# THE ROOTS OF PRACTICE: AN ANTI-COLONIAL CRITICAL DISCOURSE ANALYSIS OF WESTERN NATURE-BASED MENTAL HEALTH THERAPIES

by

Carmen Chui, BSc, University of Guelph, 2008, BSW, Ryerson University, 2017

An MRP

presented to Ryerson University

in partial fulfillment of the

requirements for the degree of

Master of Social Work

in the Program of

Social Work

Toronto, Ontario, Canada, 2018

## AUTHOR'S DECLARATION FOR ELECTRONIC SUBMISSION OF A MRP

I hereby declare that I am the sole author of this MRP. This is a true copy of the MRP, including any required final revisions.

I authorize Ryerson University to lend this MRP to other institutions or individuals for the purpose of scholarly research.

I further authorize Ryerson University to reproduce this MRP by photocopying or by other means, in total or in part, at the request of other institutions or individuals for the purpose of scholarly research.

I understand that my MRP may be made electronically available to the public.

## ABSTRACT

The Roots of Practice: An Anti-colonial Critical Discourse Analysis of Western Nature-Based Mental Health Therapies
Master of Social Work, 2018
Carmen Chui
Program of Social Work
Ryerson University

This study seeks to explore how nature-based therapies are understood in Western "mental health" practices. Specifically, horticultural and equine-assisted therapeutic models are examined for discursive themes tied to mind-body connections, attachment and healing. Additionally, texts used to teach specific therapeutic modalities are examined to further explore common concepts such as mindfulness and coping. In conducting a review of relevant literature, similar themes were revealed which contributed to a base knowledge for understanding the discourse around nature-based therapies. Engaging in an anti-colonial theoretical framework and a modified critical discourse analysis methodology, this qualitative study explores the research question: "What are the discourses which inform Western nature-based therapies?" Ultimately, this study aims to develop a more thorough understanding of how these therapies are linked to Indigenous approaches, how practices may be appropriated and used by Western practitioners, and the shift in social work towards more wholistic therapeutic practices.

## ACKNOWLEDGEMENTS

I would like to express my deepest gratitude and appreciation to my research supervisor, Dr. Jennifer Poole, for her unwavering support throughout this research process. It is because of her patience and belief in me that this paper has come to fruition. I would also like to acknowledge and thank my one participant for generously donating their time, wisdom and passion for furthering this and future research on nature-based therapies and its role in healing and recovery. It is this collective passion for examining discourses around nature-based therapy that advances the literature and interest in this field. Likewise, I would like to thank my MSW peers for their relentless rallying to cross the finish line together. I would also like to formally thank my parents for their continued support in furthering my education. Without their ongoing belief in my voice and my agency, I would not be in a position to obtain a graduate degree in Canada. Finally, I would like to formally thank my life partner and best friend for his everlasting patience, support and insight. Words cannot express the gratitude I have for the safety and strength you have fostered in me.

## TABLE OF CONTENTS

## LIST OF APPENDICES

# CHAPTER 1. INTRODUCTION

In an increasingly tense sociopolitical climate, the concept of "mental health" is becoming more categorized, rationalized and individualized in the West (Lynn, 2006; Poole, Jivraj, Arslanian, Bellows, Chiasson, Hakimy, Pasini, & Reid, 2012; Teghtsoonian, 2009). Modern modalities of therapy tend to focus on targeting specific aspects of one's physical, psychological, emotional and spiritual health without understanding the deep interconnections of all four aspects of self. From a Western perspective, "mental health" is a phenomenon which can be analyzed, measured and calculated in ways where needs can be examined under the medical microscope and isolated into accessible units of treatment. As a result, numerous therapeutic models have been developed to guide clinicians in treating "mental health" needs (Beck, 2011; De Leon, 2000; Hewson, 1994; Levine, 1997; Linehan, 2015; van der Kolk, 2014). Examples include Cognitive Behaviour Therapy, the Therapeutic Community (TC) model, horticulture therapy, Somatic Experiencing©, Dialectical Behaviour Therapy, and Eye Movement Desensitization and Reprocessing (Beck, 2011; De Leon, 2000; Hewson, 1994; Levine, 1997; Linehan, 2015; van der Kolk, 2014). Within these models, clear definitions are made for treatment (Beck, 2011; Levine, 1997; Linehan, 2015; van der Kolk, 2014), for characteristics of a person in recovery, for skills and strategies for recovery, and for stages and dimensions for recovery (Beck, 2011; De Leon, 2000; Hewson, 1994; Levine, 1997; Linehan, 2015; Poole, 2011; van der Kolk, 2014). Action plans, initiatives, strategies and commissions are then formed to tackle this rising public health crisis (Poole, 2011; Teghtsoonian, 2009). "Alternative" therapies are birthed as solutions to counter traditionally biomedical-driven models of therapy, such as psychiatry and psychology (Bettman & Tucker, 2011; Corring, Lundberg, & Rudnick,

2013; Duvall & Kaplan, 2014; Cooley, & Cupples, 2007; Tucker, Javorski, Tracy, & Beale, 2012).

I have chosen to research and write about this topic because the concept of "mental health" and "wellbeing" is near to my heart. On a surface level, I work for a not-for-profit "mental health" organization which privileges psychiatric approaches for psychological healthcare. I also historically participated in anti-stigma campaigns to raise awareness about "mental health" and supported efforts to "normalize" "mental health" symptoms elicited by interpersonal and workplace stress as well as social pressures for "success". On a personal level, I was subjected to educational institutionalization as a child which effectively labelled my intelligence and "mental health" as lacking. Even in these early years, I recognized how unnatural it was for such powerful institutions to pathologize me based on my age and my race. As I grew up and entered new academic and professional spaces, I became more aware of how my body was interpreted by others and learned to "Whiten" my identity in order to be accepted and survive, a phenomenon Poole (2011) calls "creaming".

As a result of my experiences as both an insider and outsider of the "mental health" system, I have always been drawn to "alternative" ways of healing. As I sit in my dining room writing this introduction, I am faced with three of my maternal grandfather's watercolour paintings. I am reminded of earlier days when my sister and I sat in my grandparents' home watching my grandfather quietly paint detailed images of Chinese mountainsides, majestic horses and flowers blooming in the springtime. I also think of the days when we would sit under a tree watching my grandfather participate in his Tai Chi classes. When I glance out my window, the sight of my raised vegetable garden also reminds me of my paternal grandfather's love for meticulously weeding and pruning his garden bed full of fresh vine-ripe tomatoes, jumbo squash,

heads upon heads of leafy greens and a wall of beans. As I span across my living room, I see how both my grandmothers have influenced my love for keeping houseplants and "decorating" with living plants rather than material knick-knacks. Currently, I am inspired by my partner's love for the outdoors. Hailing from the countryside in Southwestern Ontario, he is deeply connected with the ways in which food grows and is consumed. He also has a love for bird-watching and spending time by water.

By bringing these memories to the forefront, I am reminded of my cultural teachings on wholism. My teachings also parallel the cultural teachings of many Indigenous cultures across Turtle Island (what is now known by settlers as Canada). Wholistic healing can take many forms, whether it be through the arts, mindful exercises or by spending time in nature. Therefore, the tendency for modern healthcare systems to separate "mental health" from the 'whole self' negates its efforts to pursue true healing. This is why I write the words "mental health" in quotes. I believe that the concept of "mental health" is socially constructed and its continued use prevents any progress for "mental health" recovery. Since there are so many avenues for critical analysis underlying "mental health", I will focus on the impact of nature-based therapies in current "mental health" practices.

So, what is nature-based therapy? Nature-based therapies are structured therapeutic approaches grounded in one's interaction with plants, animals and/or their natural landscapes. These therapeutic programs are often labelled as "alternative" therapies to Western psychotherapy and psychiatry services. Examples include: wilderness therapy, adventure therapy, horticulture therapy, animal-assisted therapy, ecotherapy, green therapy, aquatic therapy and some exercise-based therapies. Overall, these therapies aim to reconnect people with their environments, address their needs as whole beings, and re-balance their physical, psychological

and emotional needs (Chernoff, 2015; Hewson, 1994; Letson, 2017). In some instances, nature-based interventions will also cater to a person's spiritual needs. However, in current nature-based therapy literature, there lacks a critical discussion of how the therapeutic modalities benefit all four aspects of a person. There also lacks an acknowledgment from where these modalities originated thereby risking appropriation of unique cultural concepts and practices which do not belong to Western researchers and practitioners. Therefore, as a critical social work researcher, I aspire to not only counter the medical discourse on "mental health", I also seek to re-center nature-based knowledges in Indigenous ways of living, doing and being.

## CHAPTER 2. THEORETICAL FRAMEWORK

Healy (2014) defines social work theories as "frameworks […] that offer specific guidance as to the purpose of social work, the principles for our practice and […] specific methods of intervention" (p. 7). Theoretical frameworks offer a lens by which practitioners and researchers can make sense of their practice and form a "professional base" (Healy, 2014, p. 7). This lens informs the way social workers define their roles, the values they uphold, and their approach to practice (Healy, 2014). Theories are like discourses where a philosophical frame, or combination of frames, is used to prescribe meaning and to organize concepts which shape the way in which we embody social work (Healy, 2014). These are the rules which underlie our practice, which fuel our decisions for what is "right" and what is "wrong", and which define the boundaries of our profession (Healy, 2014). Furthermore, these frames drive the way in which social workers build relationships with community members, how knowledge is gained and valued, and which social programs get funding dollars. Theoretical frameworks are "constantly evolving [with] new theories […] emerging from within these perspectives" (Healy, 2014, p. 7) therefore social work researchers and practitioners must enter social and professional spaces with an understanding of how the fluidity of their practice will ebb and flow as they gain a deeper and more reflexive understanding of their positions in social work. As titled, this research study uses an anti-colonial theoretical lens. Since anti-colonialism connects with the larger umbrella of anti-oppressive practice, I will start by discussing the impact and influences of anti-oppressive practice then dive deeper into how an anti-colonial framework can be used in critical "mental health" practice.

In response to the overwhelming number of biomedically-driven studies on nature-based therapies, many social work scholars and practitioners have adopted an anti-oppressive

framework to examine ways in which nature-based therapies can re-center wholism. Within this framework, alternative approaches to biomedical research are used to expose the unspoken and deeply-engrained oppressions within current "mental health" practices. Although these oppressive practices date back before the 1960's when "mentally ill" individuals were hospitalized against their will and spared limited to no legal rights within their psychiatric prisons (Birnbaum, 1960), their insidiousness continues to infiltrate current practice. As a result, anti-oppressive practice emerged as a framework to resist further marginalization of the "mentally ill" (Birnbaum, 1960) and to place social justice initiatives at the forefront of transformative social work (Massaquoi, 2011). In its pure form, anti-oppressive practice is "a social justice-oriented practice model […] taught in a number of schools of social work around the world and embraced by a wide swath of social workers in clinical, community, and policy settings" (Baines, 2011, p. 26). The practice attempts to draw upon multiple social justice, liberatory frameworks in order to re-center the voices of marginalized bodies (Baines, 2011; Massaquoi, 2011). This means that within anti-oppressive social work, aspects of feminism, Marxism, post-modernism, Indigenism, post-structuralism, anti-colonialism and anti-racism are included in its approach (Baines, 2011). Subsequently, due to its broad definition, I argue that anti-sanist (Perlin, 1992) and intersectional approaches to social work can be included in this framework.

Currently, as anti-oppressive concepts become integrated within mainstream social work, the context for opposing oppressive practices is being lost (Baines, 2011). The experiences of individuals and groups are once again homogenized into a singular experience of marginalization whereby the unique tensions and struggles of individuals and groups are blurred (Baines, 2011). Therefore, by virtue of categorizing all marginalized experiences as one, the concept of anti-

oppressive practice has taken on a new form of oppressive social work. Moreover, the appropriation of anti-oppressive language and concepts redefines anti-oppressive practice through a lens of individualism by giving rise to a new approach to social work called neo-liberalism. Baines (2011) defines neo-liberalism as;

> An approach to social, political, and economic life that discourages collective or government services, instead encouraging reliance on the private market and individual skill to meet social needs. In the social welfare arena, this approach has resulted in reduced funding for social programs, new service user groups, and workplaces with fewer resources and increased surveillance, management control, and caseload size. World-wide it has resulted in a growth of poverty, decrease in democracy, and increased social and environmental devastation (p. 30).

In light of the report released by the Truth and Reconciliation Commission, critical social workers must be mindful that the concept of decolonization does not become another trendy approach to practice where true intent for inclusion and reconciliation is appropriated. It must be a means for remembering Indigenous histories, implicating our positions as settlers in these stories and transforming Western social work practice. Therefore, in order to understand how an anti-colonial framework is used in this research study, we must first understand colonization and colonialism. Young (2001) defined colonization as "the subjugation of one group by another" (as cited in Chilisa, 2012, p. 9). Through the process of colonization, Indigenous territories were invaded by European "settlers, explorers, [and] missionaries" (p. 9) in both what is currently known as North America and across the world (Chilisa, 2012). Baskin (2011) further asserts that "European peoples came to this continent with a world view based on Christianity and capitalism" (p. 3) and believed in an inherent need for humankind to "fill the earth and subdue it,

rule over the fish in the sea, the birds of heaven, and every living thing that moves upon the earth" (Hamilton & Sinclair, 1991, p. 21, as cited by Baskin, 2011). Due to this belief of superiority, the colonization of Indigenous groups effectively destroyed the political, social and economic systems which existed in Indigenous communities and stripped Indigenous peoples of "control and ownership of their knowledge systems, beliefs and behaviours" (Chilisa, 2012, p. 9). In the current day, colonialism exists with the continued privileging of European values and beliefs including rationalism, diffusionism and individualism (Hart, 2009). Colonialism operates by excluding, marginalizing and appropriating Indigenous knowledges while ensuring that colonial and colonized bodies hold access to knowledges and spaces which do not belong to them (Hart, 2009). As a result, these bodies have the privilege of taking, sifting through, adapting and making knowledges their own without any consequences or acknowledgement of where these knowledges originated.

So why wasn't a post-colonial framework used in this study? Baskin (2011) argues that the idea of post-colonialism is misleading as it suggests that colonialism is over, that we currently live in a time "after colonialism". We know that this is, in fact, untrue as post-colonialism is derived from the discourse of the colonized and seeks to examine the impact of Eurocentrism on the people who have been colonized (Baskin, 2011). Post-colonialists still depend on Western models to theorize ways in which our communities can decolonize, whereas anti-colonialists envision entirely alternative and oppositional paradigms based on Indigenous concepts and frames of reference (Hart, 2009). Since decolonization is not the sole responsibility of Indigenous peoples, academics must "create space and credibility [and] bring the knowledges of Indigenous writers from the margins to into the centre" (Baskin, 2011, p. 54). Therefore, anti-colonial work requires that we not only question institutional practices, values and thoughts

which continue to perpetuate colonial erasure of Indigenous communities (Hart, 2009), it also requires that we take action, show up and join our communities in raising awareness about structural injustices which permeate our daily languages, behaviours and actions (Baskin, 2011). Hart (2009) emphasizes the importance of acknowledging the histories of Indigenous lives, the present-day tensions between Indigenous and settler communities, and the future of our collective. It is in tearing down colonial structures and envisioning a new framework in which we operate, can we reach the truth and truly reconcile. Therefore, anti-colonial social work is a means to dismantle "discursive mechanisms through which citizens and clinicians are incited to align their self-understandings and practices with the programmatic goals of government" (Teghtsoonian, 2009, p. 29).

Evidently, although colonialism is an instigator of modern social work's valuation of dominance, capitalism and individualism (Baines, 2011), I also want to recognize individual complexities by using a variety of theoretical sub-frames in this study. For example, not only will I employ an Indigenous lens to decolonize the purposes of nature-based practices (Absolon, 2016; Ball, 2012; Baskin, 2011; Bruyere, 2007; Carriere & Richardson, 2013; Hart, 2009; Meyercook & Labelle, 2008; Nesdole, Voigts, Lepnurm, & Roberts, 2014), I will also use a feminist and critical queer theory lens to examine the patriarchal influences in gender-based healthcare systems (Gray, 2007; Grote, Zuckoff, Swartz, Bledsoe, & Geibel, 2007; Jones, 2014; Meyercook & Labelle, 2008; Poon, 2011), an anti-racist and intersectional lens to re-centre the voices of racialized and marginalized bodies (Grote et al., 2007; Jones, 2014; Lynn, 2006; Poon, 2011), and an anti-sanist lens to shift the discursive mechanisms which define people who have been labelled and psychiatrized by the Western "mental health" system (Gray, 2007; Grote et al., 2007; Meyercook & Labelle, 2008; Nesdole et al., 2014; Poole, 2011; Poole et al., 2012;

Teghtsoonian, 2009). Therefore, although this research study will be primarily informed by an anti-colonial stance, aspects of other critical lenses will be used to identify any gaps in this study as well as other areas for further research.

## CHAPTER 3. LITERATURE REVIEW

Since nature-based therapies are still quite new in Western social work, there exists a majority of positivist and biomedically-driven research in this field (Barton, Griffin, & Pretty, 2012; Bettman & Tucker, 2011; Blay, Batista, Andreoli, & Gastal, 2008; Corring et al., 2013; Duvall & Kaplan, 2014; Hawthorne, Green, Folsom, & Lohr, 2009; Lariviere, Couture, Ritchie, Cote, Oddson, & Wright, 2012; Mills, Wilson, Iqbal, Alvarez, Pung, Wachmann, Rutledge, Maglione, Zisook, Dimsdale, Lunde, Greenberg, Maisel, Raisinghani, Natarajan, Jain, Hufford, & Redwine, 2015; Norton, 2010; Tucker et al., 2012; Unterrainer & Lewis, 2013). As a result, the voices of interpretive and critical researchers, as well as any "alternative" "mental health" practitioners, are limited. Since nature-based therapies "borrow" from Indigenous approaches to healing by promoting wholism and interconnectedness, it is critical for researchers and practitioners to re-center Indigenous voices and knowledges by exposing the impact of colonialism on current social work practice.

Let's begin by defining positivism. Neuman (2011) defines positivist social science, or positivism, as an approach to researching "natural science" (p. 95). Positivism is described as a "value-free" (p. 95) approach to exploring and explaining social science and prioritizes rationality as a way to derive evidence (Neuman, 2011). Moreover, positivist social scientists "prefer precise quantitative data and often use experiments, surveys, and statistics [to] seek rigorous, exact measures and 'objective' research" (Neuman, 2011, p. 95). Therefore, within positivist research studies, aspects of self, such as spirituality, are rationalized and categorized as "objects" to measure health and wellbeing (Bruyere, 2007; Carriere & Richardson, 2013; Nesdole et al., 2014). Consequently, by minimizing the importance of spirituality in practice,

current modalities of nature-based therapies are ignoring a core aspect of self for long-term healing (Bruyere, 2007; Carriere & Richardson, 2013; Nesdole et al., 2014).

Interpretive social science, on the other hand, values subjectivity (Neuman, 2011). Interpretive social science attempts to "get inside [and] develop an understanding of how each of the parts relates to the whole" (Neuman, 2011, p. 101) whereby the "evidence" is dependent on the interpretation of the environment. Neuman (2011) explains that;

> The positivist researcher may precisely measure selected quantitative details about thousands of people and use statistics whereas an interpretive researcher may live for a year with a dozen people to gather mountains of highly detailed qualitative data so that he or she can acquire an in-depth understanding of how the people create meaning in their everyday lives (p. 101).

The third type of social science research is critical social science (Neuman, 2011). Critical social science research is similar to interpretive social research where subjectivity is central to data collection and analysis (Neuman, 2011). However, critical social science differs from interpretive social science by using a more macro lens to examine social contexts of individual issues, such as poverty and structural violence (Neuman, 2011). Neuman (2011) further elaborates that critical social science criticizes interpretive social science for being too "localized, microlevel [and] short-term" (p. 108) whereby its research "fails to take a strong value position or actively help people to see false illusions around them" (p. 108). Therefore, when we re-focus the discussion on current approaches to "mental health" practices, critical social science researchers argue that the depoliticization of "mental health" masks the root causes of psychological "illnesses" (Poole et al., 2012; Teghtsoonian, 2009). Specifically, the overwhelming emphasis placed on individual attachment styles (Bettman & Tucker, 2011;

Harper et al, 2007; Tucker et al., 2013) ignores the systemic barriers which further oppress and limit the inclusion of marginalized groups (Absolon, 2016; Carriere & Richardson, 2013; Meyercook & Labelle, 2008; Nesdole et al., 2014; Teghtsoonian, 2009).

Shifting back to the literature reviewed for this research study, I began by conducting a general search for academic literature on nature-based therapies in North America. The results showed a significantly high proportion of positivist research studies. As I examined the literature, three overarching themes driving nature-based therapies were identified: healing trauma, the effects of attachment and anti-social behaviours, and the concepts of interconnection and spirituality.

**Theme 1: Healing Trauma**

The impact of trauma on overall "ill mental health" is a common theme across many areas of sociological and psychological scholarship (Blay et al., 2008; Duvall & Kaplan, 2014; Gray, 2007; Harper et al., 2007; Hawthorne et al., 2009; Mills et al., 2015; Munoz, Garrison, Enke, Freedman, Hart, Jones, Kirby, Lester, Nakamura, Pomerleau, & VanHooser, 2008; Norton, 2010). Traumatic experiences have been found to dampen people's physical and social functionalities (Blay et al., 2008; Duvall & Kaplan, 2014; Hawthorne et al., 2009; Mills et al., 2015). Therefore, nature-based therapies aim to promote individual capacities for healing and growth (Duvall & Kaplan, 2014; Hawthorne et al., 2009; Norton, 2010). In this literature review, all of the research findings showed an improvement in participants' self-esteem, overall mood and strengthened relationships with others after completing an "alternative" therapy program (Barton et al., 2012; Blay et al., 2008; Corring et al., 2013; Duvall & Kaplan, 2014; Hawthorne et al., 2009; Lariviere et al., 2012; Mills et al., 2015; Unterrainer & Lewis, 2013).

In two studies, veterans were found to show significant improvements in multiple psychological dimensions including attentional functioning, emotional tone, social involvement, order and organization and practical and personal problem orientation, after completing group-based "alternative" programs (Duvall & Kaplan, 2014; Hawthorne et al., 2009). As a result, veterans reported increased feelings of tranquility and reduced anger and aggression (Duvall & Kaplan, 2014; Hawthorne et al., 2009). In three other studies, researchers found that by promoting collectivism through group-based programs, individuals who have experienced trauma from forced silencing can work together to resist dominant interpretations of their bodies (Gray, 2007; Munoz et al., 2008; Teghtsoonian, 2009). By bringing people together through communal activities, such as nature-based therapy programs, people who were previously silenced reported feeling liberated, motivated and more solidified in their collective identities (Barton et al., 2012; Corring et al., 2013; Gray, 2007; Munoz et al., 2008).

**Theme 2: Attachment and Anti-Social Behaviours**

Findings from studies with adolescents suggests that completion of wilderness and adventure therapy programs facilitate a shift from insecure to secure attachments (Bettman & Tucker, 2011). This shift is attributed to fewer internalizing and externalizing anti-social behaviours as well increased individual abilities to communicate, share emotion, and problem solve (Bettman & Tucker, 2011; Harper et al., 2007; Lariviere et al., 2012; Norton, 2010; Tucker et al., 2012). Adolescents also demonstrated improved relationships with their families and peers after completion of wilderness therapy programs (Harper et al., 2007; Norton, 2010). Families of these adolescents noted higher instances of following house rules, participation in chores and eating meals with family (Harper et al., 2007). Positive changes were also recorded for increased school engagement, decreased drug and alcohol use, and an overall reduction in problematic

behaviours such as fighting and lying (Bettman & Tucker, 2011; Harper et al., 2007; Norton, 2010; Tucker et al., 2012). Furthermore, adolescents who simultaneously participated in group-based adventure therapy and individual psychotherapeutic counselling demonstrated even lower "problem severity" (p. 155) than adolescents who only participated in one (Tucker et al., 2012). Therefore, specific modalities of nature-based therapies proved to be good adjunct treatments to psychiatric and psychological therapies (Norton, 2010; Tucker et al., 2012).

It is important to note that in multiple studies, researchers found that improved behaviours deteriorated as time lapsed after completion of these programs when no follow up interventions were arranged (Harper et al., 2007; Tucker et al., 2012). Therefore, a recurring recommendation by researchers is for more individual and group-based community "mental health" support following the completion of adventure and wilderness therapy programs in order to achieve optimal recovery (Harper et al., 2007; Tucker et al., 2012).

**Theme 3: Interconnections and Spirituality**

In addition to outdoor therapy programs, animal-assisted therapies were found to improve self-esteem, self-confidence and the overall mood of participants (Barton et al., 2012; Corring et al., 2013; Lariviere et al., 2012; Norton, 2010). In one study, participants reported feeling deeper connections with their environments after attending a therapeutic horseback riding program (Corring et al., 2013). The horses provided a contact with another being who is responsive yet not socially threatening (Corring et al., 2013). As a result, participants reported a sense of becoming "one" (p. 123) with the horse and felt the animals mirrored their own personalities (Corring et al., 2013).

In another study, researchers found that the formation of meaningful connections with other people, animals and nature reduce "schizotypal" (p. 233) attributes such as hallucinations,

dissociations and disorganization (Unterrainer & Lewis, 2013). Depression and depressive symptoms were also shown to reduce in people living with concurrent physical and "mental health" "issues" after engaging in spiritual activities (Blay et al., 2008; Mills et al., 2015). Individual feelings of meaning and peace were associated with fewer depressive symptoms, reduced alcohol and substance use, increased participation in social activities, and enhanced cognitive insight (Blay et al., 2008; Mills et al., 2015). Furthermore, increased spiritual engagement allowed people to cope with their serious and chronic illnesses as well as improve relationships with other people and their environments (Blay et al., 2008). As a result, people who participated in therapeutic activities which enhanced their connection with nature and animals were more likely to experience a reduction in overall "mental health" concerns (Blay et al., 2008; Corring et al., 2013; Mills et al., 2015; Unterrainer & Lewis, 2013).

**Gaps in Literature**

Overall, both positivist and interpretive researchers agreed that nature-based therapies break away from individualistic practices of Western therapy and promote physical, psychological and emotional growth through connections with one's environment (Barton et al., 2012; Bettman & Tucker, 2011; Corring et al., 2013; Duvall & Kaplan, 2014; Harper et al., 2007; Norton, 2010; Teghtsoonian, 2009; Tucker et al., 2012). However, one resounding limitation noted by positivists is the difficulty for researchers to scientifically measure spirituality and its impact on psychological wellbeing (Unterrainer & Lewis, 2013). By excluding spirituality in their analyses, positivist researchers are neglecting to acknowledge that spirituality is one of the core aspects of self (Baskin, 2011). So, what does this mean in terms of knowledge construction?

**Voices involved in knowledge construction.** As mentioned above, since the voices most dominant in nature-based therapy research are positivist social scientists, it is evident that colonial values are most prominent in this field of research (Hart, 2009; Neuman, 2011). Much like colonialism's tendency to homogenize marginalized experiences, positivists assume that "everyone experiences the world in the same way" (Neuman, 2011, p. 103). Researchers studying nature-based therapies place emphasis on finding "evidence" to support a singular reality for "mental health" experiences (Neuman, 2011). Therefore, since spirituality and religiosity are difficult to measure, spiritual health is often viewed as inferior to other health markers that are more quantifiable (Blay et al., 2008; Bruyere, 2007; Carriere & Richardson, 2013; Meyercook & Labelle, 2008; Nesdole et al., 2014; Unterrainer & Lewis, 2013). As a result of minimizing the importance of spirituality, positivist researchers are effectively denouncing spirituality as a core aspect of self and wellbeing (Baskin, 2011).

The impact of a positivist dominance in nature-based therapy research allows for the creation of meaning by researchers who may not be part of the researched communities (Nesdole et al., 2014). By dominating the discourse on "mental health", Western researchers apply language to create *what* and *how* people understand "mental health" diagnoses. For example, in one study, researchers examined the connection between spirituality and "schizotypy" (Unterrainer & Lewis, 2013, p. 233). The researchers concluded that although there is an overall negative correlation between spirituality and "schizotypy", meaning spirituality was not found to contribute to higher instances of "schizotypal behaviours", there is a strong positive correlation between self-reported feelings of connectedness and "cognitive-perceptual disturbances" (Unterrainer & Lewis, 2013, p. 236). Therefore, participants who felt increased connectedness with other people and a "higher entity" (p. 236), such as within "religious movements" (p. 236),

displayed increased “schizotypal” perceptions and behaviours (Unterrainer & Lewis, 2013). Considering that positivism values categorizations of “mental health”, including categories listed in the DSM-V, these findings support the belief that higher engagement in spiritual activities cause people to have “distorted”, “odd” and “unusual” perceptions about reality (Meyercook & Labelle, 2008; Unterrainer & Lewis, 2013). So, with further interpretation, I conclude that these researchers are claiming that higher reports of spirituality cause instances of cognitive and behavioural abnormalities. Of the ten positivist research studies used in this literature review, only one acknowledged that the omission of spiritual health could be a limitation to nature-based therapeutic practice (Blay et al., 2008).

Additionally, since many of the positivist research studies used non-probability samples, the findings are heavily representative of specific populations including male, White, Christian, cisgender, heterosexual, and middle-to upper-class people who can afford to join fee-for-service recreation programs (Barton et al., 2012; Bettman & Tucker, 2011; Blay et al., 2008; Corring et al., 2013; Duvall & Kaplan, 2014; Harper et al.; 2007; Lariviere et al., 2012; Mills et al., 2015; Tucker et al., 2012; Unterrainer & Lewis, 2013). Once again, these limitations assume higher priority for dominant, Euro-centric populations when forming the discourse on “mental health”.

**Voices excluded in knowledge construction.** The dominance of positivist research paradigms and methodologies in nature-based therapy research largely excludes the voices of marginalized and intersectional bodies (Gray, 2007; Munoz et al., 2008; Nesdole et al., 2014; Teghtsoonian, 2009). One of these groups is adolescents facing social, vocational or economic challenges (Bettman & Tucker, 2011; Harper et al., 2007; Lariviere et al., 2012; Norton, 2010; Tucker et al., 2012). In five of the fifteen studies, adolescent participants were either voluntarily or involuntarily placed in wilderness or adventure therapy programs for observation (Bettman &

Tucker, 2011; Harper et al., 2007; Lariviere et al., 2012; Norton, 2010; Tucker et al., 2012). Interestingly, although the adolescents were the research subjects, the voices represented in the findings were primarily of parents, guardians, educators or staff members working with the youth rather than the youth themselves (Bettman & Tucker, 2011; Harper et al., 2007; Lariviere et al., 2012; Norton, 2010; Tucker et al., 2012). Furthermore, the voices of women and non-binary people were largely excluded. In nine studies, the researchers acknowledged the samples were male-dominant (Bettman & Tucker, 2011; Blay et al., 2008; Corring et al., 2013; Duvall & Kaplan, 2014; Harper et al., 2007; Hawthorne et al., 2009; Lariviere et al., 2012; Mills et al., 2015; Tucker et al., 2012). Only four of the fifteen studies included more female-identified participants than males (Gray, 2007; Munoz et al., 2008; Norton, 2010; Unterrainer & Lewis, 2013), and only one of the fifteen studies specifically included the voices of trans-identified and genderqueer people (Munoz et al., 2008). Across the fifteen research studies, seven identified using majority White samples (Bettman & Tucker, 2011; Blay et al., 2008; Harper et al., 2007; Hawthorne et al., 2009; Mills et al., 2015; Norton, 2010; Tucker et al., 2012) while the remaining did not specify racial identities at all (Barton et al., 2012; Corring et al., 2013; Duvall & Kaplan, 2014; Gray, 2007; Lariviere et al., 2012; Munoz et al., 2008; Teghtsoonian, 2009; Unterrainer & Lewis, 2013). Additionally, in five studies, the researchers overtly acknowledged the exclusion of specific groups including people living in long-term care homes, people weighing more than 170 lbs, people living with comorbid medical conditions, and students who reported histories of psychiatric diagnoses or treatment (Blay et al., 2008; Corring et al., 2013; Hawthorne et al., 2009; Munoz et al., 2008; Unterrainer, 2013), in order to control their outcomes.

With an increased interest in “alternative” “mental health” therapy options (Bruyere, 2007; Carriere & Richardson, 2013; Meyercook & Labelle, 2008; Nesdole et al., 2014), the lack

of non-binary, racialized and marginalized voices represented in nature-based therapy research is astounding. Specifically, from a critical research perspective, a significant concern about the lack of intersectional representation in nature-based therapy research is that it makes these modalities vulnerable to co-option and misuse by modern "mental health" practitioners. I will further elaborate on the risks of cultural co-option and appropriation by Western approaches to "mental health" in later chapters.

# CHAPTER 4. METHODOLOGY

Discourses, as discussed earlier, shape the way in which we understand and interact with our environments (Healy, 2014). Similar to theoretical frameworks, discourse is defined as "'a system or aggregate of meanings' (Taylor, 2013, p. 14, as cited by Healy) through which certain social phenomena, such as 'need', 'knowledge' and 'intervention', are constructed" (Healy, 2014, p. 3). Additionally, "discourses are the sets of language practices that shape our thoughts, actions and even our identities" (Healy, 2014, p. 3). In Western social work, specific colonial discourses dominate the knowledges and truths which underlie approaches to "mental health" practice (Poole, 2011; Teghtsoonian, 2009). This means that neoliberal and capitalist approaches to health and mental wellbeing dictate everything from the therapeutic interventions which are valued, the rules for professional engagement and rapport building, and the way in which experiences, like trauma, are categorized, individualized and rationalized (Beck, 2011; Healy, 2014). Poole (2011) further explains the concept of discourse to be "a collection of words, phrases, rules and practices bound by context, culture and time" (p. 27). As a result, discourses are so deeply engrained in our everyday lives and practices that we are often unaware of them (Poole, 2011).

Healy (2014) argues that "the concept of discourse and the method of critical discourse analysis provide important tools for social workers as [they] seek to understand and create change in, and through, our institutional contexts" (p. 4). Examining the discourses which dictate the words, phrases, rules and practices by which social workers abide will allow social workers and social service workers to implicate themselves and better acknowledge not only their subject positions as workers but their role in the larger societal context (Healy, 2014). A critical discourse analysis urges social workers to perform an "archeolog[ical]" (p. 27) dive into

discursive mechanisms which drive "mental health" therapeutic practices and to dig deeper into their practice rules and norms (Poole, 2011). Poole (2011) further elaborates that this digging will expose "how discourses are connected to each other, how some discourses come and go and how some, such as the medical discourse, become very powerful" (p. 27). Furthermore, Poole (2011) argues that "no discourse is neutral or without real, material effects" (p. 27) therefore the languages, protocols and therapeutic models at the forefront of current social work practices are not without biases. As such, a critical discourse analysis calls for social workers to reveal the power, voices, values and beliefs which promote specific approaches to "mental health" therapies, to question who benefits and who suffers from certain discourses, and to work towards transformative changes within inequitable practices.

The overarching goal of a critical discourse analysis is to address four "normative rules" (Poole, 2011, p. 29) which perpetuate discursive formations. The first type of rule emphasizes the idea of "objects of knowledge" (Poole, 2011, p. 29) and how knowledge is formed, maintained and shared. The second type of rule identifies the voices who are included in knowledge production (Poole, 2011). Particularly, whose voices are privileged and/or prioritized in "mental health" discourses? What is their relationship with the subject matter? What is their motivation for engaging with the subject matter? The third type of rule centers around the "criteria for accepting or rejecting" (p. 29) knowledge (Poole, 2011). More specifically, what qualifies as "evidence" and are these pieces of "evidence" accepted wholly or in part? Is this "evidence" similar to or borrowed from other discursive formations (Poole, 2011)? The fourth type of rule includes ways in which knowledge operates as well as the reaches and limits of these discursive formations (Poole, 2011).

In this study, I have chosen to use a modified critical discourse analysis to examine Western approaches to nature-based therapies. My objective is to critically analyze texts including literature, policies, strategies, reports, announcements, educational and training materials and news articles, alongside the transcript of the interview I conducted with a nature-based therapy practitioner, in order to identify "objects of knowledge" which define and shape nature-based therapeutic practice, the voices and "evidence" which support it, and the strategies for promoting and perpetuating this practice. The difference in this methodological approach is the inclusion of an interview to a text-based critical discourse analytic approach. The purpose of including the voice of a nature-based therapeutic practitioner is to substantiate the literature and written documents on nature-based therapeutic practice. This includes understanding the motivations for pursuing nature-based practices, the practitioner's understanding of the discourse(s) which underlie their practice, and the rules and protocols which frame their individual practice. Thus, the research question which drives this study is, "What are the discourses which inform Western nature-based therapies?"

As mentioned above, the literature reviewed for this study favours positivist research methods. Of the fifteen research studies, six used a quantitative approach, six used a qualitative approach and three used a mixed methods approach. In ten of the studies, scale-type questionnaires and surveys were used to collect data (Bettman & Tucker, 2011; Blay et al., 2008; Corring et al., 2013; Duvall & Kaplan, 2014; Harper et al., 2007; Hawthorne et al., 2009; Lariviere et al., 2012; Mills et al., 2015; Tucker et al., 2012; Unterrainer & Lewis, 2013). In one study, three questionnaires were used in a mixed method analysis of adolescents' perceptions of their attachment relationships (Bettman & Tucker, 2011). All three questionnaires used Likert scales and were completed once upon intake and once upon discharge of a wilderness therapy

program (Bettman & Tucker, 2011). In another study, two assessment tools were used to qualitatively measure five themes: having fun, bonding relationship with horse, increased confidence and self esteem, relationship gains, and the discovery of patients' learning potential by staff (Corring et al., 2013). The researchers used a Structured Clinical Interview for DSM-V (SCID) and Global Assessment of Functioning (GAF) scale to guide their intake assessments and three semi-structured interviews to assess the participants and staff's experiences (Corring et al., 2013). Furthermore, the majority of the positivist research studies examined a cross-section of participants' experiences without capturing pre-assessment and post-assessment variables which may have influenced the findings (Faulkner & Faulkner, 2014).

On the other hand, four of the fifteen studies used interpretive and critical research paradigms. The interpretive and critical frameworks included a mix of critical feminism, critical disabilities, post-structuralism, anti-sanism, critical queer theory, postmodernism, Marxism and pragmatism (Gray, 2007; Munoz et al., 2008; Teghtsoonian, 2009). Three of the studies used a qualitative approach to research (Gray, 2007; Munoz et al., 2008; Teghtsoonian, 2009). Primarily, narrative and critical discourse analyses were used to examine the impact of colonialism on people's "mental health" (Gray, 2007; Munoz et al., 2008; Teghtsoonian, 2009). The fourth study used a pragmatic approach to quantitatively measure the impact of wilderness therapy on adolescent "mental health" and family functioning (Harper et al., 2007). This last study specifically used methodologies within a family systems framework to measure adolescent and family outcomes following a 21-day wilderness family program (Harper et al., 2007).

Based on this analysis, it is clear that the majority of positivist research studies on nature-based therapies used survey research methodologies (Barton et al., 2012; Bettman & Tucker, 2011; Blay et al., 2008; Duvall & Kaplan, 2014; Hawthorne et al., 2009; Mills et al., 2015;

Tucker et al., 2012; Unterrainer & Lewis, 2013) with two studies focussing on case studies (Harper et al., 2007; Lariviere et al., 2012) while the interpretive and critical research studies used narrative and critical discourse research methodologies (Corring et al., 2013; Gray, 2007; Munoz et al., 2008; Teghtsoonian, 2009) with one case study (Norton, 2010).

For the purposes of this research study, I chose to examine five key public texts including core textbooks used for training in specific modalities of therapy, core books written by well-known trauma therapists in North America, and public reports about the importance of nature for overall urban health. The first textbook examined is *Horticulture as Therapy: A Practical Guide to Using Horticulture as a Therapeutic Tool* by Mitchell Hewson. This is the core textbook for Mitchell Hewson's "psychiatric Horticultural Therapy" online course (Horticulture As Therapy, 2018). The second textbook used is the *DBT Skills Training Manual* by Marsha M. Linehan. Since nature-based therapeutic interventions are often used to treat trauma and attachment-based concerns, the theoretical concepts outlined in Dialectical Behaviour Therapy, such as the mindfulness and emotional regulation, are central to many nature-based approaches (Barton et al., 2012; Bettmann & Tucker, 2011; Duvall & Kaplan, 2014; Harper et al., 2007; Lariviere et al., 2012; Mills et al., 2015; Tucker et al., 2013; Unterrainer & Lewis, 2014). The third text used in this analysis is a book called *Waking the Tiger: Healing Trauma* by Peter Levine. This book is one of the key texts driving Somatic Experiencing©, a relatively new approach to trauma therapy. Additionally, the City of Toronto's report titled *Green City: Why Nature Matters to Health – An Evidence Review* will be examined for its contributions to driving public interest in nature-based therapeutic practices. This report was published in 2015 as part of the City's initiative to promote "the health of residents" through examining the links between "green space and human health" (Zupancic, Kingsley, Jason, & Macfarlane, 2015, p. 32). The fifth text used is

Wellington-Dufferin-Guelph Public Health's *City of Guelph: Planning Review Through a Public Health Lens*. Specifically, the report's section on *Healthy Neighbourhood Design* and *Healthy Natural Environments* will be examined for similar themes and its contributions to municipal "mental health" strategies. I have also chosen to examine two Tedx Talks videos discussing the benefits for equine-assisted psychotherapy. The first talk is from TedxBemidji presented by Liz Letson, a Licensed Professional Clinical Counsellor (LPCC) and is called *Horses Help Humans be Real, Honest, and Present*. The second talk is from TedxWilmington presented by Mindy Tatz Chernoff called *How Horses Heal, Transform, and Empower*.

For the interview component of this research study, the following interview guide was created to address the research question in more depth. My research participant was provided with a copy of the interview guide prior to our meeting to ensure preparation, comfort and transparency. The interview questions were as follows:

1. Please tell me about your approach to practice. How long have you been in practice?
2. A lot of people are talking about nature-based therapies these days. Why do you think that is?
3. What do you know about the roots or beginnings of this way of practicing?
4. Are there any tensions in your practice or challenges to what you do?
5. What are the impacts of your practice? Who is benefitting from this approach? Who could benefit from this approach?
6. What are the (dis)connections between what you do and nature-based therapy?
7. What are the politics of doing this kind of work? Do you or your practice have any connection to the Truth and Reconciliation Commission (TRC)?
8. Is there anything else I should know?

For this research study, I interviewed one participant in total. I had initially intended to interview three participants however due to low response, I was only able to recruit and interview one nature-based practitioner. My queries for this low recruitment response will be further discussed in the following chapters of this research study. In order to protect the identity of the practitioner, an alphanumerical code was assigned and the name and specific location(s) of their practice were omitted. The participant (NBP1) identifies as a registered horticultural therapist practicing in Southern Ontario. They were provided with a copy of the consent form one week prior to meeting and the consent process was again reviewed verbally the day of the interview. Prior to starting the interview, NBP1 was reminded of the steps I have taken and will be taking to ensure their confidentiality in this research study. As part of the consent protocol, NBP1 consented to audio-recording and was informed of the member-checking process. They were informed that they will have the opportunity to review the interview transcript, to make any changes to the transcript, or to withdraw from the study by June 15, 2018. NBP1 was also offered a $5.00 gift card to Tim Horton's in appreciation for their participation prior to starting the interview process. I made clear that they can keep this gift even if they chose to withdraw from the study.

## CHAPTER 5. FINDINGS

The key findings in this research reveal an overarching discursive focus on the benefits of nature-based therapies. The key texts and interview conducted for this study suggest that nature-based therapy discourses seek to persuade us that they promote the overall health and wellbeing of individuals living with some form of "mental health" need. These needs include both formal and informal "mental health" diagnoses, cognitive and psychological distress, and "mental health" concerns caused by environmental and systemic barriers. In sifting through the texts, videos and interview transcript, four overarching discourses – what Poole (2011) calls the "talks" and what I am calling the "big talks" – emerged from the data. These discourses are: 'mind-body connections', 'environmental impacts on "mental health"', '"alternatives" or adjuncts to biomedical approaches', and 'healing and recovery'. I also identified two less dominant discourses – the "little talks" – called: the 'medical model' and 'evidence-based practice'.

### The Big Talks

**Mind-body connections.** The first dominant discourse in the data is the talk around mind-body connections. Simply, when discussing the concept of trauma, Peter Levine (1997) explains that in order to understand "symptoms of trauma" (p. 145), we need to understand the "basic physiological processes" (p. 8) which produce them. Levine (1997) states;

> When I speak of our 'organisms,' I refer to Webster's definition of 'a complex structure of interdependent and subordinate elements whose relations and properties are largely determined by their function in the whole.' Organisms describes our wholeness, which derives not from the sum of its individual parts, i.e., bones, chemicals, muscles, organs, etc.; it emerges from their dynamic, complex interrelation. Body and mind, primitive

> instincts, emotions, intellect, and spirituality all need to be considered together in studying the organism (p. 8).

Likewise, Mitchell Hewson (1994) explains that in horticultural therapy, "the physical functioning of [a person] can be restored, improved, maintained or helped" (p. 4) which then promotes cognitive and perceptual "stimuli through vision, smell, taste, touch and texture, via the perception and recognition of plants" (p. 4). As a result, Hewson (1994) argues that participants in horticultural therapy programs become more aware of external and internal stimuli which influence the way in which they "understand and deal with their emotions and feelings" (p. 4). Specifically, individuals may improve their skills, self-esteem and confidence by completing projects, tasks and activities in nature-based therapeutic programs (Chernoff, 2015; Hewson, 1994; Letson, 2017).

Much like horticultural therapy, equine-assisted therapy is also dominated by this discourse, focussing on facilitating the connection between one's internal cognitive perceptions with associated physiological responses (Hewson, 1994; Letson, 2017). Liz Letson (2017) asserts that equine-assisted therapy allows individuals to "let [their] guard down and become vulnerable in order to heal". Letson (2017) explains that "horses end up mirroring our whole human emotions" and that they "mirror relationship dynamics" and "offer a different perspective into people's lives". Therefore, by observing the actions and reactions of a horse, Letson (2017) argues that individuals are able to externalize their "fears" and learn how to cope. In one example, Letson (2017) shares that while working with a young female who had been experiencing a history of "domestic violence" and subsequent "anxiety, depression [and] oppositional behaviour", the young female was able to process the traumatic events she had experienced by observing a conflict between three horses.

Mindy Tatz Chernoff (2015) further supports this discursive focus by affirming that horses are "masters of non-predatory power" which makes them vigilant and deeply attuned to environmental threats. What she means is that although horses "don't have big claws and sharp teeth, […] they're very powerful" (Chernoff, 2015). For example, in a split second, horses can switch from a "wide angle living" to a "narrow tiny frame" when a threat is detected (Chernoff, 2015). Levine (1997) states that this quick switch is attributed to the "hyper-aroused states" (p. 179) of survival and is part of one's "survival knowledge" (p. 174). Biologically, a horse would experience "their heart rate [rise], their blood pressure [rise], adrenaline [flowing] through their system because they have to know in an instant, do I run" (Chernoff, 2015). So, equine-assisted therapists argue that much like humans, horses are "real, honest and present" (Letson, 2017) and "handle their power in ways that are not predatory" (Chernoff, 2015). Chernoff (2015) explains that "horses are like tuning forks, you have two tuning forks and you strike one and the other resonates with the same sound, frequency and vibration". However, "instead of tuning forks, it's hearts. And [the horse's] heart to our heart, and our heart to their heart" (Chernoff, 2015) connect in ways which are beyond simple definitions. By "being with […] horses […] people [can] explore things that are intangible and [make] them more tangible" (Letson, 2017). Therefore, by physically interacting with a horse, an individual can "touch [their] fears", observe the way in which a horse acts and reacts to environmental threats, draw parallels between the horse's and their own behaviours, process what their observations mean, and develop "coping skills and problem-solve" in order to heal and grow (Letson, 2017). Stepping back, we start to see how the discourse on 'mind-body connections' is rife with modernist values of rationality and categorization. Notions of "trauma" and "healing" are defined using biomedical languages for "illness" which are used as "evidence" for interventions and therapeutic modalities.

Marsha Linehan (2015), psychologist and creator of the Dialectical Behaviour therapeutic model, elaborates on how making mind-body connections can enhance an individual's ability to cope and problem-solve in difficult and stressful situations. Dialectical Behaviour Therapy is described as a "treatment" (Linehan, 2015, p. 3) modality for "chronically suicidal individuals diagnosed with borderline personality disorder" (Linehan, 2015, p. 3). In Linehan (2015)'s module about "distress tolerance" (p. 431), she argues that "very high emotional arousal can make it impossible to use most skills" (p. 431) therefore by engaging in activities which promote a "healthy" (p. 9) physiological response, a person can learn to re-ground themselves in the present moment. For example, Linehan (2015) coined a set of coping strategies called the "TIP Skills" (p. 431). She explains that "these skills are Temperature (use of cold water on the face to elicit the dive response), Intense exercise, Paced breathing, and Paired muscle relaxation" (Linehan, 2015, p. 431). Additionally, these skills can be paired with "Mindfulness Skills" (p. 161) whereby individuals experience "reality *as it is*" (Linehan, 2015, p. 161). What this means for nature-based therapies is that participants are taught to be aware of their physiological responses to real or perceived environmental distress and engage in specific strategies to diminish their states of hyper-arousal and re-ground in the present (Chernoff, 2015; Letson, 2017; Levine, 1997; Linehan, 2015). Arguably, this "evidence" for individualistic approaches to "mental health" demonstrates its beguiling simplicity for recovery thus attracts both practitioners and service users alike.

Drawing from the "evidence" for individualistic approaches to "mental health", urban centers engage with nature-based recovery discourses by using an environmental approach to urban health (Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). Toronto Public Health (2015) reported that "urban green space[s have a positive impact] on heat

island mitigation and reducing air pollution" (p. 4) which directly increases the "physical health, mental health and wellbeing" (p. 4) of residents. Similarly, Wellington-Dufferin-Guelph Public Health (2015) reported on the negative correlation between adverse "mental health" and "environmental exposure to air pollutants" (p. 1). Subsequently, access to green spaces have been found to "have a positive influence on overall physical health and wellbeing" (p. 7) thereby reducing stress and restoring cognitive health (Toronto Public Health, 2015). Wellington-Dufferin-Guelph Public Health (2015) summarizes these findings by stating;

> Research indicates that urban trees have the potential to clean the air of air pollutants, which in turn can help prevent the onset of cancer, cardiovascular disease and respiratory difficulties. Preliminary studies also suggest that urban trees and green spaces can have cooling effects, mitigating the impacts of extreme heat events which are linked to increased mortality, in particular for those with pre-existing cardiovascular and respiratory conditions. Meanwhile, studies have demonstrated that exposure to nature is not only associated with increased physical activity, but is also linked with increased general wellbeing, including improved cognitive function and reduced stress and anxiety (p. 5).

NBP1 further builds on this discussion around mind-body connections by emphasizing the role of food and farming. NBP1 asserts that;

> […] individuals in those environment [are] going to be more connected with their own environment and the people who are growing the food [and] also with the natural world which we already know has a […] grand physiological effect on people […] and hopefully […] that connection for food security [and] the sustainability of farming in […] our current climate.

Within this discursive construction of data, nature-based projects and activities which link green spaces with access to food have been shown to improve overall health (Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). Toronto Public Health (2015) identified that case studies examining the relationship between community gardens and health found that "people who use community gardens report: improved access to food, better nutrition, increased physical activity, improved mental health, [and] enhanced social health and community cohesion" (p. 18). In fact, they argue that participation in community gardens has been found to reduce "distress symptoms, [improve] overall general health and [reduce] frequency of illegal drug use than those who did not participate" (p. 18) in community garden programs (Toronto Public Health, 2015). Undoubtedly, NBP1 agrees that access to fresh foods promote consumption and absorption of nutritious foods which ultimately enhances overall healthy connections between the body and the mind (Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). Wellington-Dufferin-Guelph Public Health (2015) further found that "individuals who do not have convenient neighbourhood access to a healthy food retail outlet, like a grocery store, may be more likely to choose costly and less nutritious options (e.g., processed food)" (p. 5). When a wider macro lens is applied to this discussion, Wellington-Dufferin-Guelph Public Health (2015) also reported that "research also suggest that this unequal distribution of food retail outlets in residential areas occurs more in lower income neighbourhoods" (p. 5) so when "a local food system is adequately supported to provide development initiatives like community gardens and kitchens, healthy local food options are made accessible, while bolstering community members' food skills, social and coping skills, and overall community empowerment" (p. 5). In fact, Wellington-Dufferin-Guelph Public Health (2015) stated that "recent research in health has returned to the thinking that health is not always

decided by individual health behaviours but, rather, is largely determined by the environment in which one lives" (p. 1). This leads us into the second dominant discourse identified in the data: environmental impacts on "mental health".

**Environmental impacts on "mental health".** As discussed above, the discursive underpinnings in the data supports another talk around the impact of the environment on our overall health (Chernoff, 2015; Letson, 2017; Levine, 1997; Linehan, 2015; Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). Specifically, when looking at climate change, the "evidence" indicates that the accumulation of greenhouse gas pollution is negatively impacting not only human health but the environment at large (Wellington-Dufferin-Guelph Public Health, 2015). Wellington-Dufferin-Guelph Public Health (2015) identified how "the built environment and land use planning policies have the potential to impact certain populations disproportionately at the community level, thus becoming a health equity issue" (p. 1). As our populations continue to grow and the real and perceived needs of humans continue to multiply, our natural environment is suffering as the "built environment" (Wellington-Dufferin-Guelph Public Health, 2015, p. 1) dominates our lands, waters and air. Toronto Public Health (2015) describes one of the impacts of built environments, such as urban centers, to be the "heat island" (p. 4) effect. Due to the energy required to build and maintain artificial structures and systems, such as skyscrapers and roadways, the heat produced from these built environments contributes to increased heat production and retention, air pollution and overall heat stress, thus producing a "heat island" (p. 4) effect (Toronto Public Health, 2015). As a result, the data argues that our tolerance for coping with these environmental changes wears thin and all aspects of our health is compromised. In regards to people living with intersecting sites of oppression, Wellington-Dufferin-Guelph Public Health (2015) elaborates that;

> […] studies demonstrate that individuals and families living in lower socioeconomic status (SES) neighbourhoods are more likely to live close to a highway or major industrial area, hence exposing them to higher levels of air pollution and increasing their risk of suffering associated health conditions (p. 1).

Circling back to the biological and individualistic aspects of "wellness", Levine (1997) states that in response, our "felt sense" (p. 67) receives and interprets the changes in the green spaces around us, including the air quality we breathe and the waters which sustain us, and responds accordingly. Levine (1997) quotes Tarthang Tulku, a Tibetan Buddhist teacher, when describing the felt sense, stating, "Our feelings and our bodies are like water flowing into water. We learn to swim within the energies of the (body) senses" (Levine, 1997, p. 67). Therefore, the "felt sense" is described as a "shield-equivalent of sensation" (Levine, 1997, p. 67) whereby "a bodily awareness of a situation or person or event […] An internal aura that encompasses everything you feel and know about the given subject at a given time – encompasses […] and communicates […] to you all at once rather than detail by detail" (Gendlin, as cited by Levine, 1997, p. 67). As a result, Levine (1997) explains that;

> The felt sense blends together most of the information that forms your experience. Even when you are not consciously aware of it, the felt sense is telling you where you are and how you feel at any given moment. It is relaying the overall experience of the organism, rather than interpreting what is happening from the standpoint of the individual parts. Perhaps the best way to describe the felt sense is to say that it is the experience of being in a living body that understands the nuances of its environment by way of its responses to that environment (p. 69).

NBP1 further discusses the impact of urban environments versus rural environments on an individual "mental health" level when sharing about the therapeutic farm in which they previously worked. NBP1 explained that the "therapeutic farm […] was a […] residential home for […] people with schizophrenia [and offered] day programs for people living in the community [living with] various mental illnesses". NBP1 also shared that participants at the therapeutic farm may be living with "addictions issues" so families of participants "thought it would be better for them not to have access to whatever it is that was […] an issue" by enrolling in a rural therapeutic farm program. In reality, NBP1 noted that people connected with the therapeutic farm programs on levels beyond the geographical space, and that both staff and participants observed positive changes within themselves. NBP1 stated that the programming "wasn't necessarily gardening, it could have been […] farming or […] whatever" and that "most people found something" with which to connect. Therefore, in this particular therapeutic farm setting, individuals are not only provided with an opportunity to escape areas with high "heat island" effects, they are invited to participate in activities which promote a re-connection with our natural environment through gardening, farming, horseback riding and other skill-building activities. By facilitating the growth and strengthening of individual capacity, NBP1 reported a clear "confidence that comes from […] the skills". Moreover, NBP1 argues that "if you have only your mental health and your mental illness in your life, that takes up your entire life" therefore the therapeutic farm "helps move [the focus on mental health] out of the way" by immersing participants "in […] an environment that's supportive to […] your mental health needs and […] that's […] what [makes] horticulture therapy, equine therapy or whatever [so] meaningful". From another perspective, NBP1 spoke about their experience facilitating a training for a group of professionals who work in an office setting. NBP1 stated that they

"brought in some lilacs and […] we just passed them around, talk about what […] I do and how it benefits people and [the staff were] really into it. They were all like, 'Ah!' […] They were benefiting" from the exercises. NBP1 further humanizes the group of staff by identifying that they "have a hard day, [they] don't get outside, [they] don't stop and smell the roses, [they're] busy doing [their] job". Therefore, NBP1 expressed that nature-based therapeutic activities are "not just for people who are ill", nature connects humans at "our lowest common denominator" for health and wellbeing.

Chernoff (2015) reinforces this discursive focus on individualism by stating, "researchers have said 80% of our learning is non-verbal" therefore by engaging in non-verbal nature-based activities, such as walking or brushing a horse, individuals can learn a lot about themselves and grow within these sites of awareness. Linehan (2015) suggests that as individual awareness grows, we can "[learn] to deal with discomfort" (p. 87) and "put discomfort on a shelf and attend to [our tasks]" (p. 87). What this means from a discursive lens is that humans can overcome environmental stress and distress by applying mindfulness skills (Linehan, 2015). In fact, Linehan (2015) states that "mindfulness is a core part of mindfulness-based stress reduction [which is] an effective program for helping people with chronic physical pain" (p. 461). Therefore, by virtue of this statement alone, the discourse urges us to once again buy into the individualistic aspects of "mental health" without offering any true efforts for structural and environmental changes.

**"Alternatives" or adjuncts to biomedical approaches.** The third dominant discourse which has emerged is the talk around nature-based therapies as an "alternative" or adjunct to biomedical approaches to "mental health" (Chernoff, 2015; Hewson, 1994; Letson, 2017). As noted above, NBP1 discusses the impact of shifting our focus away from solely "mental health"

by promoting activities which re-connect our physical, spiritual and emotional wellbeing. Similarly, NBP1 argues that nature-based therapeutic approaches, such as horticultural therapy, should be integrated within current healthcare disciplines as a way to complement the primarily biomedical approaches of those disciplines. For example, NBP1 expressed;

> If I could go and […] somehow be able to provide […] education [about the benefits of horticultural therapy] on a regular basis for people in those professions, […] occupational therapy, […] physiotherapy, […] there are so many different ways you can get people out in [nature] and […] do whatever it is you do with them […] and show the most benefits.

Furthermore, NBP1 implored that;

> When there are way more people [who] experience what [nature-based therapeutic approaches] can do, how it can supplement whatever [the therapist] is doing [then we can work towards healing]. It's not that it's […] taking the place of what […] an occupational [therapist] or […] any other professional is doing, […] it [is meant to be] helpful to them especially when you're with a client […] and [be a] piece of how you connect […] and establish a relationship and […] support them to […] achieve wholeness […] As someone who [is running] therapy or [is] treating someone, [there are] a number of different modalities within their discipline that they're using […] based on who their client is, what their needs are […] This needs to be one of them and it's definitely not right now […] We need to be teaching courses on [nature-based therapies], we need to be […] providing textbooks and […] professional development […] opportunities for […] practitioners.

To further validate NBP1's suggestions for integrating nature-based approaches in current therapeutic modalities, examples can be drawn from Hewson (1994)'s guide to using

horticulture as a therapeutic tool. Although Hewson (1994) does not specifically identify ways in which different disciplines can benefit from integrating horticultural therapeutic approaches, he describes the "dynamics of how a horticultural therapist works with clients" (p. 1). Hewson (1994) describes the role of a horticultural therapist within an "inter-disciplinary treatment team which consists of the following health care personnel – psychiatrist or general practitioner, social worker, nurse, occupational and recreation therapist, psychologist and program assistant" (p. 1). This team of people would then conduct "standard physical and mental assessments" (p. 1) and "collaborate on a plan of action" (p. 1). Hewson (1994) explains that "each member of the team works towards the same goals and objectives with the client, but from the approach and perspective of their own discipline" (p. 4) therefore whatever care and/or services a horticultural therapist offers as part of the overall treatment plan would complement the recommendations of the psychiatrist, nurse, occupational therapist and other professionals on the care team. As a result, Hewson (1994) argues that in order to effectively function as an adjunctive approach to psychiatry, horticultural therapists and other nature-based practitioners should "be conversant with the medication clients receive" (p. 37). Since "many drugs have side effects and conditions that should be recognized in order to prevent or lessen injury" (p. 37), it is "pertinent" (p. 37) that nature-based therapists be familiar with the "name, treatment, possible side-effects or precautions necessary" for more commonly prescribed medications for "mental health" (Hewson, 1994). Likewise, Hewson (1994) advocates that nature-based practitioners should be familiar with "populations and [mental health] diagnostic categories" (p. 27), such as "schizophrenia" (p. 27), "depressive illness/affective disorders" (p. 29), "organic disorders" such as dementia and Alzheimer's disease (p. 30), "alcohol addiction" (p. 31), and "anorexia nervosa" (p. 32).

This "alternative" and adjunctive discourse also drives equine-assisted psychotherapeutic practice. Letson (2017) indicates that equine-assisted therapeutic approaches can address similar "disorders" (Hewson, 1994, p. 27) as listed above. Letson (2017) explained that equine-assisted psychotherapy "hold[s] a safe space for people to explore whatever comes up" in ways alternative to traditional psychological approaches to "mental health", such as cognitive behaviour therapy. For example, Letson (2017) shared;

> We had a client that was working on staying sober. She was in an inpatient treatment facility and came to see us once a week for therapy […] We did this session where […] we had a little feed pan we put grain in […] that represented her […] vulnerabilities […] She said, my biggest vulnerability was just staying sober […] so we put the sobriety out in the arena and she had these two horses to try to keep […] away from [the feed pan]. Those horses represented her problems which were her addiction and her relationship with her father. It didn't go well at first because the horses […] wanted the grain […] and she […] took off, she was out of there. [So] we [were] just […] holding a space [for her to return when she was ready]. Another time, we tried again, she took off again. She goes, this is what I always do, I run away. I run away when my dad comes around, […] I just go back to using […] It's a trigger. [When we] checked in again with her […] the third time, she came up with something […] she picked up her sobriety and you see it. She's like, I got this […] and she was able to keep her addiction and her father away.

What Letson (2017) is trying to emphasize in this story then is that "in the world of psychology, it's critical to demonstrate that therapy models, such as equine-assisted psychotherapy, are shown to be validated and reliable" as much as biomedical models for therapy. The approach Letson (2017) and her team used with the woman in the story above

highlights the use of experiential approaches to recovery by transforming something "intangible" to something "tangible". In the *DBT Skills Training Manual*, Linehan (2015) also discusses the benefits of using Dialectical Behaviour Therapy skills alongside medications. For example, Linehan (2015) indicated that "research with suicidal adolescents and suicidal college students has also found significant reductions in use of psychotropic medications, depression, and suicidal behaviours, as well as increases in life satisfaction" (p. 18) when paired with Dialectical Behaviour Therapy skills. Additionally, Linehan (2015) found that "depression remitted much faster when [elderly] individuals were treated with DBT and medication than when they were treated with medication alone" (p. 19) thus supporting the argument that non-pharmacological approaches to "mental health" are positive adjuncts to biomedical interventions.

Further to this discursive focus on "alternative" therapies, Levine (1997) argues that biomedical interventions are not required in long-term healing at all. In one example, Levine (1997) shares about Nancy, a person with whom he had been working for multiple sessions, stating;

> After the breakthrough that came in our initial visit, Nancy left my office feeling, in her words, 'like she had herself again.' Although we continued working together for a few more sessions, where she gently trembled and shook, the anxiety attack she experienced that day was her last. She stopped taking medication to control her attacks and subsequently entered graduate school, where she completed her doctorate without relapse (p. 30).

In another example, Levine (1997) further argued that pharmacological interventions may, in fact, be detrimental to healing, stating;

> By using medication to alleviate this patient's migraine symptoms, Sacks [author of *Awakenings, The Man Who Mistook His Wife for a Hat* and *Migraine*] realized that he had also blocked the man's creative source. Dr. Sacks laments, "When I 'cured' this man of his migraines, I also 'cured' him of his mathematics… Along with the pathology, the creativity also disappeared (p. 36).

Arguably, the discursive mechanisms which drive "alternative" approaches to wholistic practices supports a general shift away from traditionally biomedical interventions and towards a discourse on healing and recovery.

**Healing and recovery.** This leads us to the fourth discourse woven within the data: healing and recovery. As discussed above, nature-based therapeutic approaches, such as horticultural and equine-assisted therapies, are based in a mutual goal for overall healing and recovery (Chernoff, 2015; Hewson, 1994; Letson, 2017). Similarly, specific modalities of therapy which target somatic and behavioural experiences, such as Somatic Experiencing© and Dialectical Behaviour Therapy, highlight the importance of focusing on overall healing and recovery when discussing treatment interventions and coping strategies (Levine, 1997; Linehan, 2015).

Toronto Public Health (2015) admitted that one of the "landmark" (p. 7) studies on which they based their report "examined the relationship between green space and patient recovery in a Pennsylvania hospital" (p. 7). In fact, one of the markers for their definition of "general wellbeing" (Toronto Public Health, 2015, p. 16) is individual "recovery from illness" (Toronto Public Health, 2015, p. 16). So, in order to measure urban "health" and the "health" of residents, Toronto Public Health (2015) examines various areas of urban living, including the "built and natural environments, public transit, housing, culture, education, food and health care" (p. 3).

Within a recovery discourse, urban planning projects strive for "healthier" (Toronto Public Health, 2015, p. 22; Wellington-Dufferin-Guelph Public Health, 2015, p. 14) communities, "improved" (Toronto Public Health, 2015, p. 18; Wellington-Dufferin-Guelph Public Health, 2015, p. 5) overall health of residents and natural environments, "enhanced social health and community cohesion" (Toronto Public Health, 2015, p. 18), and overall "better health" (Toronto Public Health, 2015, p. 22) and "better care" (Wellington-Dufferin-Guelph Public Health, 2015, p. 6) measured by "reduced […] mortality and decreased stress" (Toronto Public Health, 2015, p. 22) and "improved sense of safety" (Wellington-Dufferin-Guelph Public Health, 2015, p. 6).

As a result of these larger municipal and wider efforts towards recovery, NBP1 asserts that by sharing their knowledge, skills and passion for nature-based therapy, people with whom they are working are "healing with […] the issues that we have in the food system and […] social […] issues". NBP1 further expresses there is "potential for healing" in the West by learning from "Eastern cultures" and "Indigenous communities" in Canada however takes care to acknowledge the risk of appropriation of these knowledges and practices by the dominant culture. In a final brief statement, NBP1 expresses their frustration with the capitalist tendencies of Western "mental health" services identifying the lack of consumer support for nature-based therapy programs because "it's not being marketed or […] you can't consume it" and that programs which receive funding are "packaged in a way" which elicit interest based on their perceived rarity and radicality.

## The Little Talks

**The medical model.** Evidently, the medical model continues to drive the way in which nature-based therapies are practiced. Evidenced in the data, we see the privileging of biomedical language, such as NBP1's use of the word "illness", "treatment" (Letson, 2017; Linehan, 2015,

p. 3), “trauma” (Levine, 1997; p. 145) or “post-traumatic stress” (Chernoff, 2015), “depression” and “anxiety” (Letson, 2017), “grief” (Letson, 2017), and “disorder” (Hewson, 1994, p. 29; Linehan, 2015, p. 3). The discursive focus on individualism is also evident in the language used in nature-based therapies, such as notions of “coping” and “problem [solving]” (Letson, 2017), and the development of “skills” (Linehan, 2015, p. 3).

**Evidence-based practice.** Even within an “alternative” discourse, the medical model continues to define the parameters for nature-based therapeuties, whose “evidence” is privileged in the practices, and who gets to deliver the therapeutic interventions (Chernoff, 2015; Hewson, 1994; Letson, 2017; Levine, 1997; Linehan, 2015). In fact, the title of Linehan (2015)’s first chapter begins with the word “rationale” (p. 3). NBP1 reflects this sentiment by emphasizing a desire for further “research” in nature-based therapies. As a result, they support the idea that if further research is done in the field of nature-based therapy, it would substantiate the discursive construction of data and “evidence” to warrant further funding and public support of nature-based therapeutic programs.

# CHAPTER 6. DISCUSSION

After sifting through and organizing the findings, it is clear that there are many benefits of nature-based therapeutic approaches in "mental health". In the last chapter, I identified four overarching discourses across the data indicating nature-based therapy's common goal for: (re)building 'mind-body connections', addressing 'environmental impacts on "mental health"', promoting 'alternatives or adjuncts to biomedical approaches', and facilitating 'healing and recovery'. Following these dominant discourses, two less dominant discourses were also identified: the 'medical model' and 'evidence-based practice'. In this chapter, I will further discuss and draw meaning from these findings based on my theoretical and methodological approaches. Using the discursive frames – the "talks" – as a guide, I will explore how the data shapes, sways and contributes to the larger discussion about Western nature-based therapeutic practices. Finally, I will discuss any gaps in the findings and identify how Western nature-based therapeutic practice is implicated in these discussions.

## The Talks

As I examine the texts, reports, Tedx Talks videos and interview transcript, it is apparent that nature-based therapies seek to persuade us of their wholistic approaches to healing (Chernoff, 2015; Hewson, 1994; Levine, 1997; Letson, 2017; Linehan, 2015; Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). As our environments continue to change, our individual and collective health and wellbeing changes as well (Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). Therefore, by teasing out the dominant and less dominant discourses in the data, my intention is to re-ground the findings in Indigenous knowledges and re-center the voices of racialized and marginalized peoples and

groups. By doing this, my hope is that we can dismantle current systems of oppression and work together to achieve true wholism.

**Mind-body connections.** Cyndy Baskin (2011) writes that "within Indigenous world views everything is interwoven into the whole, values and ethics are not seen as separate from anything else" (p. 85). Moreover, Baskin (2011) elaborates that "from the individual to the family, to the community, and then to all of creation – *all* of the peoples of the world, the plants and animals that feed and sustain us, the water, rocks, air, the planet, and the cosmos – *everything* is connected" (p. 113). Therefore, when we talk about health and wellbeing, we need to consider what ideal health and wellbeing means. Baskin (2011) explains;

> Each person is made up of four aspects – spiritual, physical, emotional, and psychological (Bopp, Bopp, Brown & Lane, 1984; Hart, 2002; Sterling-Collins, 2009; Verniest, 2006). The ideal state of well-being is to be balanced in all of these areas. However, many people rarely achieve this ideal state of balance, which means that we need to be involved in activities that assist us in our attempts to stay balanced. Because the four aspects – spiritual, physical, emotional, and psychological – are connected, they constantly impact on one another. Should a person become ill or be harmed in one area, then the other three areas will also be affected (p. 108).

When we relate these teachings back to Levine (1997)'s discussion about the wholeness and interconnectedness of organisms, we more clearly understand why the mind cannot be separated from the body. Additionally, NBP1 notes "I think a connection with nature, you can't deny that there's a spiritual aspect to it". As a result, when we examine the evidence for current nature-based therapeutic practices, they reveal that people feel "restored" (Hewson, 1994, p. 4) and "improved" (Hewson, 1994, p. 4) after participating in tactile nature-based activities, such as

digging their hands in soil while weeding, watering plants, and brushing horses (Chernoff, 2015; Hewson, 1994; Letson, 2017).

What is important to identify is that this concept of interconnection is not new and did not arise with the onset of Western science (Absolon, 2016; Baskin, 2009; Baskin, 2011; Hart, 2009). Teachings about the interwoven aspects of ourselves, as well as our interdependent relationship with our environments, date back before colonization when the values of wholism and respect for our Earth were embodied in each individual and collective way of life (Baskin, 2011). These teachings emphasize that if the 'whole self' is out of balance, balance cannot be restored if the unique aspects of selves are separated from one another (Baskin, 2011). Therefore, when Western scholars and practitioners talk about mind-body connections, the mind and body cannot be examined in isolation from a person's spiritual health, emotional health, social and environmental contexts (Baskin, 2011). This is largely the reason why many Indigenous scholars are choosing to reclaim the word 'wholism' by reinstating the letter 'w' (Absolon, 2016). Baskin (2011) further explains that the Eurocentric spelling of the word, 'holism', is linguistically linked to the word 'holy' which seemingly re-centers "patriarchal power and force" (p. 108). Therefore, by reinstating the 'w' in the word, the concept of wholeness is reframed to denote a sense of completion, circularity and fullness (Absolon, 2016).

Baskin (2011) argues that generally, Western ways of helping are largely based on "talk therapy instead of [w]holistic methods" (p. 136) and are "individualistic rather than […] community-based" (p. 136). Therefore, as nature-based therapies continue to shift towards using wholistic approaches to healing by concurrently treating more than one aspect of self at a time (Chernoff, 2015; Hewson, 1994; Letson, 2017; Levine, 1997; Linehan, 2015), practitioners must

be cognizant of where the teachings are grounded and take care not to re-center values of individualism in nature-based practices.

**Environmental impacts on "mental health".** Digging deeper into the concept of interconnectedness, we can apply these Indigenous teachings to findings reported by Toronto Public Health and Wellington-Dufferin-Guelph Public Health. Both Public Health entities identified that as built environments continue to grow in demand with consumerism and capitalism, discharges of air pollutants are increased thereby exposing residents to higher levels of toxicity and heat stress (Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). As residents are exposed to higher and higher levels of pollutants discharged by artificial constructions, our physical health is compromised thus our psychological, emotional and spiritual health deteriorates (Baskin, 2011; Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015). Likewise, as resources continue to be extracted from the Earth to build these artificial constructions, the Earth is stripped of its life sources faster than they can be regenerated. Unfortunately, the rapid expansion of built environments is not only problematic in Canada but also across the world. Therefore, as individuals and whole communities continue to be negatively affected, we see more public initiatives supporting environmental conservation projects and "mental health" (Toronto Public Health, 2015; Wellington-Dufferin-Guelph Public Health, 2015).

**"Alternatives" or adjuncts to biomedical approaches.** Similarly, as nature-based therapeutic approaches to "mental health" become more popular, there is an increasing push towards community-based and non-pharmacological interventions and practices (Baskin, 2011; Chernoff, 2015; Hewson, 1994; Letson, 2017; Levine, 1997; Linehan, 2015). As mentioned earlier, what stands out in the data is a collective sentiment for wholistic healing approaches.

NBP1 expresses their frustration when talking about the challenges their therapeutic farm had when securing funding for programs, stating, "because there was no medical staff on site, [the therapeutic farm] wasn't considered [an] essential service for that person's care". Of course, the purpose of the farm was not capitalize on the "mental health" of participants however NBP1 explained that without the support of psychiatrists, resources required to sustain the programs were stretched so thin that the tensions were felt across by both staff and community partners. Therefore, the shift for nature-based therapists to identify as adjuncts to biomedical models can be interpreted as a survival tactic in a neoliberal environment. Remembering Baines (2011) definition for neoliberalism, biomedical models to health and "mental health" value a specific type of measurable treatment. Therefore, in true form, neoliberal practices effectively negate assessing individual needs from a wholistic lens (Baines, 2011). Despite the abundance of evidence showing that true healing can only occur when balanced is achieve across all aspects of the self (Baskin, 2011; Levine, 1997), neoliberal social work atmospheres continue to support biomedical approaches who continue to use symptomatic approaches to treatment whereby a singular aspect of a person is addressed (Linehan, 2015; Poole, 2011). As a result, I speculate that many nature-based practitioners strategically align their approaches with biomedical models, intentionally or unintentionally, in order to gain the support of resource-keepers to survive in this increasingly competitive sector. This is perhaps why there was not much interest in participating in this study.

**Healing and recovery.** Levine (1997) asserts that "trauma begets trauma and will continue to do so, eventually crossing generations in families, communities and countries until we take steps to contain its propagation" (p. 9). So, when we talk about "coping" (Linehan, 2015, p. 69) and "dealing with threatening situations" (Levine, 1997, p. 50), we need to first understand

how individuals have come to feel so traumatized. Toronto Public Health (2015) and Wellington-Dufferin-Guelph Public Health (2015) have explored the impact of built environments on human health and "mental health" but I wonder how this over-expansion of built environments started in the first place? Drawing on Baskin (2011)'s observation of European peoples settling on this continent with "world views based on Christianity and capitalism" (p. 3), we see further evidence of how colonial capitalist tendencies have contributed to the growth of built environments. Ross (2007) echoes this sentiment by stating that "the Bible puts [humans] right at the top, set on earth to rule all the fishes in the sea, everything" (as cited in Baskin, 2011, p. 115). Ross (2007) expresses that;

> [Indigenous] teachings seem to present an opposite hierarchy. Mother Earth (with her life-blood, the waters) plays the most important role in Creation, for without the soil and water there would be no plant realm. Without the plants there would be no animal realm, and without soil, water, plants and animals, there would be no us…" (as cited in Baskin, 2011, p. 115).

Absolon (2016) further validates that for decades, "all efforts were made to sever Indigenous peoples connection from our life source, our Mother Earth to pursue capitalism and global market power" (p. 46). We see clear evidence of the impact of greed in the Residential Schools (Absolon, 2016; Baskin, 2011). Generations of Indigenous peoples, families and communities were torn apart for the purposes of European dominance, from which we still see the intergenerational effects today (Absolon, 2016; Baskin, 2011). Therefore, when talking about healing and recovery, it is critical for nature-based practitioners to understand where our drive for natural reconnection comes from. Indigenous peoples have understood the negative impact of built environments long before Western nature-based researchers and practitioners have started

writing about it (Absolon, 2016; Baskin, 2011). So, as we work towards collective healing of all life, we need to be mindful that nature-based therapeutic practice does not become another site for monetary gains at the expense of the Earth, the waters, the plants, the animals and humans.

**The medical model and evidence-based practice.** Interestingly, nature-based therapists' intended shift away from biomedical approaches has actually subjected them to a position where they are taken up again as discursive subjects. Drawing from Baskin (2011)'s argument for why post-colonialism re-centers colonial values and languages, we see how a continued reliance on medical languages and "evidence" re-centers current Western nature-based practices within a medical framework. Rather than emerging as radical approaches to health, Western nature-based practices continue to rely heavily on discursive frames for "mental health", "healing" and "recovery". From one aspect, the use of dominant languages for health and "mental health" is strategic as it reduces the emotional labour practitioners need to invest in validating and "proving" their work. From another aspect, the languages and "evidence" demonstrated by the medical model is so beguiling that practitioners are unknowingly drawn back into the discourse. Validation by the powerful and almighty medical discourse lends us, as practitioners, to feel good about our work, to find pleasure in our "interventions" and to believe that we are doing the "right" thing. Therefore, without taking pause to critically examine "alternative" approaches to "mental health", we see how easy it is for nature-based therapeutic practices to become part of the façade of the medical model.

## Gaps and Implications

Admittedly, there is a gap in research bridging the benefits of different nature-based therapeutic approaches. NBP1 expresses that since "nature-based therapy is not its own one discipline and working together, [it] is very disjointed". As a result, the research dedicated in

each area of nature-based practice, whether it is horticultural therapy or equine-assisted therapy, can be narrow and self-fulfilling. Therefore, although there is a general consensus that the wholistic aspects of nature-based therapy are beneficial (Absolon, 2016; Baskin, 2011; Chernoff, 2015; Hewson, 1994; Letson, 2017), the therapeutic modalities risk working in isolation from one another and from other sociopolitical efforts to heal the Earth as a whole. Specifically, when we look at horticultural therapy, NBP1 expresses that although nature-based practitioners are not necessarily "disjointed in a bad way […] we hadn't come together as a […] group of professionals […] You've got people doing forest bathing and you've got people doing […] equine therapy and never do they […] talk". NBP1 further asserts that it is "not to say that you can't still […] maintain the boundaries of your discipline […] but […] those crossovers, […] that's possible to […] connect". I speculate that this divide, whether intentional or unintentional, is due to the fact that nature-based therapeutic practice is not part of a larger interest in which funders want to invest. Therefore, in order to gain support and funding, nature-based therapies need to be "packaged and 'pushed' into the 'mainstream'" (Poole, 2011, p. 56) in ways which appeal to current funders' interests. Since biomedical models of practice are currently revered as "evidence-based […] interventions" (Linehan, 2015, p. 18) which warrant attention, praise and most importantly, funding (Teghtsoonian, 2009), therapeutic modalities which are "alternative" to biomedical approaches must adopt the "[languages] of 'evidence-based' [strategies]" (Teghtsoonian, 2009, p. 33) which "shape treatment choices in particular directions" (Teghtsoonian, 2009, p. 33) in order to prove its credibility in the therapy world. We see this in the packaging of mindfulness, for example, where concepts of wholism and interconnections are reduced to individual coping skills (Linehan, 2015). We also see this in the homogenization of

identities which creates a singular expectation for "coping abilities" regardless of gender, race or class.

So, when we focus on the experiences of women, Grote et al. (2007) wrote about the layered barriers which perpetuate the disadvantage of women in society. Grote et al. (2007) identifies;

> […] women who are depressed and economically disadvantaged rarely seek or receive treatment in mental health settings […] Thus, failure to engage and retain women who are economically disadvantaged in potentially beneficial and efficacious mental health services constitutes a significant public health problem (p. 296).

This hesitation for accessing Western "mental health" services is further explained in terms of "cost [of services], limited time and competing priorities, […] inconvenient or inaccessible clinic locations, limited clinic hours, transportation problems, and child care difficulties" (Grote et al., 2007, p. 296). Likewise, individuals who are racialized face similar barriers in addition to cultural understandings of health and "mental health" (Grote et al., 2007; Meyercook & Labelle, 2008). When discussing race, Poon (2011) begins by stating;

> In social work, race is an ideological concept specifically used to describe particular types of bodies: people of colour. On the other hand, unmarked and unnamed, "White" is considered neutral or not a colour. The concept of race is thus a social marker that differentiates people of colour from the White population […] Here, race refers to people of colour exclusively, not Whites […] If […] meanings are produced through difference, then only by comparison can the bodies of people of colour become intelligible. If Whites are seen as the norm and the standard, then people of colour are deficit or "lack" (p. 146).

Therefore, access, from a Western and White context, does not consider instances of accessibility which includes language needs, environmental needs, social needs, and/or economic needs.

Furthermore, individuals who identify as non-binary, transgender, Two-Spirit and/or queer are further marginalized as the majority of current Western "mental health" services operate under a fixed and binary framework (Meyercook & Labelle, 2008). Under Western concepts of "mental health", individuals are viewed as either healthy or unhealthy, competent or incompetent, capable or incapable, compliant or incompliant. So, individuals who do not identify as White, male, heterosexual, cisgender, middle-to-upper class, able-bodied, and/or psychologically healthy must endure the additional emotional labour to conform and/or perform in ways which prove worthiness, credibility and trust (Powell, 2012). As a result, individuals who embody intersecting identities are forced to navigate the social world by constantly amplifying and/or minimizing aspects of themselves (Poon, 2011). Specifically, Poon (2011) explains that for queers of colour, "by reducing queers of colour to having fixed attributes, the discourse conceptualizes their bodies as objects that can be examined and categorized […] In this way, it is assumed that the racialized queer bodies are 'manageable' by people who possess the 'right' skills, knowledge, and values [and] to learn about their cultural codes and specificities is thus considered paramount to providing effective health and mental health services" (p. 148). Tying this discussion back to the Western idea of "mental health", we can see how there is an expectation for individuals, regardless of identities, to be sane (Perlin, 1992). In an inherently colonial system, gender variant, racialized and marginalized bodies must learn to draw upon what they know in order to survive. It is in these instances that "lived experience becomes material *and* discursive practice" (Lynn, 2006, p. 111).

So, why does this all matter? Returning to my original research question, "What are the discourses which inform Western nature-based therapies?", it is clear that without engaging in critical reflexivity, Western nature-based therapeutic practices risk being swept in a colonial undertow of rationality, categorization and capitalism. The newness of nature-based therapies opens the practice to interpretation which subjects the knowledges and intentions to appropriation. As nature-based therapies become more popular in Western, "mainstream" practice, practitioners must remind themselves of the true purpose of their practice. If wholism and healing are truly centered in nature-based therapeutic practice, let us work together to re-center the voices of the marginalized and rid ourselves of the temptations of capitalist power and greed.

**Critical Reflection**

Unbeknownst to me, the dominant discourses around nature-based therapies are so powerful that I, the research analyst, believed them. In the first draft of this research study, I found myself believing in the "evidence" and used discursive constructions of languages around healing and recovery to defend nature-based therapeutic practices. One of the greatest struggles for doing anti-colonial work in Western nature-based therapies is shaking the strong and ever-evolving hold of colonial discourses in "mental health". Undoubtedly, when examining nature-based practices from a biomedical lens, the "evidence" makes sense. It validates our positions of power and makes us feel good about the work we do. We are drawn to believe that nature-based practices are radical and revolutionary. However, as I apply a critical lens to this discourse analysis, I realize that not only is this idea of radicality not true, there is also an underlying fear and risk of retribution for shining light on the insidiousness of current "mental health" practices, especially if one is in a precarious state of employment. So, as critical practitioners work to

dismantle discursive mechanisms which drive nature-based “mental health” therapies, we must be strong in how we can come together in resistance and be mindful in how we protect ourselves against the discursive charms of colonialism.

# CHAPTER 7. CONCLUSION

Jones (2014) warned that "while some may slip into a moralizing position that blames the white 'transgressor' or the 'other', blaming either obfuscates systematic and institutional contexts that privilege some and oppress others" (p. 29). Therefore, I must clearly state that the goal of this research study is not to blame Western nature-based practitioners for the perpetuation of colonialism. What I am seeking to do is to draw attention to the colonial values which drive "mental health" therapeutic practices and the continued harm that is being done to Indigenous, racialized and marginalized communities. What I have come to understand is that in present-day Canada, we are all colonized. Whether we are bred from the first European colonizers, are new immigrants who have settled in Canada, or have Indigenous blood coursing through our veins, we are all living and operating in a colonial system which defines the way we live, work, study and find pleasure.

Therefore, when we talk about healing and alternative approaches to therapy, whether they are nature- (e.g. farming or horseback riding), somatic- (e.g. yoga or meditation), or behavioural-based (e.g. daily affirmations or healthy eating) practices, it is our duty as anti-oppressive practitioners to identify sites of power where oppression and cultural appropriation occur. It is our responsibility to learn and raise our own awareness in how we, as individuals, contribute to the continued oppression of racialized and marginalized bodies. Moreover, as we work towards raising the truth and reconciling the harms enacted on Indigenous peoples and communities, it is our responsibility, as settlers and as beneficiaries of colonialism, to resist against practices which have been normalized and transform the discourses on "mental health". After all, the two cardinal rules which guide social work practice are to "first do no harm [then]

to cure sometimes, to relieve often [and] to comfort always" (Birnbaum, 1971, p. 626). Let's do better.

**APPENDIX A: RECRUITMENT FLYER**

RYERSON UNIVERSITY

# PARTICIPANTS NEEDED FOR RESEARCH IN MENTAL HEALTH THERAPEUTIC PRACTICE

Are You:

- Trained and certified in a mental health therapeutic approaches (i.e. horticulture therapy and/or equine-assisted therapy)?
- Actively practicing in your respective fields of mental health therapy in Southern Ontario?

If you answered yes to the above noted questions you are invited to volunteer in this study of nature-based therapies in mental health. This study will explore the how nature-based therapies are talked about and practiced in contemporary social work. This includes examining specific nature-based therapeutic models.

You will be asked to participate in an interview in person, over the phone or via Skype to discuss your experiences and motivations for pursuing your field of therapeutic practice.

Your participation will involve a 60 – 90 minute interview with follow up, as required.

In appreciation of your time, you will receive a $5 Tim Horton's gift card.

If you are interested in participating in this study or for more information please contact:

Carmen Chui, MSW Student
School of Social Work, Ryerson University
Tel: 1-416-639-1748
Email: carmen.chui@ryerson.ca

This research study has been reviewed and approved by the Ryerson University Research Ethics Board and is not funded.

## APPENDIX B: PARTICIPANT CONSENT FORM

**Ryerson University**
**Written Consent Agreement**

You are being invited to participate in a research study. Please read this consent form so that you understand what your participation will involve. Before you consent to participate, please ask any questions to be sure you understand what your participation will involve.

**AN ANTI-COLONIAL CRITICAL DISCOURSE ANALYSIS OF NATURE-BASED THERAPIES IN MENTAL HEALTH**

**INVESTIGATORS:** This research study is being conducted by Carmen Chui, MSW Candidate, and Jennifer Poole, MSW, PhD, from the School of Social Work at Ryerson University.

**POTENTIAL CONFLICT OF INTEREST:** Although this study is not funded, you should be aware that I am a current employee at the Canadian Mental Health Association of Waterloo Wellington (CMHA WW). Therefore, there is a perceived conflict of interest that I may have influence over your current or future affiliations with CMHA WW. Please note that my intention is to better understand the approaches underlying nature-based therapies and how they are taught and practiced. I intend to keep this research study completely separate from my work with the CMHA WW by removing any identifying information, including your name and city/region in which you practice, in my Major Research Paper in order to protect your privacy and minimize any risk to your practice.

If you have any questions or concerns about the research, please feel free to contact Carmen Chui at carmen.chui@ryerson.ca.

**PURPOSE OF THE STUDY:** The purpose of this study is to explore how nature-based therapies are talked about and practiced in contemporary social work. This research study seeks to examine the ideas and ideologies which inform nature-based therapeutic modalities and their use and growing popularity. 3 mental health practitioners will be recruited for this study. Eligibility includes active certification in horticulture therapy and/or equine-assisted therapy, and current practice in Southern Ontario. These results will be used for the Major Research Paper of Carmen Chui in completion of her Master of Social Work degree.

**WHAT YOU WILL BE ASKED TO DO:** If you volunteer to participate in this study, you will be asked to do the following things:

- Provide consent by signing two copies of the consent form (one for you to keep and one for my records).
- Provide information such as name, education including therapeutic modalit(ies) in which you are trained/certified, telephone number, and email address.

- Answer open-ended questions from your own perspective and based on your own experiences.
    - Questions include: Please tell me about your approach to practice. How long have you been in practice? Why do you think a lot of people are talking about nature-based therapies these days? Are there any tensions in your practice or challenges to what you do? What are the impacts of your practice?
- Following this interview, you will have up until June 15, 2018 to withdraw information that you have provided. There will be no consequences for doing so and your information will be erased immediately.
- The interview should last approximately 60 to 90 minutes.
- The interview will be held in person at a mutually-agreed upon location, over the phone, or over Skype.
- After your participation, you can contact Carmen Chui for any follow-up questions you may have.
- Research findings will be available to participants through Ryerson University's Digital Repository website (http://digital.library.ryerson.ca/), under the Social Work category, upon completion of this research study (after August 2018).

**POTENTIAL BENEFITS:**

- Participants will be provided with an outlet to share their experiences
- Participants will provide personal ideas on key concerns regarding existing mental health system, strategies and initiatives
- Participants may experience validation for their experiences and further their understanding that the system rather than individual actions are contributing to marginalization
- Participate in creation of anti-oppressive and anti-colonial mental health services by re-centering voices of people using mental health services

I cannot guarantee, however, that you will receive any benefits from participating in this study.

**WHAT ARE THE POTENTIAL RISKS TO YOU AS A PARTICIPANT:**

The potential risks of your participation are low. Although there are no physical risks to your participation nor any risk for injury, please note that you may experience feelings of discomfort during and after the interview. Since the research study aims to disrupt dominant discourses in mental health, you may feel discomfort in acknowledging social work's role in perpetuating the marginalization of some groups. Furthermore, you may feel discomfort in contributing to literature which implicates Western social work practice. If you feel uncomfortable during the interview process, you may skip answering a question or stop participation, either temporarily or permanently.

**CONFIDENTIALITY:**

Only the two researchers involved with this study will have access to your information. The encrypted and password-protected audio-recordings, consent form and written interview notes will be stored in my research supervisor's locked office at Ryerson University. After the interviews have been transcribed, alphanumerical codes will be used and any identifying information, audio-recordings and written notes will be destroyed. The key to the codes will be stored in a separate locked cabinet than the consent information and collected data. You will have the right to review and edit the recordings to remove or add information before June 1, 2018.

**INCENTIVES FOR PARTICIPATION:** The incentives for participation include having your voice heard in current discourses in mental health practices. Your participation has indirect benefits to advancing anti-oppressive mental health therapies in Canada. You will also be offered a $5 Tim Horton's gift card after the interview for your time and knowledge.

**COSTS TO PARTICIPATION:** There should be no costs to participation as interviews will be scheduled based on mutual availability and offered in person, over the phone or through Skype.

**COMPENSATION FOR INJURY:** By agreeing to participate in this research, you are not giving up or waiving any legal right in the event that you are harmed during the research.

**VOLUNTARY PARTICIPATION AND WITHDRAWAL:** Participation in this study is completely voluntary. You can choose whether to be in this study or not. If any question makes you uncomfortable, you can skip that question. You may stop participating at any time and you will still be given the incentives and reimbursements described above. If you choose to stop participating, you may also choose to not have your data included in the study. You will also have the right to review and edit the recordings to remove or add information. The deadline to withdraw or to make any changes to the data is June 1, 2018. Your choice of whether or not to participate will not influence your future relations with Ryerson University or the investigators, Carmen Chui and Jennifer Poole, involved in the research.

**QUESTIONS ABOUT THE STUDY:** If you have any questions about the research now, please ask. If you have questions later about the research, you may contact:

Carmen Chui
MSW Student
School of Social Work
Ryerson University
Email: carmen.chui@ryerson.ca

Jennifer Poole, MSW, PhD.
Associate Director, Graduate Program and Associate Professor
School of Social Work
Ryerson University
350 Victoria Street
Toronto, Ontario
Canada M5B 2K3

Tel. (416)979-5000 ext. 556253
Fax (416)979-5214
Email: jpoole@ryerson.ca

This study has been reviewed by the Ryerson University Research Ethics Board. If you have questions regarding your rights as a participant in this study please contact:

Research Ethics Board
c/o Office of the Vice President, Research and Innovation
Ryerson University
350 Victoria Street
Toronto, ON M5B 2K3
416-979-5042
rebchair@ryerson.ca

## REFERENCE LIST


Absolon, K. E. (2016). Wholistic and ethical: Social inclusion with Indigenous peoples. *Social Inclusion, 4*(1), 44-56. doi: 10.17645/si.v4i1.444

Ball, J. (2012). Identity and knowledge in Indigenous young children's experiences in Canada. *Childhood Education, 88*(5), 286-291. doi: 10.1080/00094056.2012.717866

Baines, D. (2011). An overview of anti-oppressive social practice: Neoliberalism, inequality, and change. In D. Baines (Ed.), *Doing anti-oppressive practice: Social justice social work* (pp. 25-47). Black Point, NS: Fernwood Publishing.

Barton, J., Griffin, M., & Pretty, J. (2012). Exercise-, nature- and socially interactive-based initiatives improve mood and self-esteem in the clinical population. *Perspectives in Public Health, 132*(2), 89-96. doi: 10.1177/1757913910393862

Baskin, C. (2011). *Strong helpers' teachings: The value of Indigenous knowledges in the helping professions*. Toronto, ON: Canadian Scholars' Press Inc.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York, NY: The Guilford Press.

Bettmann, J. E., & Tucker, A. R. (2011). Shifts in attachment relationships: A study of adolescents in wilderness treatment. *Child Youth Care Forum, 40,* 499-519. doi: 10.1007/s10566-011-9146-6

Birnbaum, M. (1971). Some remarks on "the right to treatment". *Alabama Law Review, 23*(3), 623-639. Retrieved from https://heinonline-org.ezproxy.lib.ryerson.ca/HOL/Page?public=false&handle=hein.journals/bamalr23&page=623&collection=journals

Birnbaum, M. (1960). The right to treatment. *American Bar Association Journal, 46*(5), 499-504.

Retrieved from https://www.jstor.org/stable/25721181?seq=1#page_scan_tab_contents

Blay, S. L., Batista, A. D., Andreoli, S. B., & Gastal, F. L. (2008). The relationship between religiosity and tobacco, alcohol use, and depression in an elderly community population. *The American Journal of Geriatric Psychiatry, 16*(11), 934-943. doi: 10.1097/JGP.0b013e3181871392

Bruyere, G. (2007). Making circles: Renewing First Nations ways of helping. In J. Coates, J. R. Graham & B. Swartzentruber (Eds.), *Spirituality and social work: Selected Canadian readings* (pp. 259-272). Toronto: Canadian Scholars' Press.

Carriere, J., & Richardson, C. (2013). Relationship is everything: Holistic approaches to Aboriginal child and youth mental health. *First Peoples Child & Family Review, 7*(2), 8-26. Retrieved from http://journals.sfu.ca/fpcfr/index.php/FPCFR/article/view/214/190

Chernoff, M. T. (2015). *How horses heal, transform, and empower* [Tedx Talks video]. Retrieved from https://www.youtube.com/watch?v=QBZkFquIqog

Chilisa, B. (2012). *Indigenous research methodologies.* Thousand Oaks, CA: SAGE Publications.

Corring, D., Lundberg, E., & Rudnick, A. (2013). Therapeutic horseback riding for ACT patients with schizophrenia. *Community Mental Health Journal, 49*(1), 121-126. doi: 10.1007/s10597-011-9457-y

De Leon, G. (2000). *The therapeutic community: Theory, model, and method.* New York, NY: Springer Publishing Company.

Duvall, J., & Kaplan, R. (2014). Enhancing the well-being of veterans using extended group based nature recreation experiences. *Journal of Rehabilitation Research and Development, 51*(5), 685-696. doi: 10.1682/JRRD.2013.08.0190

Faulkner, S. S., & Faulkner, C. A. (2014). Chapter seven: Quantitative research designs. In S. S. Faulkner & C. A. Faulkner (Eds.), *Research methods for social workers: A practice-based approach* (pp. 111-125). Chicago, IL: Lyceum Books Inc.

Gray, J. (2007). (Re)considering voice. *Qualitative Social Work, 6*(4), 411-430. doi: 10.1177/1473325007083354

Grote, N. K., Zuckoff, A., Swartz, H., Bledsoe, S. E., & Geibel, S. (2007). Engaging women who are depressed and economically disadvantaged in mental health treatment. *Social Work, 52*(4), 295-308. doi: 10.1093/sw/52.4.295

Harper, N. J., Russell, K. C., Cooley, R., & Cupples, J. (2007). Catherine Freer wilderness therapy expeditions: An exploratory case study of adolescent wilderness therapy, family functioning, and the maintenance of change. *Child Youth Care Forum, 36*(2-3), 111-129. doi: 10.1007/s10566-007-9035-1

Hart, M. A. (2009). Anti-colonial Indigenous social work: Reflections on an Aboriginal approach. In R. Sinclair, M. A. Hart & G. Bruyere (Eds.), *Wicihitowin: Aboriginal social work in Canada* (pp. 25-41). Black Point, NS: Fernwood Publishing.

Hawthorne, W. B., Green, E. E., Folsom, D., & Lohr, J. B. (2009). A randomized study comparing the treatment environment in alternative and hospital-based acute psychiatric care. *Psychiatric Services, 60*(9), 1239-1244. Retrieved from https://search-proquest-com.ezproxy.lib.ryerson.ca/docview/213100939?pq-origsite=summon

Healy, K. (2014). *Social work theories in context: Creating frameworks for practice* (2nd ed.). New York, NY: Palgrave Macmillan.

Hewson, M. L. (1994). *Horticulture as therapy: A practical guide to using horticulture as a therapeutic tool.* Guelph, ON: Greenmor Printing Company Limited.

Horticulture As Therapy. (2018). *Horticulture as therapy.com: Home of Canada's first psychiatric Horticulture Therapy (HT) workshop and online course.* Retrieved from http://www.horticultureastherapy.com/Courses.html

Jones, R. G. (2014). Divided loyalties: Exploring the intersections of queerness, race, ethnicity, and gender. In S. C. Howard (Ed.), *Critical articulations of race, gender, and sexual orientation* (pp. 23-46). Maryland: Lexington Books.

Lariviere, M., Couture, R., Ritchie, S. D., Cote, D., Oddson, B., & Wright, J. (2012). Behavioural assessment of wilderness therapy participants: Exploring the consistency of observational data. *Journal of Experiential Education, 35*(1), 290-302. doi: 10.5193/JEE35.1.290

Letson, L. (2017). *Horses help humans be real, honest, and present* [Tedx Talks video]. Retrieved from https://www.youtube.com/watch?v=YrxH06aG_jw

Levine, P. A. (1997). *Waking the tiger: Healing trauma.* Berkeley, CA: North Atlantic Books.

Linehan, M. M. (2015). *DBT skills training manual* (2nd ed.). New York, NY: The Guilford Press.

Lynn, M. (2006). Discourses of community: Challenges for social work. *International Journal of Social Welfare, 15*(2), 110-120. doi: 10.1111/j.1468-2397.2006.00431.x

Massaquoi, N. (2011). Crossing boundaries to radicalize social work practice and education. In D. Baines (Ed.), *Doing anti-oppressive practice: Social justice social work* (pp. 214-228). Black Point, NS: Fernwood Publishing.

Meyercook, F., & Labelle, D. (2008). Namaji. *Journal of Gay & Lesbian Social Services, 16*(1), 29-51. doi: 10.1300/J041v16n01_02

Mills, P. J., Wilson, K., Iqbal, N., Iqbal, F., Alvarez, M., Pung, M. A., Wachmann, K., Rutledge,

T., Maglione, J., Zisook, S., Dimsdale, J. E., Lunde, O., Greenberg, B. H., Maisel, A., Raisinghani, A., Natarajan, L., Jain, S., Hufford, D. J., & Redwine, L. (2015). Depressive symptoms and spiritual wellbeing in asymptomatic heart failure patients. *Journal of Behavioral Medicine, 38*(3), 407-415. doi: 10.1007/s10865-014-9615-0

Munoz, V., Garrison, E. K., Enke, A., Freedman, D. A., Hart, J., Jones, D. L., Kirby, A., Lester, J., Nakamura, M., Pomerleau, C. A., & VanHooser, S. E. (2008). Transpedagogies: A roundtable dialogue. *Women's Studies Quarterly, 36*(3/4), 288-308. Retrieved from http://www.jstor.org.ezproxy.lib.ryerson.ca/stable/27649803?pq-origsite=summon&seq=1#page_scan_tab_contents

Nesdole, R., Voigts, D., Lepnurm, R., & Roberts, R. (2014). Reconceptualizing determinants of health: Barriers to improving the health status of First Nations peoples. *Canadian Journal of Public Health, 105*(3), e209-e213. Retrieved from https://search-proquest-com.ezproxy.lib.ryerson.ca/docview/1548005123?pq-origsite=summon

Neuman, W. L. (2011). Chapter 4: The meanings of methodology. In W. L. Neuman (Ed.), *Social research methods: Qualitative and quantitative approaches* (7th ed.) (pp. 90-122). New York, NY: Pearson Education Inc.

Norton, C. L. (2010). Into the wilderness – a case study: The psychodynamics of adolescent depression and the need for a holistic intervention. *Clinical Social Work Journal, 38*(2), 226-235. doi: 10.1007/s10615-009-0205-5

Perlin, M. L. (1992). On "sanism". In M. Perlin (Ed.), *The hidden prejudice: Mental disability on trial* (pp. 21-58). Washington, DC: American Psychological Association.

Poole, J. (2011). *Behind the rhetoric: Mental health recovery in Ontario*. Black Point, NS: Fernwood Publishing.

Poole, J. M., Jivraj, T., Arslanian, A., Bellows, K., Chiasson, S., Hakimy, H., Pasini, J., & Reid, J. (2012). Sanism, 'mental health', and social work/education: A review and call to action. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice, 1*, 20-36. Retrieved from http://journals.library.mun.ca/ojs/index.php/IJ/article/view/348/227

Poon, M. K-L. (2011). Writing the racialized queer bodies: Race and sexuality in social work. *Canadian Social Work Review, 28*(1), 145-150. Retrieved from https://search-proquest-com.ezproxy.lib.ryerson.ca/docview/901146285?pq-origsite=summon

Teghtsoonian, K. (2009). Depression and mental health in neoliberal times: A critical analysis of policy and discourse. *Social Science & Medicine, 69*(1), 28-35. doi: 10.1016/j.socscimed.2009.03.037

Toronto Public Health. (2015). *Green city: Why nature matters to health – An evidence review*. Retrieved from http://www.ecohealth-ontario.ca/files/Green_City_Why_Nature_Matters_to_Health_An_Evidence_Review.pdf

Tucker, A. R., Javorski, S., Tracy, J., & Beale, B. (2012). The use of adventure therapy in community-based mental health: Decreases in problem severity among youth clients. *Child Youth Care Forum, 42*(2), 155-179. doi: 10.1007/s10566-012-9190-x

Unterrainer, H-F., & Lewis, A. J. (2013). The Janus face of schizotypy: Enhanced spiritual connection or existential despair? *Psychiatry Research, 220*(1-2), 233-236. doi: 10.1016/j.psychres.2014.07.028

Van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma.* New York, NY: Penguin Random House.

Wellington-Dufferin-Guelph Public Health. (2015). *City of Guelph: Planning review through a*

*public health lens*. Retrieved from https://www.wdgpublichealth.ca/sites/default/files/file-attachments/report/ht_report_2015-planning-review-through-a-public-health-lens-city-of-guelph_access_0.pdf

Zupancic, T., Kingsley, M., Jason, T., & Macfarlane, R. (September 2015). *Green city: Why nature matters to health – An evidence review*. Retrieved from http://www.ecohealth-ontario.ca/files/Green_City_Why_Nature_Matters_to_Health_An_Evidence_Review.pdf