear evident with relation to leaving the clinic room. While various factors could support this, as discussed above, the core competencies inherent to clinical psychology are highly relevant here. Our results suggest that clinical psychologists effectively bring this lens to whatever intervention and approach they encounter (BPS, 2017). A key competence of clinical psychologists is their ability to evaluate scientific evidence to inform practice (EACLIPT, 2019). This may require additional guidance from organisations and the dissemination of evidence related to these approaches. There are many advantageous reasons to leave the clinic room for the right client and for the right reasons. Our research helps to make psychologists aware of these possible advantages and begins to develop ideas about how and when to use them. Being aware of the risks and preparing well for them is beneficial, as is having knowledge regarding how to best take advantage of the additional elements to make it worthwhile. It is important to note that a level of organisational support is likely required, and networks of practice would also be beneficial for clinicians interested in these approaches (Labrecque et al., 2024). The capacity for leadership by clinical psychologists in these areas is also an area for potential. Clinical psychologists often demonstrate leadership on mental health teams and the appropriate use of these approaches, as well as allying with other professions which use them, may allow for a more inclusive approach to be adopted by mental health teams.

**Conclusion**

The overall aim of this thesis was to help understand how clinical psychology practices can be used outside of clinic rooms as an intervention for mental health conditions and to enhance other therapeutic activities, including surf therapy, and to understand the

experiences and perceptions of clinical psychologists when they conduct interventions outside of the clinic.

Study one is the first research study focused specifically on the psychological components of surf therapy interventions and builds on previous research by showing that psychological components are useful additional elements to surf therapy interventions and may have unique contributions as well as enhancing the outcomes of surf therapy interventions. However, the quality of reporting hinders definitive conclusions about their contributions, and the evidence to date suggests that oversight is needed on psychological components to avoid unintentional harm. Further research is needed on the training and supervision of facilitators, the active ingredients or mechanisms of change, the underpinning theoretical models, and the target populations and presentations that surf therapy may be effective with, as well as how to tailor interventions for different presentations.

Our findings from Study two show that clinical psychologists in a variety of services and practices leave the clinic at least occasionally, and when they do, there are opportunities to enhance the therapy and to reach additional clients, as well as risks and fears associated, all happening within the context of organisations. Moreover, there is a recognition of the benefits and appeal of non-traditional approaches. Clinical psychologists can benefit from applying their scientist practitioner lens and professional competencies to these approaches in order to effectively implement them for the benefit of themselves, their services, and their clients. It highlights the additional needs for training and guidance for clinical psychologists, as well as the strengths they bring to these additional challenges. This is the first research of its kind on the experiences of clinical psychologists when they leave the clinic room, without a focus on a particular element such as nature or assertive outreach, and helps to understand the professional landscape of clinical psychologists working in Ireland.

Despite the barriers identified in Study two, what was clear from our participants was the desire to support and help their clients. Both studies have identified ways clinical psychologists can strive to provide excellent care for clients by using their skills as clinical psychologists in other areas and environments. Our findings highlight not only the potential of these approaches but also of the potential of clinical psychology to best address the needs of clients in a modern world where disconnection from nature and biomedical models dominate treatment systems, and to create room for alternative approaches.

**Personal reflections of the author**

My own experiences engaging in practice using assertive outreach in places such as client homes, public spaces, and nature have shaped both my motivation to carry out and my interpretation of this thesis. My first experience of this was visiting the home of a client, an older adult, in my first placement. I was anxious and uncomfortable initially and I struggled with the additional organisational elements. I struggled to maintain boundaries when the client would ask for additional support such as a to have a lift to a local shop I would be passing. I saw the benefits in this approach at the same time, I saw how the client's dog helped them regulate during difficult conversations, the client brought up memories triggered by objects in their home, and it allowed us to carry out a tree planting to mark the end of therapy. That case will always be close to my heart. At later stages I worked in cafes, homes, and local walks, sometimes with other professionals, sometimes without. All of these provided challenges and opportunities, some similar to the accounts given by the participants in Study two. Finally, I carried out sessions in nature, at the requests of clients. I believe these sessions would not have happened at all had I not agreed to these terms of engagement. They were with clients from populations who typically struggle to engage in traditional therapies, and we were able to complete what I believe was meaningful work as a result of my being open to using non-traditional spaces for therapy. I was sure to engage in bracketing

throughout the research, keeping a reflective journal, discussing findings with the research team, and keeping in mind my preconceptions throughout the process.

In my reflections on my role within a medically-dominated, coercive mental health system, I re-evaluate whether my adoption of assertive outreach approaches is paternalistic, whether I am suggesting I know what is best for clients. One case comes to mind of a client who disengaged from the service. I offered to meet them in the community, which they accepted. Shortly after this they disengaged from the service again, but in a much more positive manner. I accepted this and it did seem to me that demonstrating to the client that I was willing to meet them where they were, meant they had a more positive experience of the service, and may be more willing to seek help in the future if they want to and require it.

I also observed a session of surf therapy, facilitated by my supervisor Dr Liam Shine, working in an adult mental health service. I spoke to the participants and saw how much of an impact the intervention had on them. One participant was driving nearly two hours to make sure they could attend. The intervention was clearly meaningful to them. And I found each of these interventions was meaningful to me. I do not believe these interventions are for everyone or every condition, but I do think as a clinical psychologist, a profession which prides itself on its ability to adapt to client needs, to have a range of expertise and interventions available to them, and to have knowledge and understanding of these approaches, is important.

While interviewing clinicians I was aware of my borderline insider status: although not a fully qualified clinical psychologist I am a similar age to many of the participants. Although I work in publicly-funded services, one of the privately-working psychologists assumed my knowledge of private practices. When explaining the research to participants before recording the interview, as I had intentionally left the recruitment detail vague to avoid a bias towards those with strong opinions on the topic, I used my own experiences, and the

experiences of participants to prompt reflection. A large number of participants reported at the beginning having no experience of these approaches, and then during or after the interview telling me about an experience they had forgotten about or not considered. One participant noted they regularly held supervision both as a supervisor and supervisee outside of the clinic.

From carrying out this research I feel I have a better understanding of the experiences of other clinical psychologists as well as more of an understanding of these practices. It has helped inform and shape the clinical psychologist I hope to be; one that values person-centred approaches and advocates for these within services.

## References

Ahern, E., Crawley, L., Arnal, L., Creaven, A.-M., & Rogers, E. M. (2026). The Next Generation of Psychologists: An Irish Perspective on Competency Development in Research and Clinical Practice. In G. J. Rich, E. Nordmann, H. R. Searight, M. R. Mampane, J. Reece, & A. Padilla Lopez (Eds), *Teaching Psychology Globally* (pp. 323–335). Springer Nature Switzerland. https://doi.org/10.1007/978-3-032-09977-8_23

Bartholomew, L. K., Parcel, G. S., Kok, G., & Gottlieb, N. H. (2006). *Planning health promotion programs: An intervention mapping approach, 2nd ed* (pp. xxiv, 765). Jossey-Bass/Wiley.

Bauman, A. E., Sallis, J. F., Dzewaltowski, D. A., & Owen, N. (2002). Toward a better understanding of the influences on physical activity: The role of determinants, correlates, causal variables, mediators, moderators, and confounders. *American Journal of Preventive Medicine*, *23*(2), 5–14.

Bellairs-Walsh, I., Nichterlein, M., Assan, B., & Stargatt, R. (2025). Intensive Outreach for Mental Health: Young People's Experiences of an Intensive Outreach Model on Recovery and Engagement. *Community Mental Health Journal*, *61*(4), 693–703. https://doi.org/10.1007/s10597-024-01387-z

Benninger, E., Curtis, C., Sarkisian, G. V., Rogers, C. M., Bender, K., & Comer, M. (2020). Surf therapy: A scoping review of the qualitative and quantitative research evidence. *Glob. J. Community Psychol. Pract*, *11*, 1–26.

Beranbaum, S., Kouri, N. A., Van der Merwe, N., & D'Andrea, W. (2024). The impact of surf therapy on risk-taking and interpersonal closeness among violence-exposed youth. *Global Journal of Community Psychology Practice*, *15*(2).

Berghmans, E., Vliegen, N., Destoop, M., & Luyten, P. (2024). Engagement strategies in an assertive outreach context: A mixed-methods systematic review. *Journal of Mental Health*, 1–13. https://doi.org/10.1080/09638237.2024.2390363

Bettis, J., Kakkar, S., & Chan, C. D. (2020). Taking Access to the Community: An Ecological Systems Framework for In-Home Counseling With Older Adults. *Adultspan Journal*, *19*(1), 54–64. https://doi.org/10.1002/adsp.12087

Bettmann, J. E., Cambron, C., & Long, E. (2023). Improvement in Veterans' Openness to Seeking Professional Psychological Help After Participating in Therapeutic Adventure Trips. *Ecopsychology*, *15*(1), 1–12. https://doi.org/10.1089/eco.2022.0040

Bettmann, J. E., Scheinfeld, D. E., Prince, K. C., Garland, E. L., & Ovrom, K. V. (2019). Changes in psychiatric symptoms and psychological processes among veterans participating in a therapeutic adventure program. *Psychological Services*, *16*(4), 525.

Bijkerk, L. E., Oenema, A., Geschwind, N., & Spigt, M. (2023). Measuring Engagement with Mental Health and Behavior Change Interventions: An Integrative Review of Methods and Instruments. *International Journal of Behavioral Medicine*, *30*(2), 155–166. https://doi.org/10.1007/s12529-022-10086-6

Brennan, M., Stain, H. J., & Marshall, J. (2024). Mapping the landscape: Surf therapy program delivery. *Journal of Outdoor and Environmental Education*. https://doi.org/10.1007/s42322-023-00152-2

Carr, A. (2012). *Clinical psychology: An introduction* (1. publ). Routledge.

Catty, J., Burns, T., Knapp, M., Watt, H., Wright, C., Henderson, J., & Healey, A. (2002). Home treatment for mental health problems: A systematic review. *Psychological Medicine*, *32*(3), 383–401. https://doi.org/10.1017/S0033291702005299

Conde, E. F. Q., Sauerbronn, M. C., da Silva Cerqueira, C., & Nepomuceno, L. B. (2024). Effects of Surf Therapy on Mental Health During the Coronavirus Disease Pandemic:

A Brief Experience Report. *Alternative Therapies in Health and Medicine*, *30*(11), 6–10.

Cooley, S., Jones, C. R., Kurtz, A., & Robertson, N. (2020). 'Into the Wild': A meta-synthesis of talking therapy in natural outdoor spaces. *Clinical Psychology Review*, *77*, 101841.

Cooley, S., & Robertson, N. (2020). *The use of talking therapy outdoors*.

Cooley, S., Taylor, E., Ceslikauskaite, K., & Robertson, N. (2023). Outdoor therapy: Maverick or mainstream? A survey of clinical psychologists. *Clinical Psychology Forum*, *1*(370), 21–31. https://doi.org/10.53841/bpscpf.2023.1.370.21

Cuijpers, P., Harrer, M., & Furukawa, T. A. (2026). Innovations to improve outcomes and uptake of psychotherapies for mental disorders: A state-of-the-art review. *World Psychiatry*, *25*(1), 4–33. https://doi.org/10.1002/wps.70002

Davison, T. E., Koder, D., Helmes, E., Doyle, C., Bhar, S., Mitchell, L., Hunter, C., Knight, B., & Pachana, N. (2017). Brief on the Role of Psychologists in Residential and Home Care Services for Older Adults. *Australian Psychologist*, *52*(6), 397–405. https://doi.org/10.1111/ap.12209

*DCP Briefing Paper No 30: The role of psychologists in Crisis Resolution Home Treatment (CRHT) Teams: Cover* (p. bpsrep.2008.inf143). (2008). British Psychological Society. https://doi.org/10.53841/bpsrep.2008.inf143

Deci, E. L., & Ryan, R. M. (1985). *Intrinsic Motivation and Self-Determination in Human Behavior*. Springer US. https://doi.org/10.1007/978-1-4899-2271-7

Des Jarlais, D. C., Lyles, C., Crepaz, N., & TREND Group. (2004). Improving the reporting quality of nonrandomized evaluations of behavioral and public health interventions: The TREND statement. *American Journal of Public Health*, *94*(3), 361–366. https://doi.org/10.2105/ajph.94.3.361

Dobud, W. W., & Harper, N. J. (2018). Of Dodo birds and common factors: A scoping review of direct comparison trials in adventure therapy. *Complementary Therapies in Clinical Practice*, *31*, 16–24. https://doi.org/10.1016/j.ctcp.2018.01.005

Donisi, V., Poli, S., Berti, L., Gobbin, F., Giusto, G., Capurso, M., Gagliani, M., Campo, A., Presti, G., Deledda, G., Harris, R., & Rimondini, M. (2024). Combining acceptance and commitment therapy with adventure therapy to face vulnerability: Examples and insights from a sailing experience. *Journal of Contextual Behavioral Science*, *32*, 100759. https://doi.org/10.1016/j.jcbs.2024.100759

Drake, C. J., Keith, M., Dober, M. R., Evans, S., & Olive, L. S. (2021). A qualitative investigation into the perceived therapeutic benefits and barriers of a surf therapy intervention for youth mental health. *Complementary Therapies in Medicine*, *59*, 102713. https://doi.org/10.1016/j.ctim.2021.102713

Eldredge, L. K. B., Markham, C. M., Ruiter, R. A., Fernández, M. E., Kok, G., & Parcel, G. S. (2016). *Planning health promotion programs: An intervention mapping approach*. John Wiley & Sons.

Felder, L. (2026). *Inviting nature into the room: A conversation with clinical psychology* [Doctoral Thesis]. University of Southampton.

Gomes, P., Fazenda, N., Gomez-Baya, D., Rauktis, M. E., & Provost, G. (2020). Surf.Art in Portugal: Daring, Accomplishing and Transforming Portuguese Youth and Their Communities. *Global Journal of Community Psychology Practice*, *11*(2). https://doi.org/10.17161/gjcpp.v11i2.20677

Hoffmann, T. C., Glasziou, P. P., Boutron, I., Milne, R., Perera, R., Moher, D., Altman, D. G., Barbour, V., Macdonald, H., Johnston, M., Lamb, S. E., Dixon-Woods, M., McCulloch, P., Wyatt, J. C., Chan, A.-W., & Michie, S. (2014). Better reporting of

interventions: Template for intervention description and replication (TIDieR) checklist and guide. *BMJ*, *348*, g1687. https://doi.org/10.1136/bmj.g1687

Hopewell, S., Chan, A.-W., Collins, G. S., Hróbjartsson, A., Moher, D., Schulz, K. F., Tunn, R., Aggarwal, R., Berkwits, M., Berlin, J. A., Bhandari, N., Butcher, N. J., Campbell, M. K., Chidebe, R. C. W., Elbourne, D., Farmer, A., Fergusson, D. A., Golub, R. M., Goodman, S. N., … Boutron, I. (2025). CONSORT 2025 statement: Updated guideline for reporting randomised trials. *BMJ*, *389*, e081123. https://doi.org/10.1136/bmj-2024-081123

International Surf Therapy Organisation. (2023, July 26). *ISTO Evaluation Framework*. https://intlsurftherapy.org/isto-evaluation-framework/

Jelalian, E., Mehlenbeck, R., Lloyd-Richardson, E. E., Birmaher, V., & Wing, R. R. (2006). 'Adventure therapy' combined with cognitive-behavioral treatment for overweight adolescents. *International Journal of Obesity*, *30*(1), 31–39. https://doi.org/10.1038/sj.ijo.0803069

Joschko, L., Pálsdóttir, A. M., Grahn, P., & Hinse, M. (2023). Nature-Based Therapy in Individuals with Mental Health Disorders, with a Focus on Mental Well-Being and Connectedness to Nature—A Pilot Study. *International Journal of Environmental Research and Public Health*, *20*(3), 2167. https://doi.org/10.3390/ijerph20032167

Kirwin, M., Harper, N. J., Young, T., & Itzvan, I. (2019). Mindful adventures: A pilot study of the outward bound mindfulness program. *Journal of Outdoor and Environmental Education*, *22*(1), 75–90. https://doi.org/10.1007/s42322-019-00031-9

Knowles, N., Ladwa, A., Price, L., Wright, K., Gillison, F., Harrison, J., & Anderson, R. (2026). Explaining how, why, for whom and when surf therapy improves mental health and wellbeing in adults: A realist synthesis. *Advances in Mental Health*, *0*(0), 1–27. https://doi.org/10.1080/18387357.2026.2644914

Labrecque, L., Larouche, A., Gauthier-Boudreau, J., & Lalande, D. (2024). Risk and protective factors for burnout among psychologists and neuropsychologists: A scoping review. *Professional Psychology: Research and Practice*, *55*(4), 299–312. (2024-78564-001). https://doi.org/10.1037/pro0000573

Lamb, J., Dowrick, C., Burroughs, H., Beatty, S., Edwards, S., Bristow, K., Clarke, P., Hammond, J., Waheed, W., Gabbay, M., & Gask, L. (2015). Community Engagement in a complex intervention to improve access to primary mental health care for hard-to-reach groups. *Health Expectations*, *18*(6), 2865–2879. https://doi.org/10.1111/hex.12272

Larkin, M., Boden, Z. V. R., & Newton, E. (2015). On the Brink of Genuinely Collaborative Care: Experience-Based Co-Design in Mental Health. *Qualitative Health Research*, *25*(11), 1463–1476. https://doi.org/10.1177/1049732315576494

Leonard, A., Tairi ,Tatiana, & and Blampied, N. M. (2024). Tai Wātea/Waves of freedom: An evaluation of a surf therapy programme for improving psychosocial functioning in young men at high risk of adverse life outcomes. *Journal of Adventure Education and Outdoor Learning*, *24*(3), 488–508. https://doi.org/10.1080/14729679.2022.2153370

Malkomsen, A., Røssberg, J. I., Dammen, T., Wilberg, T., Løvgren, A., Ulberg, R., & Evensen, J. (2022). How therapists in cognitive behavioral and psychodynamic therapy reflect upon the use of metaphors in therapy: A qualitative study. *BMC Psychiatry*, *22*(1), 433.

Marshall, J. (2014). *Evaluation Report East Lothian pilot*. The Wave Project Scotland.

Marshall, J., Ferrier, B., Martindale, R., & Ward, P. B. (2020). A grounded theory exploration of programme theory within Waves of Wellness surf therapy intervention. *Psychology & Health*, *0*(0), 1–23. https://doi.org/10.1080/08870446.2023.2214590

Marshall, J., Ferrier, B., Ward, P. B., & Martindale, R. (2020). I feel happy when I surf because it takes stress from my mind": An Initial Exploration of Program Theory within Waves for Change Surf Therapy in Post-Conflict Liberia. *Journal of Sport for Development*, *9*(1), 1–17.

Marshall, J., Kamuskay, S., Samai, M. M., Marah, I., Tonkara, F., Conteh, J., Keita, S., Jalloh, O., Missalie, M., Bangura, M., Messeh-Leone, O., Leone, M., Ferrier, B., & Martindale, R. (2021). A Mixed Methods Exploration of Surf Therapy Piloted for Youth Well-Being in Post-Conflict Sierra Leone. *International Journal of Environmental Research and Public Health*, *18*(12), 6267. https://doi.org/10.3390/ijerph18126267

Marshall, J., Ward, P. B., Martindale, R., & Ferrier, B. (2024). A Pragmatic Delphi Exploring Barriers and Facilitators to Emergency Responder/Healthcare Workers' Participation in the Blue Light Surf Club Therapy Intervention. *Global Journal of Community Psychology Practice*, *15*(1). https://doi.org/10.17161/gjcpp.v15i1.22925

McMullen, L. M., & Tay, D. (2023). Research review of psychotherapists' use of metaphors. *Psychotherapy*, *60*(3), 255–265. https://doi.org/10.1037/pst0000473

McNeil, K. A., Mitchell, R. J., & Parker, V. (2013). Interprofessional practice and professional identity threat. *Health Sociology Review*, *22*(3), 291–307. https://doi.org/10.5172/hesr.2013.22.3.291

Naor, L., & Mayseless, O. (2021a). The Art of Working With Nature in Nature-Based Therapies. *Journal of Experiential Education*, *44*(2), 184–202. https://doi.org/10.1177/1053825920933639

Naor, L., & Mayseless, O. (2021b). Therapeutic factors in nature-based therapies: Unraveling the therapeutic benefits of integrating nature in psychotherapy. *Psychotherapy*, *58*(4), 576–590. https://doi.org/10.1037/pst0000396

Olive, L., Dober, M., Mazza, C., Turner, A., Mohebbi, M., Berk, M., & Telford, R. (2023). Surf therapy for improving child and adolescent mental health: A pilot randomised control trial. *Psychology of Sport and Exercise*, *65*, 102349. https://doi.org/10.1016/j.psychsport.2022.102349

Olive, L., Parker, R., Dober, M., Drake, C., Keith, M., & Telford, R. (2020). Intervention mapping: Using theory and evidence to inform the ocean mind surf therapy program for improving youth mental health. *Global Journal of Community Psychology Practice*, *11*(2), 1–21.

Palm, R., & Hochmuth, A. (2020). What works, for whom and under what circumstances? Using realist methodology to evaluate complex interventions in nursing: A scoping review. *International Journal of Nursing Studies*, *109*, 103601. https://doi.org/10.1016/j.ijnurstu.2020.103601

Potts, K., & May, J. (2024). "It's the closest I can get to meditation sometimes": Volunteering as a Surf Therapy Mentor. *Global Journal of Community Psychology Practice*, *15*(2). https://doi.org/10.17161/gjcpp.v15i2.22930

Rogers, C. R. (1974). A theory of therapy and personality change: As developed in the client-centered framework. In *Perspectives in abnormal behavior* (pp. 341–351). Elsevier.

Rucińska, Z., & Fondelli, T. (2022). Enacting Metaphors in Systemic Collaborative Therapy. *Frontiers in Psychology*, *13*, 867235. https://doi.org/10.3389/fpsyg.2022.867235

Schubert, S., Buus, N., Monrouxe, L. V., & Hunt, C. (2023). The development of professional identity in clinical psychologists: A scoping review. *Medical Education*, *57*(7), 612–626. https://doi.org/10.1111/medu.15082

Shahnaz, I., Rose-Clarke, K., Michelson, D., & Gronholm, P. C. (2025). Codesign of Mental Health Interventions With Young People From Racially Minoritised Populations: A Systematic Review of Methods and Outcomes. *Health Expectations : An International*

*Journal of Public Participation in Health Care and Health Policy*, *28*(2), e70204. https://doi.org/10.1111/hex.70204

Snelling, M. (2015). *Breaking cycles of violence, one wave at a time: A formative evaluation of the Waves for Change Surf Therapy programme* [University of Cape Town]. OpenUCT. http://hdl.handle.net/11427/20657

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

*Waves for Change | Surf Therapy | South Africa*. (n.d.). Waves for Change. Retrieved 16 April 2026, from https://waves-for-change.org/

World Health Organization. (2024). *Psychological Interventions Implementation Manual: Integrating Evidence-Based Psychological Interventions into Existing Services* (1st ed). World Health Organization.

Yu, G., Liu, R., & Zhang, W. (2022). Therapeutic metaphors: Theories, empirical efficacy and underlying mechanisms. *Advances in Psychological Science*, *30*(7), 1546.

# Appendices

## Appendix 1. Journal criteria taken from Global Journal of Community Psychology Practice.

### Author Guidelines

We follow APA guidelines (http://www.apastyle.org/) for submissions. Please limit manuscript to 20 pages, double-spaced with 1-inch margins, plus references, tables and figures. Since we do not have a print version of the Journal, we are not bound by page lengths, but please keep your text readable, succinct and relevant.

**Appendix 2. Full list of search terms**

**Google scholar**

"surf therapy"|"surf school"|"surf program"|"surf programme"|"Surfing lesson"|"surfing experience"|"surfing medicine"|"sea surfing"|"adaptive surfing"|"surfing intervention" “psychology”|”therapy”|”mindfulness”|”meditation”|”wellbeing”|"mental health"

**PUBMED**

( ( "surf therap*" ) OR ( "surf school" ) OR ( "surf progra*" ) OR ( "Surfing lesson" ) OR ( "surfing experienc*" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing intervention" ) ) AND ( ( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) )

**Psycinfo**

( ( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ) ) AND ( ( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) )

**EBSCO**

( ( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea

surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ) ) AND ( ( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) )

**Cochrane**

( surf NEXT therap* ) OR ( surfing NEXT therap*) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( surf NEXT progra* ) OR ( surfing NEXT progra* ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( surfing NEXT experienc* ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( surfing-based NEXT therap* ) OR ( surf-based NEXT therap* ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" )

AND

( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" )

**Embase**

( ( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ) ) AND ( ( psychology )

OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) )

**Cinahl**

( ( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ) ) AND ( ( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) )

**SCOPUS**

( ALL ( ( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ) ) AND ALL ( psychology ) OR ALL ( therapy ) OR ALL ( mindfulness ) OR ALL ( meditation ) OR ALL ( wellbeing ) OR ALL ( "well being" ) OR ALL ( "mental health" ) )

**WebofScience**

Combined searches #1 and #2

#1

ALL=(( "surf therap*" ) OR ( "surfing therap*" ) OR ( "surf school" ) OR ( "surfing school" ) OR ( "Surf Camp" ) OR ( "Surfing Camp" ) OR ( "Therapeutic surfing" ) OR ( "surf progra*" ) OR ( "surfing progra*" ) OR ( "Surfing lesson" ) OR ( "Surf lesson" ) OR ( "surfing experienc*" ) OR ( "the wave project" ) OR ( "surf medicine" ) OR ( "surfing medicine" ) OR ( "sea surfing" ) OR ( "adaptive surfing" ) OR ( "surfing practice" ) OR ( "surf practice" ) OR ( "surfing based therap*" ) OR ( "surf based therap*" ) OR ( "surf instructor" ) OR ( "surfing instructor" ) OR ( "surfing intervention" ) OR ( "surf intervention" ))

#2

ALL=( ( psychology ) OR ( therapy ) OR ( mindfulness ) OR ( meditation ) OR ( psychodynamic ) OR ( wellbeing ) OR ( "well being" ) OR ( "mental health" ) )

# Appendix 3. Extraction table part 1

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| (Nada et al., 2025) | Journal Article | Therapeutic intervention targeting the personal and social skills of each participant. Tailored to each group attending based on difficulties identified by school such as concentration, behaviour problems, resistance to frustration and time management. | Qualitative (content analysis) Interviews | Age 7 to age 14 | 363 in surf therapy intervention (in sample 16 children interviewed, two from each cohort, two school teachers, one school psychologist) | Mixed no breakdown | "On the poverty line". Children from families at risk of social exclusion, learning difficulties, behavioural issues, students with absenteeism issues. Some participants had learning difficulties. | Northern Portugal |
| (Drake et al., 2021) | Journal article | This study aims to investigate potential therapeutic pathways and barriers to participation in a surf therapy program for youth at risk of mental health problems from the perspective of participants, surf mentors and program coordinator. | Qualitative (Inductive thematic analysis) mix of focus groups and interviews | Participants aged 8 to 18 | 19 (9 children and 9 mentors and 1 coordinator) | Mixed no breakdown | Referred by mental health professional (help seeking for mental health difficulty) | Australia |
| (Olive et al., 2023) | Journal Article | Feasibility and acceptability of Surf therapy program to improve symptoms of mental ill health among children and adolescents | Quantitative (Independent T-Test) | 6-18 (intervention group 8-18 M=11.89 SD = 2.63) | 36 (18 in intervention group) | F=9 M=9 | Referral from Mental health professional excluded if actively suicidal or psychotic | Coast of Victoria, Australia |
| (Hearn et al., 2025) | Journal Article | The aim of the current study was to investigate the feasibility and effectiveness of a group therapy program that combines physical activity, including surf therapy, with cognitive behavioural therapy for treating depression among adolescents. | Quantitative (Repeated measures ANOVA) | age 13 to 18 | 32 outpatients | F=28 M=4 | Primary diagnosis of depression, basic swimming ability, excluded acute psychosis, substance abuse, acute suicidality, bipolar disorder, severe OCD, anxiety disorder, eating disorder, Autism | Freiberg Germany |

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | Spectrum disorder, social disorders. No suicide attempts in previous 12 months. | |
| (Conde et al., 2024) | Journal Article | This study aimed to present and discuss the results obtained in a psychosocial project that combined actions for mental health promotion, using integrative and complementary practices with surfing and training sessions. More specifically, the study investigated whether participation in surf therapy could influence resilience capabilities, reduce dysexecutive symptoms, and improve mood states. | Mixed methods (t-test and reflexive thematic analysis) | 22 to 45 years (mean 34.1 years; SD 8.8 years) | 10 | F=9 M=1 | Historical and current presence of anxiety or depression | Brazil |
| (Marshall, Ferrier, Martindale, et al., 2020) | Journal Article | he objective of this study was to interrogate programme theory within surf therapy, as delivered by the Waves of Wellness Foundation (WOW) in Australia. | Qualitative (Grounded Theory) | 14-24 (M=18.4 SD 2.8) | 16 | Not included | none specified | Australia |
| (McKenzie et al., 2021) | Journal Article | 1. Advance current understandings of surf therapy as an alternative therapy for youth populations.<br><br>2. Inform future research by examining participants' experiences of the program. | Mixed Methods (Graphs and descriptive statistics and reflexive thematic analysis | 14 to 17 | 9 participants for Quant 4 for Qual | F=8 M=1 | Self - referral (1 ADHD 1 OCD anxiety Depression 1 Anxiety) | Australia |
| (Francesch i et al., 2024) | Journal Article | This exploratory pre-to post-intervention study examined the effects of a novel surf therapy program for women who experienced abuse, trauma, and/or mental illness on emotional regulation, resilience, body acceptance, and gratitude. | Quantitative (ANOVA) | 25-54 (M=36.32 SD 7.79) | 27 | All women | Trauma survivors - previously reported abuse/ trauma | Los Angeles |

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| (Leonard et al., 2024) | Journal Article | (1) Does the Tai Wātea surf therapy program reliably improve participants' psychosocial functioning?<br>(2) Which aspects of participants' psychosocial functioning are most improved following attendance in the program?<br>(3) Provided that CB-AT programming does not look like traditional therapy and offers excitement to young people, are program attrition rates lower than that of other community-based programs for justice-involved clients | Quantitative (Modified Brinley Plots) | M=19.8 SD 2.4 | 27 participants | All male | Not in employment or full-time education | New Zealand |
| (Marshall et al., 2021) | Journal Article | The aim of this study was to provide a mixed methods evaluation of the associated impact of a range of surf therapy programs across Sierra Leone | Mixed methods (Wilcoxon signed rank tests and thematic analysis) | Aged 7 to 22 M=12.9 | N=58 | M=35 F=23 | Criteria for referral was referral partners believing individuals would benefit | Sierra Leone |
| (Marshall, Ferrier, Ward, et al., 2020) | Journal Article | This study sought to explore and contribute to key knowledge gaps within the W4C evidence base by developing an initial exploratory program theory based on participant experiences of surf therapy in Liberia. | Qualitative (constant comparative analysis) | 11-25 M=15.8 SD=3.6 | 23 | M=17 F=6 | Taken part in Waves for change for 6 months | Liberia |
| (Beranbaum et al., 2024) | Journal Article | The evaluation aims to assess the impact of W4C surf therapy using a multi-method assessment and methodologically investigate the benefits and drawbacks of various assessment approaches for youth psychosocial programming. A secondary aim of the present study was to determine the feasibility and utility of behavioural and self-reported measures | Quantitative (Repeated measure ANOVA) | 9-17 M=11.26 | 233 | F= 134 M=99 | Referred through school personnel based on perceived vulnerability to anxiety, depression, attention deficits and aggression and or exposure to trauma or loss | South Africa |

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| | | administered in a naturalistic setting. | | | | | | |
| (van der Merwe & Yarrow, 2020) | Journal Article | Explored the feasibility and unique (unintended) benefits of its surf therapy programme W4C to children with ASD. | Qualitative case study using thematic analysis, descriptive statistics | 13-17 | 45 | M=40<br>F= 5 | ASD diagnosis | South Africa |
| (Snelling, 2015) | Masters Thesis | Evaluate Waves for change programme and intervention delivery | Quantitative (multiple regression) | M=12.42 (SD= 1.42) | 183 referred, 55 in final intervention analysis | M=86 F=28 | Referred through school personnel based on perceived vulnerability to anxiety, depression, attention deficits and aggression and or exposure to trauma or loss | South Africa |
| (Wilkie et al., 2022) | Journal Article | The aim of the present evaluation was to assess whether surf-therapy intervention promoted wellbeing according to quantitative survey and physiological data. A second aim was to conduct an REM session with a sub-sample of participants at approximately one year follow-up to assess whether the impact of the intervention had longevity and, thus, determine whether it is an appropriate long-term use of service resources | Mixed Methods (Paired T-tests wilcoxon signed ranks test and ripple effects mapping) | Over 18, M=48.27 SD 13.56 | 15 | M=11 F=4 | Moderate to severe impairment from ABI | South Wales, UK |
| (Gibbs et al., 2022) | Journal Article | the aim of this study is to characterise the experiences of a surfing intervention in individuals living with the residual effects of brain injury, and to reflect on potential mechanisms through which reported improvements in wellbeing may function in a conceptual model. | Qualitative - Reflexive approach to Thematic Analysis | 18+ (M=42.4 SD 12.88 Range 29-69) | 15 | M= 10 F= 5 | Moderate to severe brain injury | South Wales, UK |

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| (Pereira, 2020) | Journal Article | The current study is the first randomized controlled trial conducted to examine the effectiveness of the Wave by Wave intervention in reducing emotional and behavioral problems and increasing wellbeing in youth in residential childcare. A further objective of this study was to explore the impact of the Wave by Wave intervention in several dimensions that are potential protective factors, including individual factors (self-esteem, emotion regulation, behavioral and attentional regulation, sleep quality and physical activity) and relational factors (pro-social behavior and social connectivity). Finally, another aim was to evaluate aspects related to the intervention process, such as the fidelity of intervention implementation. | Quantitative (ANCOVA) | M=13.64 (SD 2.89) | (45 in intervention group) | M=31 F=14 | In residential Care | Portugal |
| (Matos et al., 2017) | Journal Article | It was hypothesized that the 1) participants on Surf-Salva Camp 2016 would have decreased values on behavioural problems and 2) the majority of the participants would feel that had learned surfing skills, self-regulation strategies, social and emotional skills and feel part of the group. | Quantitative (t-tests) | 10-16 M=13 SD = 1.7 | 48 total, first analysis 29, second analysis 32 | Mixed but breakdown unclear | Adolescents in a situation of vulnerability and psychosocial risk, living in institutions providing temporary or permanent residential care. | Portugal |
| (Sarkisian et al., 2020) | Journal Article | The program evaluation utilized a mixed-method approach employing qualitative methods to assess program process and quantitative methods to assess the program outcome. | Mixed methods (t-test and ANOVA and qualitative analysis unspecified) | 6-19 | 152 | Unknown | Recruited through "youth serving" organisations. Participants either receiving public mental | USA Los Angeles |

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | health care or in foster care | |
| (Gomes et al., 2020) | Journal article | 1.Does a structured youth development surfing intervention (SURF. ART) associate with reduced levels of emotional symptoms, conduct problems, hyperactivity/inattention and peer relationships problems? 2.Does a structured youth development surfing intervention (SURF. ART) associate with increased pro-social skills? 3.Do gender, age, dosage of intervention (time spent) and engagement in the program (points earned) moderate these association? | Quantitative (Manova) | 7-17 (m=8.54 SD=1.53) | 69 | M=28 F=41 | none | Portugal |
| (Cavanaugh, 2010) | Doctoral thesis | 1. How do children with ASD and their parents perceive changes in social competence as a result of the child's participation in the two-day surf camp curriculum? 2. How do children with ASD perceive changes in their self-concept as a result of their participation in the two-day surf camp curriculum? 3. How do children and their surf camp staff/volunteer members perceive changes in social skills as a result of camper participation in the two-day surf camp curriculum? 4. What are participating parents' perceptions relative to the components and outcomes of the two-day surf camp curriculum? 5. How consistently are surf camp staff/volunteer members able to follow the surf camp curriculum protocol that includes social | Quantitative, some qualitative (ANOVA and qualitative analysis unspecified) | 10-16 M=13.17 | 11 children, 18 parents, 26 volunteers | F=2 M=9 | ASD | Texas |

| Study title | Type of publication | Research question or aims (Verbatim) | Type of evidence (analysis type) | age group | Sample size | gender | Participant requirements | geographic location |
|---|---|---|---|---|---|---|---|---|
| | | skill expectations for children with ASD? 6. To what degree do children apply the SURF Steps as part of their surf camp curriculum? | | | | | | |
| (Santos et al., 2020) | Journal Article | Detail the partnership between Matosinhos city hall and the school of higher education of Porto's attempt to develop a surf therapy curriculum | Experiences of authors (analysis unspecified) | six to ten years old | unknown | unknown | unknown | Portugal |
| (Britton, Kinderman, & Carlin, 2020) | Journal Article | Explore how young surfers engage with and utilise the sea and surf as health-enabling through the use of an in-situ participatory evaluation method, bodymapping. | Qualitative, semi structured interviews and participatory observation (word frequency) | eight to seventeen | 12 | F=7 M=5 | ASD. Not a requirement but noted that there was a mix of psychological, anxiety, and learning issues associated with ASD. | Donegal, Ireland |
| (C. M. Rogers et al., 2014) | Journal Article | To examine the feasibility of and preliminary findings for using a sports-oriented occupational therapy intervention as part of the complement of services for OEF and OIF veterans experiencing symptoms of PTSD and depression. 1. Will veterans with PTSD and depressive symptoms consistently attend the program? Will participants in the 5-session, 5-wk community based occupational therapy intervention report a reduction in PTSD and depressive symptoms? | quantitative (the percentile bootstrap method on the difference scores) | 24-30 | 11 both pre and post 14 pre | F=1 M=13 | Veterans with PTSD. Mostly unemployed or in college. | United states of America |

**Appendix 3. Extraction table part 2.**

| Study title | Surf project name if relevant | length of intervention | Number of sessions | Session length | Qualitative themes | Measures used and data type | Psychological outcomes |
|---|---|---|---|---|---|---|---|
| (Nada et al., 2025) | "Onda Social" project | 1 school semester per cohort | 12 to 18 | 2.5 hours | Personal and social development, wellbeing, academic outcomes | Observational fieldnotes, semi structured interviews with young people, school teachers, school psychologists. Logbooks, participant observation, semi structured interviews | Psychologist reported an improvement and competence acquisition in four domains, specifically emotional social student motivation and school performance. |
| (Drake et al., 2021) | Oceanmind | Six weeks | 6 | 2 hours | Self-efficacy, interpersonal skills and forming a mentorship being potential therapeutic pathways of the surf therapy intervention | Semi structure interviews and focus group | Themes identified: self-efficacy, interpersonal skills and forming a mentorship being potential therapeutic pathways of the surf therapy intervention. Surf instruction techniques and family engagement were both identified as potential barriers that negatively affect participant engagement. Additionally, the natural environment was identified as both a potential therapeutic pathway and a barrier |
| (Olive et al., 2023) | Oceanmind | 6 weeks | 6 sessions | 2 hour session, each week | N/A | Strengths and difficulty questionnaire, RCADS-S | Improvements in SDQ subscales - emotional problems, overall difficulties, hyperactivity and inattention, and peer problems not sustained at 12 weeks follow up. RCADS |

| Study title | Surf project name if relevant | length of intervention | Number of sessions | Session length | Qualitative themes | Measures used and data type | Psychological outcomes |
|---|---|---|---|---|---|---|---|
| | | | | | | | showed improvements in depressive and anxiety symptoms not sustained at 12 weeks post. |
| (Hearn et al., 2025) | N/A | 12 weeks | Eleven 90 minute sessions of exercise, followed by week long trip to Sylt where participants took part in dailysurf lessons with two CBT group therapy sessions during this week | 90 minutes | n/a | Children's Depression Rating Scale - Revised, Beck Depression inventory II, emotional regulation strategies, self esteem measures | Significant improvements in Children's Depression Rating Scale-R scale with a large effect size which were sustained at 3 month follow up |
| (Conde et al., 2024) | sUrFF Terapia | 5 weeks | 10 | 2 hours | Detailed in a Portuguese language journal but summary where the action promoted social inclusion, wellness, mental health, and recovery the self-esteem. The qualitative data analysis also indicated anxiety reduction, increased confidence, and promoted pleasant and fun moments. | Resilience Scaled ; Dysexecutive Questionnaire ; Brunel Mood Scale ; some qualitative responses | Improvement in resilience. Reported improvements in emotional regulation and confidence via qualitative measures. |
| (Marshall, Ferrier, Martindale, et al., 2020) | Waves of Wellness | 8 weeks | 8 | 2 hours | a) Safe Space, (b) Social Support, (c) Sensory Grounding, (d) Mastery and (e) Respite | Interviews | N/A |
| (McKenzie et al., 2021) | Waves of Wellness | 8 Weeks | 8 | 2 hours (45 minutes mental health talk then one hour surfing) | Higher order theme - A shared Experience with two lower order themes which include a unique learning environment and personal growth. | Rosenberg Self Esteem Scale, Patient Health Questionnaire for Adolescents, Brief Resilience Scale, Social Connectedness Scale - Revised, Semi structured interview for qualitative | Improvements from pre to post but not sustained at follow up |
| (Franceschi et al., 2024) | Groundswell | 8 weeks | 8 | Ninety to one hundred and twenty minutes | n/a | Body Appreciation Scale (BAS-2), The Connor-Davidson | Body acceptance and resilience were |

| Study title | Surf project name if relevant | length of intervention | Number of sessions | Session length | Qualitative themes | Measures used and data type | Psychological outcomes |
|---|---|---|---|---|---|---|---|
| | | | | | | Resilience Scale (CD-RISC-10), The Affective Style Questionnaire, the Gratitude Questionnaire six item form (GQ-6) | increased. emotional regulation improved. gratitude scores unchanged |
| (Leonard et al., 2024) | The Tai Wātea | Eight weeks | Unclear | Approximately two hours 90 minute surf session, group learning and discussion based on surfing analogies, cultural work, guest speaker who spoke about overcoming personal hardship, also had one to one counselling with registered drug and alcohol counsellor who used CBT and MI, one to one mentorship sessions with local youth worker focused on practicalities of exiting the justice system and accessing educational and occupational opportunities. | N/A | Youth Outcome Questionnaire Self-Report Y-OQ-SR | 25/27 participants demonstrated reliable improvement in psychosocial functioning, 20 of these were clinically significant |
| (Marshall et al., 2021) | The Wave Alliance | 10-12 weeks | 10 to 12 sessions | two hours | Open ended questionnaires: different for each site, qualitative impacts were Feeling calmer, improved socialising, improved academic attendance, behavioural improvements, improved socialising reduction in bad behaviours academic performance, improved mindset, improved | Youth Outcome Questionnaire - self report version 2.0 - open ended questionnaire | Three of the four sites were associated with significant large positive effects on participant wellbeing which aligned with positive qual outcomes. |

| Study title | Surf project name if relevant | length of intervention | Number of sessions | Session length | Qualitative themes | Measures used and data type | Psychological outcomes |
|---|---|---|---|---|---|---|---|
| | | | | | academic effort, improved socialising, reduction in bad behaviours | | |
| (Marshall, Ferrier, Ward, et al., 2020) | Waves for Change | 17 weeks | 11 sessions | Unclear | Available in the form of a graphic but generally Social, Skills Curriculum/Banana Culture, and Surfing | Interviews | Participants report greater use of coping skills in day-to-day life |
| (Beranbaum et al., 2024) | Waves for Change | 10 month long curriculum with weekly sessions | 33 | Unclear | n/a | Community Experiences Questionnaire, Perceived Stress Scale for Children, Implicit association task for self-esteem, The inclusion of other in the self, Balloon analogue risk task for youth, The brief sensation seeking scale for children, | no impact on stress, increase in interpersonal closeness, Less risk taking behaviour, Less sensation seeking, improvement in emotion regulation |
| (van der Merwe & Yarrow, 2020) | Waves for change (adapted) | 12 months (16 week intervention delivered twice.) | 16 in intervention (total unclear) | 3 hour sessions | Confidence and sense of identity, Peer and adult relationships, communication initiation and verbal output, unique/unintended benefits coping in new unpredictable environments other than school and home, coping with sensory sensitivity, strengthen skills for independence, listening to children's voices with Makaton | Focus groups with parents/caregivers, 6 teachers, and occupational therapists after the 4 month pilot. Surf mentor observations, children provided Makaton symbols (a unique language programme using systematic multi modal approach of speech, signs and symbols to teach communication, language and literacy. | Development of coping strategies in their lives |
| (Snelling, 2015) | Waves for change | 32 weeks spread over 1 year | Minimum 2 sessions offered a week | 3 hour sessions | n/a | Children's hope scale and the strengths and difficulties questionnaire, social and health assessment scales | No improvement in psychosocial wellbeing |
| (Wilkie et al., 2022) | Surfability | 5 weeks | 5 | 2 hours | Ripple Effects Mapping almost a year later. attended by four. Three hour session. Themes included The physical an emotional experience of a nature based challenge, experienced of a mindset shift, long | HRV, Warwich Edinburgh Mental Wellbeing scale - short version, Hospital anxiety and Depression Scale, Visual Analogue Scale (lines participants marked answers in psychological | Statistically significant reduction in anxiety, and significant increases in Wellbeing and happiness pre and post intervention. No significant |

| Study title | Surf project name if relevant | length of intervention | Number of sessions | Session length | Qualitative themes | Measures used and data type | Psychological outcomes |
|---|---|---|---|---|---|---|---|
| | | | | | term wellbeing promoting behaviour change | areas). Ripple effects mapping workshop | change in ~HRV or HADS scores. In qualitative data participants noted a powerful mindset shift. |
| (Gibbs et al., 2022) | | | | | Overarching themes 1) Connection to Nature, 2) Facilitating Trust and Safety, 3) Managing and Accepting Difficult Emotions; 4) Facilitating Positive Emotion, Meaning and Purpose, 5) Building Community through Social Connection; 6) Positive Change, and 7) Barriers and Opportunities | | |
| | Surfability | 5 weeks | 5 | 2 hours | | Interviews | N/A |
| (Pereira, 2020) | | | | | | Strengths and difficulties questionnaire, Revised Children's anxiety and depression scale, the Kidscreen-10, The Rosenberg self esteem scale, the emotion regulation questionnaire for children and adolescents, The test of everyday attention for children, The Pittsburgh sleep quality index, | No change in child report measures, caretaker reported measures found moderate to high interaction |
| | Wave by Wave | Run with 3 groups, once a week, three hour sessions. | 21 | 3 hours | n/a | The youth activity profile, | effects for all measures. |
| (Matos et al., 2017) | | | | | | | Improvements in effort and perseverance, problem solving, time management, social competences, interpersonal relationships, emotional adjustment. |
| | Surf Salva - inspired by waves for change | 4 weeks | 8 sessions | 4 hours | N/A | Strengths and Difficulties questionnaire, The Youth experience survey. | Learning sea safety and surfing seen as positive elements. Improvement |

| Study title | Surf project name if relevant | length of intervention | Number of sessions | Session length | Qualitative themes | Measures used and data type | Psychological outcomes |
|---|---|---|---|---|---|---|---|
| | | | | | | | s in SDQ scores from tutors. |
| (Sarkisian et al., 2020) | Jimmy Miller Memorial Foundation of JMMF Ocean Therapy Program | 1 day | 1 | All day | Drawings rated on opportunities for learning and fun, expressing a positive attitude about their self-identity or self-concept, feeling safe, experiencing social support and inclusion | Children's hope scale and rated drawings done by participants. Children's hope scale | Pre and post-test, and 3 month follow up on the Children's Hope Scale which showed an increase pretest to post-test which was sustained to one month follow up. |
| (Gomes et al., 2020) | Surf.Art | 3 years | Weekly for 3 years | 4 hours | n/a | Strengths and difficulties questionnaire (Portuguese) | Reduction in general difficulties reaching a strong effect size. increased effect beyond 2 years. |
| (Cavanaugh, 2010) | Learning through sun sand and SURF | two days | 2 | 2 full days plus social events before and after camp | | Social skills improvement system, Piers Harris Children's self-concept Scale 2nd edition, Parent perceptions of the surf camp curriculum, the Surf Steps Checklist, Surf camp curriculum activity observation checklist some open ended questions | Both children and parents reported they felt children improved their social skills, volunteers disagreed |
| (Santos et al., 2020) | n/a | unknown | unknown | unknown | n/a | accounts from the researchers | n/a |
| (Britton, Kinderman n, & Carlin, 2020) | Liquid Boatriders Club | 8 weeks | 8 | 2 hours | Hard to pin down because it's part of body mapping. They don't do thematic analysis on the parent interviews. | Semi structured interviews with parents and children and Body Mapping | n/a |
| (C. M. Rogers et al., 2014) | n/a | 5 weeks | 5 | 4 hours | n/a | The PTSD checklist-military version (PCL-M), The major depression inventory | Reduction in PTSD symptoms on the PCL-m and reductions in the major depression inventory |

**Appendix 4 MultiPsych guidelines**

Free Format submission

MultiPsych offers Free Format submission for a simplified and streamlined submission process.

Free Format submission means authors can format their manuscript and references in the style or format they would prefer. Wiley will update the formatting into the journal style if the manuscript is accepted for publication. Review Wiley's page on Free Format submission to learn more about how it works.

While there are no requirements for the formatting you choose, we still ask authors to use a consistent format throughout the manuscript and include all information necessary for conducting peer review. Information such as ORCID IDs and co-author details are necessary for conducting timely and ethical peer review. In keeping with the latest guidelines of the International Committee of Medical Journal Editors, each author's contribution to the paper is to be quantified.

**Appendix 5: Recruitment flyer**

We are looking to recruit practicing clinical psychologists for a research study on current practices in clinical psychology. This entails an interview lasting approximately 30-50 minutes on Microsoft Teams. If you are interested please contact the researcher, Dr Feargus Fawsitt, at 113221781@umail.ucc.ie and further information can be provided.

This research is being carried as the student's research as part of the Doctorate in Clinical Psychology in the University College Cork's School of Applied Psychology.

**Appendix 6: Interview Schedule**

To start us off, could you tell me about yourself, What age are you? Where did you qualify? How many years have you been qualified as a Clinical Psychologist? Any area of expertise? What Province do you work in? HSE or private?

I'm interested in psychological therapies being delivered in non-traditional settings, such as part of nature-based activities. Are you aware of these approaches?

I'm going to be asking you about both carrying out therapy outside of clinic spaces, and carrying out therapy during other activities

What, if any, experience carrying out psychological interventions outside of the clinic space?

Can you describe some of your experiences of conducting therapy in these spaces?

What if any experience carrying out psychological interventions during other activities such as nature walks, surfing, or other activities?

Can you describe some of your experiences of conducting therapy during these activities?

What are your views regarding carrying out psychological interventions outside of the clinic space?

What are your views regarding carrying out psychological interventions during other activities?

What, if any, might the benefits of these interventions be for clients?

What, if any, might the benefits of these interventions be for clinical psychologists?

Are there non-specific therapeutic factors that might make a difference in these approaches?

Is there anything about these environments or activities that contributes to the therapy?

What, if any, might the disadvantages of these interventions be for clients?

What, if any, might the disadvantages of these interventions be for clinical psychologists?

Are there any groups you can think would benefit from these kinds of interventions?

Are there any groups you think are not suited to these interventions?

What additional challenges would these interventions pose for clinical psychologists?

What might the risks of these interventions be?

What supports might be helpful for clinicians interested in these approaches?

What are the things that stop you from utilising these approaches?

Have you read any journal articles or books related to these topics?

Any personal experiences of these approaches?

Any other points you didn't get a chance to say?

**Appendix 7: Coding Sample**

| Transcript | Coding |
|---|---|
| **Participant**<br>Yeah. Like I'm kind of keen as well I'm loose enough with it, but the therapeutic frame like the way the old psychoanalysis would have kind of conceptualised having a therapeutic frame and part of the purpose of it is that. You know, you keep certain things same. The room, the time you start and finish in order in order that the person can get quite dysregulated during the time that they're in the appointment, I don't know, is that how a lot of psychologists practise. But I would see a value in in that in having a kind of, I suppose you're trying to create a very safe place for people and a steady, predictable kind of environment. Like I get a little bit annoyed when I have to. You know, if that they want me to go to an inpatient meeting or something like that, it's like, well, I see people on Tuesday morning. It's not part of the medicine, is that I tried to see them at that time at that place and. | Doesn't see the therapeutic frame too rigidly<br><br>The therapeutic frame is important<br><br>Service obligations interfering with the therapeutic frame |
| Interviewer<br>Yeah. | |
| **Participant 3**<br>And I'm watering that down a bit. If I say, well, now the appointment's on Wednesday. Let's ask the reality HSE and I do it, but I suppose some of the intention and having a good therapeutic frame is that the person can go deep and be. Very expressive in their in the appointment and that it kind of and that it finishes, you know that it's like, you know, that's the end of it. Now you kind of finish talking about the topic and you dry yourself up and you carry on go on into the world. And I think that, that idea helps people to feel like I can go into it and come out of it and carry on with my day, like with somebody this morning in the DBT group talking about. | Service obligations interfering with the therapeutic frame<br><br>The therapeutic frame as containing |
| Interviewer<br>Yeah. | |
| **Participant 3**<br>Yeah. Still.<br>Interviewer<br>So that frame provides safety. So do you see those kind of activities as more I guess one off or special cases as opposed to the? Or do I guess? Yeah. Is it an alternative? Is it a supplemental? What? What do those spaces add to therapy or those activities or approaches? | |
| **Participant 3**<br>Like, sorry, this is a separate approach. Like if you're, if you're outside of the typical therapy space. | |

Interviewer
Yeah. So like you said, with the with the singing that what it provided was something that isn't being provided by the HSE effectively or by those very constrained therapy spaces that you have available. Do you see it as adding something as being for people who that doesn't suit. Do you see it as something everyone can benefit from? Is it something that could replace it? Or is it something that's an alternative to? I guess how do you how do you kind of situate it?

**Participant 3**
Is it? I suppose it's slightly different to therapy and I suppose I kind of think like what I provide is therapy and I think people should do therapy, but also do other things. And I think there's probably a lot to be said for.

Is this for Psychology?

Interviewer
Yeah.

**Participant 3**
That maybe for centuries and centuries, humans have drummed and danced and sang, and that these were these were ways that people dealt with the difficult things in their lives. And therapy has a role in that. But it's not the only Antidote to human misery or stress. It's not the only way to approach it, but it is the way I do it. And I suppose if I'm going to do therapy, I'll probably try and do it in an office in that kind of traditional way. Now, I'd prefer if the office was a bit more. Flexible, but I'm probably not going to be on a surfboard or something at the same time, yeah.

Alternative approaches have value

Would not want to do some alternative approaches