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– ARTICLE –

FORMER REFUGEES' THERAPEUTIC LANDSCAPES IN DUNEDIN, NEW ZEALAND

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ABSTRACT

During resettlement, former refugees often face challenges for their physical, social and mental health and wellbeing such as past trauma, language and cultural differences. However, little is known about the therapeutic role outdoor spaces play for mitigating or worsening former refugees' resettlement experiences. In this article, we draw on the therapeutic landscapes concept to show how the physical, symbolic and social aspects of outdoor places in Dunedin, New Zealand, such as the beach and urban green spaces, contribute to or complicate former refugees' wellbeing during the resettlement process. Group interviews with fifteen former Syrian refugees (four families), who also shared personal photographs of their meaningful therapeutic landscapes, reveal that participants' therapeutic landscapes ranged from pristine scenic spots to everyday places such as backyards. However, diverse barriers to access (for example, mobility) hinders the regular utilisation of the therapeutic qualities of these spaces. We therefore argue that these barriers need to be addressed at the local, social and governmental level to ensure former refugees can fully enjoy and utilise diverse therapeutic landscapes and their health and wellbeing promoting qualities.

Keywords: therapeutic landscapes; refugees; place; nature; health; wellbeing

INTRODUCTION

Globally, the refugee crisis continues to be a growing issue with more than 25 million refugees reported in 2017 (UNHCR 2018). Millions of people need to resettle and adjust to a new life – often in an unfamiliar country and culture – affecting their mental, physical, and social health and wellbeing (Shrestha-Ranjit *et al.* 2017). Studies have shown the important role of employment, educational and social initiatives as well as culturally appropriate health care

provision for easing the resettlement process (Kearns and Andrews 2010; Gaillard and Hughes 2014; Ager and Strang 2008; Morken and Skop 2017). However, being and feeling well in place (Kearns and Andrews 2010) and the role played by everyday spaces for counteracting or worsening some of the challenges refugees face settling in a new place has gained less attention (Kale 2019). In particular, little is known about how the natural and built environment and social aspects of local, easy to access outdoor places can contribute to refugees' wellbeing in their new environment or what factors hinder refugees to use these places that have therapeutic value for them.

Drawing on Gesler's (1993, 2009) therapeutic landscapes concept, this article sheds light on former refugees' conceptualisation and use of therapeutic landscapes and the barriers they encounter in accessing these diverse landscapes. We begin with an assessment of the literature and the challenges of displacement to showcase how little attention has been paid to everyday and pristine outdoor spaces with therapeutic qualities for refugees' wellbeing. We then consider the contribution of outdoor spaces to social, physical and mental wellbeing to set the scene for our use of Gesler's (1992) concept of therapeutic landscapes. Following a brief summary of our research design, we outline the places and activities that former refugees conceptualise and use as therapeutic landscapes based on their physical, social and symbolic values. The findings highlight that both landmarks and everyday places contribute to refugee wellbeing, but there are constraints that need to be overcome to ensure access to and utilisation of these therapeutic landscapes.

Shifting discourses within refugee studies globally and in New Zealand

Refugees and their legal, health, educational and social needs have been the focus of many disciplines, including but not limited to geography, law, anthropology and economics (Skran and Daughtry 2007; Ehrkamp 2017). The dominant areas of interest, however, can be narrowed down to debates over how to define a refugee (Black 2001; Skran and Daughtry 2007; Marshall 2011), discussion of physical and mental trauma (Schweitzer 2006; George 2010), policy and legal rights of refugees (Burnett 2015; Behrman 2014) and refugee integration and citizenship (FitzGerald and Arar 2018; Ager and Strang 2008). Refugee research has therefore been rightfully critiqued as focusing too narrowly on policy, numbers, trends and refugees as 'victims' (Bakewell 2008; Sydnor 2011; Ehrkamp 2017; Khiabany 2016). One suggestion for expanding the focus beyond these four dominant areas includes examining refugees' everyday experiences

and recognising them as people with diverse histories, agency and abilities (Sydnor 2011; Ehrkamp 2017; Bakewell 2008; Khiabany 2016).

Studies have begun to look at experiences of belonging, refugee subjectivities and agency (Gill 2010; Burrell and Horschelmann 2019; Marlowe, Bartley, and Hibtit 2014). The exclusion of media discourses and politics surrounding refugees has also been a focus (Burrell and Horschelmann 2019; MacDonald 2017). Other studies examined refugees' everyday life during the resettlement process by focusing on social capital (Elliot and Yusaf 2014), identity and acculturation (Marlowe, Bartley, and Hibtit 2014), and practices related to place, mobility and feeling at home (Basnet 2016).

Refugees' wellbeing related to being and feeling well in place (Kearns and Andrews 2010) has been an underlying, but not explicitly discussed, concern in these studies. Fewer studies have paid direct tribute to the everyday experiences of refugee health and wellbeing and these studies remain dominated by a focus on health care and its therapeutic qualities. For example, Lawrence and Kearns (2005), Mortensen (2011) and Shrestha-Ranjit *et al.* (2017) explored the readiness of services to support healthcare needs of refugees. However, studies exploring refugees' everyday experiences with a focus on how their new local outdoor environments therapeutically shape their wellbeing are strikingly absent.

RESETTLEMENT, OUTDOOR SPACES, HEALTH AND WELLBEING

After displacement, refugees face challenges for their mental, physical and social health and wellbeing ranging from loneliness, language barriers, and economic hardship to a lack of social capital (Shrestha-Ranjit *et al.* 2017; Correa-Velez, Gifford, and Barnett 2010; McMichael *et al.* 2017) . To counteract some of these social, physical and mental challenges, scholars have begun to look at green outdoor spaces as an arena for counteracting, improving or maintaining a good status of health and wellbeing. Green spaces are generally associated with self-reported improvements on health and wellbeing (Kaplan and Kaplan 1989; Bell *et al.* 2014; van den Berg *et al.* 2015). Public green spaces and community gardens also contribute to former refugees' social connections and thus being and feeling well. These community spaces foster feelings of nostalgia or connections to their own culture, while also shaping refugees' sense of belonging to their host community (Rishbeth and Finney 2006; Harris, Minniss, and Somerset, 2014; Kale 2019), and mitigating stress stemming from educational, housing and work challenges (Hordyk, Hanley, and Richard 2015; Coughlan and Hermes 2016).

While this qualitative research suggests the generally positive impact of green spaces for the social, physical and mental wellbeing of refugees, these studies primarily focus on just one factor (for example, social or physical wellbeing) and one particular green space (such as the park or an activity like gardening). The majority of studies invite refugees to voice their experiences in specific, pre-identified 'natural' environments, rather than letting refugees drive the discussion to reveal the physical, social and symbolic environments that are therapeutic for them. We argue instead for a more holistic approach that recognises the role that *any* space including but not limited to the 'natural' environment can have in promoting social, physical and mental wellbeing for refugees during and after resettlement. To move beyond the dominance of green spaces in existing discussions (see, for example, Rishbeth and Finney 2006; Hordyk, Hanley, and Richard 2015) we deploy Gesler's concept of therapeutic landscapes to identify the environments that are meaningful for refugees' wellbeing in their new home city.

UTILISING THE 'THERAPEUTIC LANDSCAPES' CONCEPT FOR REFUGEE STUDIES

Gesler's (1992) metaphorical therapeutic landscape concept explores the connections between landscapes, and the related notions of place and space, health and wellbeing. The concept draws on a holistic understanding of health and wellbeing. Thus, therapeutic landscapes are created through an interplay between physical landscape features (for example, greenery, water or built features), symbolic aspects (such as values and meanings) and social dimensions (for example, interpersonal, community attachment) of being and feeling well in places (see Figure 1) (Gesler 2009; Finlay 2018; Bell *et al.* 2018).

While the concept has only been explored fleetingly within refugee studies (Sampson and Gifford 2010; Liamputtong and Kurban 2018), it has been widely used in geography to understand both the traditional therapeutic aspects of healing spaces such as religious sites (Gesler 1993; Gesler 2003; Williams 2010) or hospitals (Curtis 2011) and everyday spaces and activities such as swimming (Foley 2015) or preparing food (Sperling and Decker 2007). These studies show that environmental, social and individual factors 'interact to bring about healing in specific places' (Gesler 1992, 735) while simultaneously highlighting the geographical situatedness of health enhancing experiences, knowledges and practices. Such a situatedness is explored, for example, in the context of refugee studies in Sampson and Gifford's (2010) study on place making with young Australian refugees. Places that were experienced as restorative and encouraged wellbeing were highlighted as important for feeling more at home

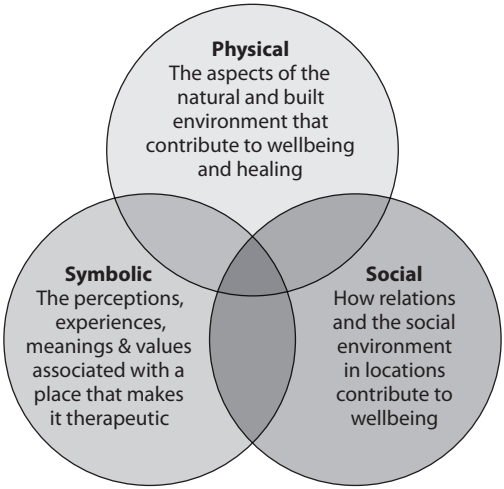

Figure 1. An illustration of the interconnected nature of the dimensions of therapeutic landscapes based on Gesler's (1992; 2009) and Finlay's (2018) discussions.

(Sampson and Gifford 2010). Similarly, considering the challenges of exclusion that migrants face, Townsend and Pascal (2012) showed how becoming familiar with locally renowned therapeutic landscapes allowed Australian migrants' development of a sense of identity and home in their host country. These studies, however, generally failed to identify the barriers to accessing therapeutic landscapes or strategies for coping with and overcoming these barriers to access *their* therapeutic landscapes. Therapeutic landscapes have therefore been shown to have positive self-reported outcomes for refugees, but which environments and places are therapeutic for refugees and identifying barriers to accessing these spaces has not yet been explored.

METHODS

To interrogate this aspect further, we draw on semi-structured interviews during which some families shared photos of their therapeutic landscapes. The research project was approved by the University of Otago Human Ethics Committee (Reference number 18/074). An additional short anonymous demographic survey was administered to gather information about home countries, age, gender and education levels of participants. A total of fifteen former Syrian refugees (four families) from Dunedin, New Zealand, participated in group interviews.

Dunedin was chosen as the research location because former refugees and their experiences are under-researched in the city, as it only became a resettlement location in 2015. Since then, 582 refugees from Syria, Afghanistan, and Palestine have settled in the city (Munro, 2019). Additionally, the first author could draw on her existing networks for participant recruitment and conveniently and cost-effectively meet with participants at times and locations that suited them. Families were recruited through contact with various agencies in Dunedin that support refugees.

Participants had been in Dunedin for between five months and two years at the time of the interviews. There were four male adult participants, four female adult participants, six female adolescent or child participants, and one adolescent male participant. Child and adolescent participants were aged between nine and sixteen years of age, and adult participants were aged approximately thirty to forty-five years old. Although we did not purposefully select participants, all participants were able-bodied and physically mobile. Based on the quota refugee selection processes, the majority of former refugees who come to New Zealand, and therefore Dunedin, are able-bodied.

Interviews with the families were conducted between June and August 2018. A range of topics were covered including outdoor places that participants enjoyed using and why they enjoyed them, if outdoor places helped them feel they belonged in Dunedin, and if there were any barriers or enablers to using these places. Before the interview commenced the first author offered participants an iPad to voice their therapeutic landscapes visually through photos. The rational was to use these purposefully taken photos as prompts for the interview and to overcome potential language barriers, but also to allow participants command over this activity within their busy schedules. However, two families opted out of this method, and two chose to share photos they had already taken before the study took place. This therefore shows that purposefully taking photos of therapeutic landscapes was meaningless for participants. On the one hand, photos were not the preferred tool to communicate their situated sense and lived experience of therapeutic landscapes. On the other hand, they felt that only already taken photos can effectively communicate their therapeutic landscapes as these are assembled and 'emerge in action … out of a specific set of events and experiences' (Irving, 2015, 134) and lived histories. Thus a more cooperative and migrant led approach to using photography to explore former refugees' therapeutic landscapes might yield additional insights in the complex amalgamations of perceptions, feelings and materiality of therapeutic landscapes.

The interviews took place in English with one couple having a friend present to interpret. In addition, two key stakeholders who work with the former refugee community were interviewed to add context and perspective to the experiences of former refugee participants. Interviews were audio recorded, with consent obtained from participants. To protect the identities of participants, all have been assigned pseudonyms. In addition, notes were taken of the places their photos depicted and the activities taking place there.

After conducting the interviews, data from former refugees and key stakeholders was transcribed and coded thematically using *NVivo* software (QSR International 2020). Using descriptive and analytical codes, themes were identified in participants' experiences (Cope 2016). Using Saldana's (2009) model, a coding framework was developed into the three dimensions of therapeutic landscapes shown in Figure 1 from the interview and notes of photographs shown during interviews.

DUNEDIN'S THERAPEUTIC LANDSCAPES

Former refugees in Dunedin revealed they used a diverse variety of therapeutic landscapes at a range of scales. These included small scale everyday places or activities, medium scale places such as local parks or school playgrounds, and larger scale destinations such as the beach or the Botanic Garden (see Table 1 for more examples and details). These findings suggest that former refugees' therapeutic places include both ordinary, everyday places and more pristine landmarks located further away. These different locales were valued for their physical, social and symbolic values as we discuss in more detail below.

The physical dimension: natural and built environments

The physical dimension of therapeutic landscapes is made up of areas of the natural environment that contribute to healing such as water, the built environment or scenic beauty (Gesler 2009). For this dimension, it is the material design or the landscape itself that supports wellbeing (Finlay 2018). These physical attributes that encourage health and wellbeing were clear in the experiences of participating former refugees and were closely interrelated with the social and symbolic dimensions.

Outdoor places with physical attributes that encouraged wellbeing included various Dunedin beaches, the Botanic Garden with its café and playground, as well as, more generally, the scenic beauty of the city. Water was noticeably intertwined with former refugees' therapeutic places. Nearly every participant

Table 1. *The diversity of therapeutic landscapes that former refugees discussed ranging from larger scale destinations, medium scale areas to small scale everyday locations or activities.*

Large Scale Destinations Within or Surrounding Dunedin	
Location	**Examples of physical, symbolic and social dimensions of therapeutic landscapes present at location**
The Botanic Garden	*Physical*: feeding the ducks, the bird aviary *Social*: picnic with friends or family *Symbolic*: reminders of home in the greenery
Beaches (Brighton Beach, Tunnel Beach, Saint Clair Beach)	*Symbolic*: Similarities and memories of home country *Physical*: playing in the water, relaxing watching the water
Mount Cargill	*Physical*: the scenery and beauty of the mountain *Other places*: Signal Hill, Marlow Park (the Dinosaur Park) and Memorial Park (Mosgiel)
Medium Scale/Local Areas	
Location	**Examples of physical, symbolic and social dimensions of therapeutic landscapes present at location**
Local Parks and Playgrounds or schools	*Social*: playing with friends *Physical*: Using the built environment such as play equipment
Cycling/running/walking in community	*Physical*: the scenery and green/blue spaces in their local community *Social*: time with family or friends
Small Scale Everyday Locations and Activities	
Location	**Examples of physical, symbolic and social dimensions of therapeutic landscapes present at location**
Backyard	*Physical*: the greenery available here *Social*: time with family or friends playing games
Gardening	*Social*: time together with friends and family *Symbolic*: reminders of home where they used to garden
Walking or seeing animals in local areas	*Social & physical*: walking friend's dog, seeing horses/ other animals in community, interactions with animals

noted the beach as a place where they enjoyed spending time. Furthermore, it was not the specificity of an individual beach that they highlighted as important, but the physical elements that these beach landscapes have in common. Experiencing the coast is sought, rather than specific characteristics of coastal locations (see also Bell *et al.* 2015). Physical elements including the sounds, changing views and the immersive feelings that the coast creates facilitated

restorative and healing experiences (Bell *et al.* 2015; White *et al.* 2010). Amira (age nine, two years in New Zealand), for example, was asked if she liked playing on the swings and see-saws at the beach and responded, 'Yeah, but I like watching the water more'.

At a small to medium scale, participants enjoyed green spaces through the scenery of the city, playing at local parks and engaging in everyday activities such as gardening and playing in their backyard. These activities were enjoyable and relaxing for participants and provided food and reminders of Syria, supporting arguments that green spaces provide health benefits and are restorative for mental and physical health (Kaplan and Kaplan 1989; Hordyk, Hanley, and Richard 2015). The physical presence of green spaces, parks and scenery, provided places of beauty and respite in participants' daily lives. Ayesha spoke of how greenery added enjoyment to her day as she walked to places: 'I feel like just walking down the hill. It feels like you're having fun, it's like you're seeing the view and the … greenery' (Ayesha, in her thirties, five months in New Zealand).

This experience reflects a broader theme from participants in this study as well as the findings of others such as Hordyk, Hanley, and Richard (2015) that show the stress-reducing effects of green spaces that improve mental and physical wellbeing of immigrants or former refugees during resettlement. The small, everyday interactions with the natural and built environment appeared to promote the wellbeing of former refugees as they settled in the city, with several participants noting the safety, cleanliness, lack of pollution and comparably compact size of Dunedin to their home cities as characteristics that were positive and beneficial to them. Natural and built environments are often entangled as former refugees highlighted their therapeutic landscapes as safe and enjoyable locations for spending a relaxed and restorative time. Although this is attributable to the physical and material environment, interlinked with these physical aspects are the symbolic dimensions of spaces that contributed to these healing experiences.

Symbolic dimensions

Former refugees' therapeutic landscapes clearly indicate that the values and meanings they attach to these places add to their therapeutic aspects (Gesler 2009). The associated meanings, values and emotions, be they directly experienced or linked to memories in their home countries or other places they settled in, make these outdoor places therapeutic (Wilson 2003; Finlay 2018). For example, landmarks such as Signal Hill or Mount Cargill in Dunedin are

described by participants as symbols for identifying with their new home. However, landmarks and places that spark memories and nostalgia appear as the most prevalent therapeutic aspect. For example, Faris (in his forties, five months in New Zealand) discussed the differences between the greenery in Dunedin and compared it to his home of Syria. While he enjoyed the outdoor areas and the greenery on offer in Dunedin, he was not used to simply having trees and green areas to look at, rather than fruits and vegetables that were commonly grown in Syria. In contrast, while visiting one of Dunedin's beaches, Hanna and Faris (in their forties, five months in New Zealand) could transport themselves back to their times of enjoying the beach and 'picnics' or 'walks' when living in Syria. In other words, participants drew on their '[p]ersonal place-related memories' (Gastaldo 2004, 157) and experiences from their home country to create new therapeutic landscapes (see also Rishbeth and Finney 2006).

The social dimension

Finally, the social dimension clearly emerged as an important factor for former refugees' therapeutic landscapes in Dunedin. This dimension consists of social relations and social environments (Gesler 2009). It focuses on how the relationships individuals have with others affect wellbeing in places such as institutions, the home, and public spaces (Finlay 2018). Outdoor places that former refugees particularly enjoyed for their sociability included various beaches around the city, the Dunedin Botanic Garden, and those associated with everyday activities such as sport or gardening. Throughout the interviews, it became obvious that family and people speaking a familiar language was of central importance to most participants, fostering sociability and facilitating social interactions with others:

> *Sara:* We like to take, like make [a] picnic.
>
> *Interviewer:* A picnic?
>
> *Sara:* Yeah and with, like, with friends or, uh yeah, we will, like, we will, like, do friends and we do like talking in Arabic language, yeah … we playing in the [Botanic] garden, there's like … we playing with the ducks.

Small scale everyday places and activities also fostered social connections that contributed to creating therapeutic landscapes. Participants spoke of spending time as a family digging gardens or playing in their backyard. Activities such as walking or cycling encouraged social connections through time spent with

friends and family. These activities helped to foster social connections within families and with former refugees or others living in Dunedin. This reflects what previous literature has discussed about the importance of social relations, interactions, and emotions that are connected to experiences for building a sense of place, belonging, attachment and identity (Williams 1998; Low and Altman 1992; Kyle and Chick 2007; Kale 2019; Sampson and Gifford 2010).

Interestingly, sport emerged as important for most child and adolescent participants. Football, badminton, rugby and swimming were among the sports participants enjoyed. Omar (aged fourteen, two years in New Zealand) said that playing sports made him feel more confident, while his sister Leila (aged twelve, two years in New Zealand) enjoyed the teamwork involved in playing sports. Another participant Jamila (aged sixteen, two years in New Zealand) did not have time to play sport due to secondary school assessments, but she associated sport with health and enjoyed playing them. She noted an attempt to start up a sport group to play together: 'and I think if we like make a … group of international and Kiwis [to] like play game[s] like every, each week like it make fun more' (Jamila, aged sixteen, two years in New Zealand).

Although no one had initiated such a group, this suggests sport is important for creating connections to others and promoting the health and wellbeing of those who participate in sport. Running, playing, walking and cycling together have social aspects that are helpful and suggest therapeutic processes that promote health and wellbeing through social support and spending time together (Doughty 2013). The social dimension therefore facilitates social connections, interactions, friendships and family time that counters the potential isolations and challenges of resettlement. These social dimensions of therapeutic landscapes are crucial during resettlement as former refugees have often lost networks, places, culture and family (Savic *et al.* 2013; Sampson and Gifford 2010) and may be isolated or excluded which impacts their health (Correa-Velez *et al.* 2010; McMichael *et al.* 2017). The social elements that therapeutic landscapes provide may help address some of these challenges. Our findings follow Sampson and Gifford (2010, 116), indicating that former refugees' therapeutic landscapes help to form 'positive connections to place' and thus promote health and wellbeing during resettlement.

Barriers to Dunedin's therapeutic landscapes

While former refugees had positive experiences and benefited from outdoor places as therapeutic landscapes, there were barriers to the use of their therapeutic landscapes although some participants had created strategies to over-

come these. Beyond the overarching barriers of the challenges of resettlement and adjusting to a new city, such as the loss of connections to their home country, culture and social groups (Sampson and Gifford 2010), three key barriers emerged from participants' experiences. These were: transportation, climate and time constraints.

Transportation difficulties were a key barrier to the ability of participants to access therapeutic landscapes. This was particularly evident for beaches or scenic walks that were located further away from their homes and that were not so easily accessible by public transport. Such access was an even greater barrier for the two former refugee families who had been in New Zealand for five months and did not yet own a car or have a licenced driver. In contrast, the two families who had lived in the country longer (between one and two years) had cars and at least one licenced driver so transportation was less of a barrier.

Part of the issue for participants without a car was financial cost and a perception that the public transport system was difficult to navigate. Key stakeholders noted the lack of bus timetables in Arabic making transport more difficult to use for families with less ability to speak and read English, particularly when they were first settling in Dunedin. While some participants did not struggle with using the public bus system, participants without cars who were reliant on them spoke about how buses were difficult to use and the timetable was inconvenient. Zain explained his family's difficulties with transport: 'It's just like the transportation and the distance, because uh using the public buses is not that much convenient, it's costly and we don't have a car. So that's why you know we always tend to, to rely on [a friend], and his generosity to you know take us' (Zain, in his thirties, five months in New Zealand).

Zain's account of struggles with public transport were common among the other former refugees. A friend interpreting for Hanna and Faris (in their 40s, five months in New Zealand) told how, 'They love to, they love to go to green spaces but very far for them, so it's hard for them to go outside'. The lack of a car and the challenges of learning English and adjusting to life in Dunedin made accessing therapeutic landscapes beyond walking distance difficult for them. This is particularly an issue as other research shows mobility issues can be problematic for resettlement and integration, causing difficulty accessing job opportunities, education, medical care (Bose 2014; Blumenberg and Smart 2010) and, in our case, their therapeutic landscapes. Difficulties of not driving not only limits access to therapeutic landscapes, but more generally to places that promote health and wellbeing including medical care facilities (Lawrence

and Kearns 2005), employment agencies and social arenas (Marete 2005; Bose 2014). More broadly, then, addressing barriers to transport is crucial for facilitating mobility and access to therapeutic landscapes which have implications for the health and wellbeing of former refugees.

Climate was the second barrier to therapeutic landscapes. Most participants mentioned the cold weather or rain that discouraged their use of the outdoor places that improved their wellbeing. This was mainly seasonal with several participants noting that they used the beach and Dunedin Botanic Garden more during the summer months than winter because it was lighter and warmer with perceived better weather. Participants seem to have bought into the local discourse that summer time means spending time outdoors while winter is the time to retreat indoors (Ergler, Kearns, and Witten 2016; Ergler 2020). Sara's statement that she did not use outdoor places much in winter is therefore not surprising: 'Not much, yeah, because, like winter [it is] raining cold and we can't go, yeah, but like we like uh sun, we can like picnic or like visit friends' (Sara, aged fifteen, one year in New Zealand).

Others described how the perceived cold temperatures prevented them from using outdoor places. Hanna and Faris lived close to one of Dunedin's beaches but they had not yet visited it due to 'the cold weather'. Additionally, comparisons were made to the climate in Syria and Lebanon or other departure countries noting that the climate was similar in some ways but the perceived coldness in Dunedin remained a barrier for using the city's therapeutic landscapes throughout the year. For some participants, however, the temperate Dunedin climate was a welcome change from the tropical environment they had previously lived in and was one of the positive aspects of living in Dunedin. Many participants also occasionally enjoyed places such as a park or a beach, even in winter. However, all participants were longing for summer to increase the abilities to utilise their favourite therapeutic landscapes more fully. Zara, who had lived in Dunedin for just over two years, spoke of her memories from the previous summer in Dunedin and how she and her family had enjoyed it: 'Last year summer was very beautiful. And this winter not so cold. Like when we came. Yeah this … [is the] third winter … but this winter is ok [and] beautiful … not like when we came [in] 2016 it was very, very cold' (Zara, in her forties, two years in New Zealand).

The experiences of participants suggest that the therapeutic and health promoting qualities of outdoor places seems to shift with seasons. Colder temperatures and seasons can affect what type of places are used and when, but it does not completely prevent the use of outdoor places. Studies have shown that norms

around seasons impact the play and use of the outdoors in New Zealand, and thus a cultural shift may be necessary to utilise these spaces all-year-round (Ergler 2020).

The final barrier raised by many participants was time constraints. Along with adjusting to life in Dunedin, participants had multiple commitments such as work, school or language classes to attend and family duties including young children to look after. These duties were prioritised over going to outdoor places that acted as therapeutic landscapes. While participants enjoyed spending time in green and blue spaces they were aware they had other responsibilities that had to be prioritised: 'But actually, it will be just, you know, to balance … because we can't spend the whole time at those parks and we have [other] duties so we just need to balance' (Zain, in his thirties, five months in New Zealand).

The duties Zain speaks of differ depending on participants but commonly affected their ability to use spaces. Family was central to these time constraints, illustrating the importance of family to former refugees (McMicheal, Gifford, and Correa-Velez 2011). As a mother who is kept busy by several young children, Zara's time to spend in green or blue spaces was limited because it was 'cold and uh also we haven't time … we are very busy, yeah'. Others had busy parents narrowing the times that they could visit destinations they enjoyed: 'Yeah, now it's like because my dad works so we can't, just the Sunday [we can], we can't like go [on other days]' (Sara, aged fifteen, one year in New Zealand).

School also constrained time for the adolescent participants as they could not spend as much time in these spaces. This was particularly the case for Jamila (aged sixteen, two years in New Zealand) who was completing her first year of NCEA examinations which prevented her from spending as much time in outdoor places or playing sports: 'I like to play [sports] but now this year I can't play because I have NCEA and hard to study a like, the school time is like just for study not for play like this year' (Jamila, aged sixteen, two years in New Zealand).

Jamila's experience echoes previous research on the challenges of schooling for former refugees (Kia-Keating and Ellis 2007) and the importance placed on doing well academically by former refugee students and their family (McMichael, Gifford, and Correa-Velez 2011). Despite acting as a barrier to accessing therapeutic spaces, most adolescent and child participants enjoyed school and the connections they had at school, suggesting school encourages health and wellbeing.

As previous sections have highlighted, therapeutic landscapes offer health proving aspects that are beneficial for former refugees' health and wellbeing. Specifically, the use of these outdoor places can offer support in building place attachment (Kale 2019), identity (Townsend and Pascal 2012), and a feeling of home or place-making (Sampson and Gifford 2010). Therefore, it is clear that support for resettlement and other strategies that help to overcome these barriers and improve access to these areas would be beneficial. As the next section shows, participants had already created some strategies to overcome these barriers.

DUNEDIN REFUGEES' STRATEGIES TO OVERCOME BARRIERS

To overcome the barriers of climate, mobility and time, participants came up with creative solutions. For instance, to address transportation issues, participants utilised their networks to access therapeutic destinations. Several participants revealed how their friends, neighbours or volunteers helped with their transportation to places such as the park or the beach. Faris and Hanna (in their forties, five months in New Zealand) illustrated the importance of these bridging connections (de Anstiss, Savelsberg, and Ziaian 2019) for accessing therapeutic spaces and, more generally, for the resettlement process:

> *Interviewer:* Do [Faris and Hanna] often go to the Dinosaur Park [popular playground drawing visitors from all over the city]?
>
> *Friend:* Only once they went with [neighbour] because they don't know anything about parks and things. So they went with [neighbour] there.

Their friendship with a neighbour allowed them to get out of the house to places such as the Dinosaur Park (Marlow Park) and to blue and green spaces. Connections that former refugees form through getting to know their neighbours, and formal events such as *pōwhiri*,[3] organised by the Red Cross and other NGOs, enabled better access to outdoor places and their therapeutic landscapes.

These experiences point to the importance of time and resettlement processes for access to therapeutic landscapes and overcoming barriers. For example, the contrast in mobility between participants who had been in Dunedin for one or two years compared to the two families who had been in Dunedin for only five months suggests that as families learn to cope with the inaccessible and hard to navigate bus schedule and route system, the more familiar it becomes, and the more often they use it. Support through resettlement helps to over-

come these barriers, such as one key stakeholder who taught former refugees to drive, and the Red Cross mentor programme which assists former refugees to drive with the help of volunteers in Dunedin (Red Cross 2018). Therefore, given time and resources, former refugees' mobility is likely to improve, as it had for the two participating families who had been in Dunedin longer. The resettlement process can mitigate transportation issues through ownership of a car as well as acquiring more English to more easily navigate the public bus system. However, experiences of being immobile without a car point toward wider structural issues and the dominance of automobiles in New Zealand cities (Bean, Kearns, and Collins 2008; Faherty and Morrissey 2014).

Others would take advantage of their smaller scale local places and activities as an alternative to further away sites, illustrating how everyday places and activities can still promote wellbeing–even with barriers. Ayesha explained how she overcame immobility through the use of local areas: 'it's like we have to have a car to go now [to green spaces]. But we can go walking, but sometimes we walk down the hill, we go walking, so we usually we run, [with] my daughters, so it's, it's very nice, and the view is lovely' (Ayesha, in her thirties, five months in New Zealand).

As such, even with the barriers that prevented participants from going to the larger destinations, participants found therapeutic elements in their community and activities in their day to day lives (Williams 2007; Sperling and Decker 2007). Every day, more small-scale locations and activities, such as gardens, gardening, walking or cycling in their community, provided outdoor experiences that were enjoyable for participants and accessible despite the identified barriers. While challenges to access outdoor places exist, they can be attributed to the larger challenges of resettlement (Savic 2013; Shrestha-Ranjit *et al.* 2017; McMichael, Gifford, and Correa-Velez 2011).

CONCLUDING REMARKS

We have provided a preliminary insight into creating, maintaining and improving access to everyday therapeutic landscapes for former refugees in their new home city, Dunedin. Our findings, drawing on a boutique sample, point towards the need for a better understanding of the role of outdoor places and their therapeutic qualities. The findings therefore offer several points of departure for future research.

First, the findings demonstrate that therapeutic spaces occurred at a range of scales including pristine landmarks (for example, the Botanic Garden), neigh-

bourhood destinations (parks, playgrounds) and smaller everyday places and activities that offered therapeutic elements, such as gardens. This emphasises the importance of the more mundane everyday places for wellbeing as well as larger destinations (Williams 2007; Sperling and Decker 2007). Pristine landmarks and everyday places were of value during the resettlement process as they contributed to being and feeling well in a new environment (Kearns and Andrews 2010). Therapeutic elements included sensory, smell and sound experiences of the physical landscapes (see also Bell *et al.* 2018), as well as the symbolic reminders of home countries and the sense of nostalgia these provoked (see also Harris, Minniss, and Somerset 2014). The social aspects of outdoor places also facilitated connections to family and friends through gatherings at parks or playing sports (Rishbeth and Finney 2006). Therefore, our study points to the health promoting characteristics of therapeutic landscapes for former refugees or migrants and how therapeutic landscapes can help to form social connections, a sense of belonging or feeling at home, and a sense of identity in a new location. For further examples, see Sampson and Gifford (2010), Liamputtong and Kurban (2018) and Townsend and Pascal (2012).

However, interconnectedness of the physical, social and symbolic environment warrants considerable further attention beyond single city case studies. Attention to different age groups and along diverse axes of difference would also provide a better understanding of the healing and therapeutic qualities for a diversity of refugees. Moreover, these studies should be, similarly to ours, driven by the study participants rather than reporting on the therapeutic qualities of pre-defined spaces as so many studies have already done (Hordyk Hanley, and Richard 2015).

Second, our fifteen participants revealed that to enjoy and utilise the therapeutic values of these places, more attention needs to be paid to barriers preventing access to them, and the strategies through which former refugees can overcome particularly their barriers of immobility. More research is needed to better understand how refugees can be supported in navigating and using existing systems, and which destinations should be served more frequently by public transport or bike lanes. More generally, a study is needed of how we can plan for a health promoting, therapeutic city to ensure everyone, irrespective of age or abilities, can utilise therapeutic landscapes.

Time constraints were also a barrier since most participants had multiple commitments including working, studying English, attending school and looking after children. A better understanding of the need for support systems or respite is therefore warranted, along with knowledge transfer and sharing of easily ac-

cessible local destinations, such as through local health promoting, therapeutic landscapes maps created by councils or resettlement organisations.

Climate and seasonality also prevent the use of outdoor places, particularly in winter, as participants did not enjoy using outdoor places in the wet and cold. Summer allowed for more use of these areas and the majority of participants were looking forward to the warmer months when they planned to use these areas more. This showcases the need to ensure weather appropriate clothing is available, accessible and affordable (Jancovik 2009), but also to normalise the use of outdoor spaces all-year-round (Ergler 2020). This could be through educational programs or organised activities by councils and resettlement organisations. Additionally, there is a need to gain a better insight of the seasonal elements of therapeutic landscapes. Consequently, a more detailed understanding of diverse barriers for accessing therapeutic landscapes is needed, one which acknowledges the diversity of refugees and their diverse circumstances, age, gender and abilities.

Overall, our exploratory study points towards the importance of pristine landmarks and everyday spaces for assisting and mitigating the resettlement process, and creating spaces for interaction with locals and their new home town. But it also argues that providing spaces per se instrumentalises therapeutic landscapes and disregards that therapeutic landscapes are assembled in time and space by bringing social, physical and symbolic together. However, to ensure access to therapeutic landscapes early in the resettlement process, barriers (especially the issue of transportation) need to be addressed to allow the utilisation of diverse outdoor places and ensure they are inclusive and welcoming for everyone.

NOTES

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3 A *pōwhiri* is a Māori welcoming ceremony normally held at a marae or at Māori meeting grounds. Red Cross New Zealand and other support organisations arrange pōwhiri for newly arrived former refugees (see Tourism New Zealand 2018 and Red Cross n.d. for further information).

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