COMMON FACTORS OF ADVENTURE THERAPY

BY

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ABSTRACT

The objective of this project was to determine if the common factors of traditional psychotherapies could be found in adventure therapy. The study uses secondary research methods, in which the literature has been reviewed. The results have shown that, indeed, the common factors denoting the effectiveness of traditional psychotherapies are also found in adventure therapy. One can then extrapolate that adventure therapy continues to develop as an effective and legitimate means of treatment when compared to traditional forms of psychotherapy.

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INTRODUCTION

Mental illnesses affect almost all Canadians in some way, directly or indirectly. The term "mental illness" is used broadly to describe alterations in mood, thinking and behaviour, as well as other aspects of mental functioning. These can range from behavioural problems and dysfunctional personal characteristics to developmental disorders (Langlois, Samokhvalsv, Rehm, Spence & Gorber, 2012).

Langlois et al. (2012) describe the substantial impact of mental illnesses on the quality of life. It is said that of "the ten leading causes of years lost due to disability in the world, mental illnesses accounted for four: major depression was ranked second (among males), schizophrenia was fifth among males and sixth among females, and bipolar disorder was seventh among males and eighth among females" (p. 7). Mental illnesses can cause serious impairments in emotional functioning, which may lead to social and physical limitations. Depression can cause an individual to lose all interest in life, and posttraumatic stress disorder often causes flashback episodes, where the event seems to be reoccurring, thus disrupting day-to-day activities. Another difficulty associated with mental illnesses is that frequently, two or more mental illnesses are simultaneously present, that is, they are co-morbid.

When individuals are exploring their options for treating mental illness, it is important to consider the possibility that some treatments may result in the individual's illness becoming better or worse compared to those who have not received such treatment. This suggests it is important to consider which treatments and techniques are effective for which disorders, and which treatments and techniques can be harmful.

This paper will explore the use of adventure therapy for treating mental illnesses; specifically, it will be looking at common factors that contribute to clients' positive outcomes across the well-established psychotherapies. It is proposed that these common factors should be present in adventure therapy programs if such programs are to be recognized as a bona fide form of treatment. Particular areas of focus include creating an understanding of what the common factors are and how they fit into the field of adventure therapy. Herein, I will provide evidence recommending the use of adventure therapy, delineating those elements of adventure programming and therapeutic processes which should be present in order to bring about positive change for clients.

PROBLEM STATEMENT

When considering adventure therapy, practitioners promote it as an effective method of treating psychological problems. Yet, there is a lack of empirical evidence supporting these claims. The lack of evidence and support for adventure therapy decreases its acceptance and its potential to develop into a frequently used and respected method of psychological treatment. Empirical research evaluating the accomplishments and effectiveness of adventure therapy as a treatment strategy would be beneficial when assessing which methods and techniques will work with which populations. This type of research would also assist adventure therapy programs in gaining recognition from mental health professionals and support from funding agencies.

In summary, there is a significant lack of empirical research and evidence into the field of adventure therapy. This results in a lack of professional acceptance and respect from the mental health field for the treatment strategy, which subsequently leads to

insufficient recognition and infrequent use of adventure therapy, and a lack of funding from various mental health and other agencies.

RESEARCH QUESTION

An important consideration when generating outcome research to support adventure therapy as a psychological treatment is determining what, exactly adventure therapy programs do in order to successfully bring about change within specific populations. Research has examined the effects of adventure therapy. However, there is little research reviewing the processes that creates these positive outcomes. The research question being proposed is, "What are the relevant factors specific to adventure therapy that elicit change and positive outcomes in clients?"

HYPOTHESIS

If adventure therapy programs are to be recognized as legitimate means of therapeutic treatment in relation to established forms of psychotherapy, they must share the same therapeutic factors that are known to be effective in bringing about change and positive outcomes. The following study will, in fact, identify these common factors and demonstrate their presence in adventure therapy, thereby providing support that adventure therapies are working toward meeting the criteria used by other more traditional psychotherapies when achieving positive change and success within their client populations.

OBJECTIVES: OVERALL AND SPECIFIC

The overall objective of the research project is to fulfill the requirements of the Bachelor of Interdisciplinary Studies degree program. Specifically, the research project will be used to identify common factors found across successful therapeutic orientations

that contribute to improved client outcomes. This will be used to determine if these common factors are also part of the adventure therapy experience. From these objectives, the results can help identify which factors are important in creating positive outcomes in the adventure experience and contribute to establishing standards in the field of adventure therapy. This research is meant to be used to connect the field of adventure therapy to the overall field of mental health. It will encourage professionals to move away from identifying what it is that distinguishes adventure therapy from traditional therapy, and to acknowledge what adventure therapy shares with traditional therapeutic models.

RESEARCH DESIGN AND METHODS

The study has used secondary research to identify the elements and factors found in adventure therapy that bring about positive change in clients. Secondary research was also used to identify those elements and factors that contribute to positive outcomes for clients in the wider field of psychotherapy. The results were then compared in order to examine the similarities and differences between the adventure therapy process and the traditional psychotherapy process. The research conducted included sources from published texts, statistics, media, documents, analyses, school courses, and expert reports, and explored the common elements among psychotherapies and specifically those seen as being effective in adventure therapy.

ADVENTURE THERAPY

First of all, what is adventure therapy? Prouty, Paniccucci, and Collinson (2007) say that adventure therapy is a relatively new field, and the definition of adventure therapy does not seem to have a set of clear characteristics. This assertion has been supported in literature where an agreement of a consistent and accepted definition is

lacking (Russell, 2001). The problem is that adventure therapy is used synonymously with wilderness or outdoor therapy, therapeutic adventure, and outdoor experiential education (Bilodeau, 2011). Prouty et al. (2007) found that some experts in the field of adventure therapy argue that a distinction can be made between adventure therapy and therapeutic adventure. They say that adventure therapy involves diagnostic assessments and treatment whereas therapeutic adventure does not involve the diagnostic assessment and treatment but rather focuses on behavioural change.

The following definition includes the commonalities that I recognized in an attempt to define adventure therapy. Adventure therapy is a deliberate and strategic facilitation process in which kinesthetic experiential methods, activities and the environment are used to help clients change behaviour, affect, or cognition. This process is used to create positive outcomes for clients by engaging them and creating a parallel between their life experiences and the therapeutic experience. This process contains real and/or perceived risks which are intended to promote the interpersonal and intrapersonal relationships among participants (Bosch & Oswald, 2010; Crisp, 1998; Gass, Gillis, & Russell, 2012; Gillis & Ringer, 1999; Gillis & Thomsen, 1996; Ltin, 1995; Prouty et al., 2007).

The most current definition of adventure therapy is provided by Gass et al. (2012); they define it as "the prescriptive use of adventure experiences provided by health professionals, in natural settings that kinesthetically engage clients on cognitive, affective and behavioural levels" (p. 1). This definition fits into the greater field of psychotherapy.

PSYCHOTHERAPIES

What is psychotherapy? Psychotherapy began early in the twentieth century. It has developed and is now recognized as an invaluable form of treatment for a variety of

mental health problems and personal crises. Over time, the number and types of psychotherapies have grown and diversified. There are a number of professionals and paraprofessionals who participate in psychotherapeutic activities, such as social workers, nurses, and counsellors. All of them share the goal to improve the mental health of clients. Although the goal of psychotherapy is to improve mental health, there are many differences in the ways to reach this goal, including differences in theoretical orientations.

The differences in theoretical orientations are often a hot point in psychotherapy research; in particular, there is controversy over what is the best form of treatment for a specific population. Even professionals with the same educational degree may have varying beliefs as to which theoretical orientation is most appropriate to use. Variations in treatment modalities exist because different training programs emphasize different theoretical orientations and practicum experiences (Cooper, 2008).

THE ORIENTATION DEBATE

Within the field of psychotherapy there are multiple theoretical orientations that guide practitioners in what they do and why they do it. Typically, professionals and paraprofessionals will have allegiance to a certain school of thought. This is not to suggest it is a bad thing; it may just be a result of their personal training and experience. However, this inspires a debate over the efficacy and effectiveness of the different therapeutic orientations. On one side of this debate there are researchers who argue that some therapies are more efficacious for certain psychological distresses than are others. On the other side of the debate there are researchers who argue that different therapies are

equal in their efficacy. Those researchers suggest it is because all therapies do similar things, not their specific theoretical orientations, that makes them efficacious.

COMMON FACTORS APPROACH

Within psychotherapy literature the term "dodo bird verdict" (Cooper, 2008, p. 52) has been used to describe the equivalence of the different bona fide therapies. One of the explanations for the dodo bird verdict is based on the idea that non-specific factors common to all therapies are what contribute to the therapeutic change. This approach, the "common factors" approach, was coined by Saul Rosenzweig in opposition to the idea of specific techniques of a particular therapeutic approach being the determinants of therapeutic change. However, and understandably so, the common factors approach still has its critics (Cooper, 2008).

The common factors approach has been criticized for being over generalized. Chambless (2002) has stated that there are some forms of psychological distress, such as depression, which react positively to a wide range of therapies whereas there are other forms of psychological distress, such as anxiety disorders, which react better to specific therapies. Additionally, the idea that all therapies are equally effective for all mental illnesses may be ignoring the fact that different clients may benefit from different types of therapy (Beutler et al., 1991). This argument may not be valid if one believes that the common factors alone contribute to positive psychological outcomes. It may be more prudent to acknowledge that both common factors and specific theoretical techniques impact outcomes and that both are important to the therapeutic process (Cooper, 2008).

Further to this, both common factors and specific theoretical techniques are associated with positive therapeutic outcomes. There has been research supporting both

sides of the argument. Therefore, it is important that those practices and principles that are essential in creating positive change in all therapies can also be identified in the field of in adventure therapy. This includes specific factors and non-specific factors known as the principles of change. As described by the American Psychological Association/Society for Psychotherapy Task Force, principles of change include client factors, therapist factors, relational factors, and techniques that are associated with positive outcomes (Beutler & Castonguay, 2006). Next, these principles of change will be explored individually. The purpose is to identify them in the overall field of psychotherapy and in the field of adventure therapy.

CLIENT FACTORS

When thinking about why therapy works, it is a basic presumption that it is because of what therapists do and the circumstances they create. Nevertheless, Bohart and Tallman (1999) have pointed out that is is actually the clients and what they bring to the therapeutic process that is the principle factor in determining therapeutic change. The dodo bird verdict lends itself nicely to the belief that it is the extent of the clients' ability to make use of the therapeutic recourses available to them (Cooper, 2008) that results in therapeutic change.

Thus psychotherapy becomes an educational tool for clients in which the therapists help the clients use their inherent capacities for change. "In education, students' built-in capacities for learning are used, mobilized, and supported so that students develop new perspectives, new skills, or their own creative capacity for invention" (Bohart & Tallman, 1999). This idea of psychotherapy being an educational process matches nicely with the idea/philosophical background of adventure therapy, where education is deeply

embedded. Let us take a closer look at the philosophical background of adventure therapy and how it relates to client factors.

PHILOSOPHICAL BACKGROUND OF ADVENTURE THERAPY

Adventure therapy is rooted in the principles and philosophies of learning by doing while experiencing isolation, dangers, fears, risks and contingency challenges. These philosophies can be traced as far back in history as 437–322 B.C. to Plato and Aristotle's ideas about education and development in young people and, specifically, the idea that, "to learn the virtues one must live the virtues" (Miles & Priest, 1990, p. 121). That is to say, people are capable of learning lessons about virtues best by exhorting people into adventurous situations that demand that those virtues be exercised (Miles & Priest, 1999).

William James, the 19th century philosopher and psychologist, followed a similar theme in his essay "The Moral Equivalent of War." In this essay James argues for the virtues of "fidelity, cohesiveness, tenacity, heroism, conscience, education, inventiveness, economy, wealth, physical health, and vigor" (James, 1949, p. 319), which are brought out in war. However, James hates war and says there needs to be a better situation or set of circumstances where these virtues can be taught. James proposed using nature-based adventure as a substitute to war in order to teach these virtues. The philosophical belief advocating adventure and experiential education continued into the works of John Dewey (Hunt, 1999).

It has been stated that there are three foundational theories and concepts that form the basis of adventure therapy. They are detailed below:

1. All learning is rooted in experience.

2. People construct their own knowledge.

3. Individuals learn using various styles.

The first theory comes from John Dewey, who is sometimes considered the "father of experiential education." Dewey believed that all learning was rooted in the experience (Dewey, 1956). In Dewey's model, as discussed by Learie (2009), Dewey advocated a model of experiential education which included social engagement, responsible participation in problem solving, intellectual and emotive and practical action (Archambault, 1964). Dewey believed that not all experiences are educative and can have negative effects; his theory is the basis for teaching practices within adventure education (Miles & Priest, 1999; Prouty et al., 2007).

The second theory comes from Eleanor Duckworth who, based on her work with Jean Piaget, believed that people construct their own knowledge. Duckworth uses Piaget's analogy of a child as a scientist in which a child, like a scientist, experiments with their physical environment and from their actions they construct explanations for how things work. The student must learn in their own personal way, making the role of the teacher, or therapist in this case, a facilitator of experiences. The job of a therapist is to create a space and time for the student to develop their own knowledge and skills. Duckworth stresses the importance of process in learning and the value of making mistakes, which relates to how Piaget believed children progress from one intellectual stage to the next (Duckworth, 1987; Miles & Priest, 1990; Prouty et al., 2007).

The third and last of the major foundations is David Kolb's experiential learning theory. Kolb defines four distinct learning styles: diverging, assimilating, converging, and accommodating. These four styles are based on a four-stage learning cycle (see Figure 1) described as follows:

1. Concrete experience, which provides a basis for…;

2. Reflective observation, where these observations are assimilated into…;

3. Abstract concepts, leading to new action that the person can…; and

4. Active testing and experimenting with…, thus creating new experiences.

Kolb suggests that people will learn according to all four styles but naturally prefer a certain single style over the others (Prouty et al., 2007; Smith, 2001).
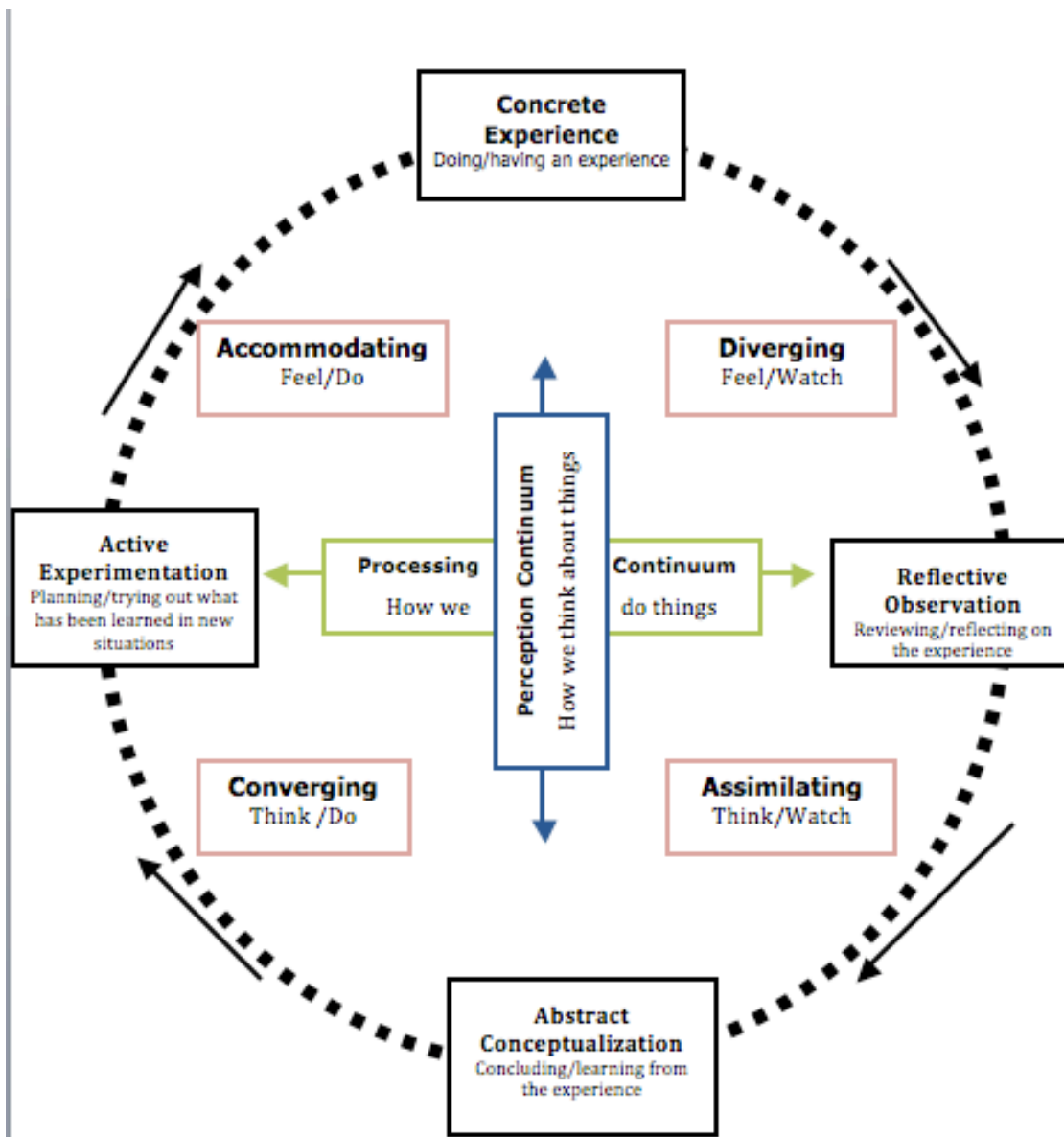
Figure 1. Kolb's learning cycle diagram.

As stated by Gillis and Ringer (1999) since the start of Outward Bound, "a wilderness-based program teaching self discipline and team work through adventure activities" (p. 29), these experiential education programs have stretched out into therapeutic settings. Gass (1993) has taken the principles of experiential education and applied them to adventure therapy:

Experiential Education	Adventure Therapy
1. The Learner is a participant rather than a spectator in learning. 2. The learning activities require personal motivation in the form of energy, involvement, and responsibility. 3. The learning activity is real and meaningful in terms of natural consequences. 4. Reflection is a critical element in the learning process. 5. Learning must have present as well as future relevance for the learner and the society in which he/he is a member.	1. The client becomes a participant rather than a spectator in therapy. 2. Therapeutic activities require client motivation in the form of energy, involvement and responsibility. 3. Therapeutic activities are real and meaningful in terms of natural consequences for the client. 4. Reflection is a critical element of the therapeutic process. 5. Functional change must have present as well as future relevance for clients and their society.

Figure 2. Experiential education to adventure therapy (from Gass, 1993, p. 4-5).

Just as psychotherapies are educational for clients, it has been demonstrated that adventure therapy also matches this description (Gass, 1993), thus attributing client factors to one of the therapeutic elements that should be present in adventure therapy. Some of these client factors include attitudes, expectations, and preferences.

CLIENT FACTORS COUNTINUED – ATTITUDES TOWARDS THERAPY

One of the most influential determinants that have been seen to bring about change in clients is the clients' level of participation during therapy (Cooper, 2008). Orlinsky, Ronnestad and Willutzki (2004) noted that clients who are more willing to work cooperatively with their therapists and follow their instructions or do the therapeutic tasks with little or no resistance do better in therapy. When clients show high levels of resistance while working through the therapeutic process it is interpreted as a strong predictor of poor outcomes. Consistently clients' openness in comparison to their defensiveness is a noticeable predictor of positive outcomes.

The clients' willingness to be open and to work through the therapeutic process may be attributed to their level of autonomous motivation for therapy. This self-governed choice for therapy has contributed to the predictions of positive outcomes. Zuroff et al. (2007) studied how the autonomous motivation of clients in cognitive behavioral therapy and interpersonal therapy affected their response to therapy. They found that clients with high autonomous motivation were twice as likely to respond well to therapy compared to those with moderate levels of autonomous motivation, and four times as likely to respond well compared to those with low levels of autonomous motivation.

CLIENT FACTORS – EXPECTATIONS

Outcome expectations are another intrinsic client factor that have been found to be important in creating change for clients. When clients enter therapy with hope, faith and even confidence that therapy will be beneficial to them, they tend to have better outcomes than clients who are skeptical of therapy. This is supported by studies where clients still show improvements when in a therapy wait list group and placebo groups. Just the fact that clients feel they are being helped, or are going to receive help, instills hope that they will improve. Of course this is within reason; a person's expectations must not be extreme or unreasonable. When someone's hopes and expectations were extreme or unrealistic, poorer outcomes have been seen (Cooper, 2008).

Another form of expectations is process expectations. These are clients' expectations of the therapeutic process. That is, what they think will and should happen during therapy. These expectations are an important aspect because they can impact the resulting outcomes. When clients know what will happen in therapy as well as what gains they can expect to get, they will benefit more from it. This is a good reason for psychotherapists to go over expectations with the clients beforehand (Cooper, 2008).

Pre-therapeutic procedures can be used for the psychologist to explain and work with their clients on the goals of treatment, what can be expected throughout the process, and the expected behaviours for the therapist and client. This should be done prior to treatment in order to prepare the client for things that may arise throughout treatment as well as to provide them with realistic and appropriate expectations for improvement within the time frame (Cooper, 2008). This may be particularly important for those

clients interested in adventure therapy, but who may not understand, or have a different understanding of the process.

Another aspect of expectations is predilections. Predilections are what a client believes the origin of their problem to be, and based on this what they believe will be helpful to them. As an example of how predilections can affect outcomes, let us explore a study by Elkin et al. (1989). This study looked at patient-treatment fit. The researchers determined which patients believed that their depression stemmed from psychological factors and that psychological treatment would be best for them. They also determined which patients believed their depression was based on poor physical health/biochemical problems and thought medicine would best treat their depression. It was found that clients who received treatment that was congruent with their beliefs had lower dropout rates and were more engaged in the treatment, leading to better outcomes than those clients who received treatment that was incongruent with their beliefs.

Similar results have been found with client preferences for therapy when clients know their therapeutic options and have a preference for receiving a particular type. In a study by Devine and Fernald (1973), when clients were in a therapy that they liked and preferred to be in, they did significantly better than those in a therapy that they disliked and would have preferred to be engaged in another form of treatment. However, Cooper (2008) contrasts this by saying that in "a systematic review of 32 randomized controlled studies in which clients had the option of choosing a particular treatment, it was found that those who received their preferred approach, in general, did not do any better than those who were randomly allocated to it" (p. 68).

CLIENT FACTORS – PROCESS AND STAGES OF CHANGE

One of the most important developments and a foundational element in all psychotherapy theories is the process of change. Capuzzi and Gross (1995) believed that virtually all major counseling theories might be viewed as sharing two basic similarities: they all draw attention to their respective processes of change and their respective interventions. The process of change has been identified as the ways in which individuals attempt to change with or without therapy.

This largely comes from the work of Prochaska, Velicer, Diclemente and Fava (1998). Prochaska et al. determined that a large degree of change during therapy is ascribed to 10 statistically separate processes of change.

1. Consciousness raising: Information about the self and the problem are explored and brought to concrete awareness.

2. Self-reevaluation: The self is reevaluated with respect to the antecedents and potential solutions to the problem.

3. Self-liberation: The potential for a desirable outcome and the changes required for it are examined in terms of ability and commitment.

4. Counter conditioning: Alternatives for problem behavior are constructed and tested.

5. Stimulus control: Stimuli that are associated with or encountered before the activation of the problem behaviours are avoided.

6. Reinforcement management: Rewards from the self or others become contingent upon changes required to meet goals.

7. Helping relationships: Interpersonal relationships with people who care, are further developed by trusting them and being open.

8. Dramatic relief: Affect is experienced and expressed regarding the problems and potential solutions.

9. Environmental reevaluation: Problems and potential solutions are considered with regard to how they influence the physical environment.

10. Social liberation: The opportunity for more desirable behaviours becomes increasingly available and valued by society (Petrocelli, 2002, p. 24).

Prochaska and Diclemetes have also been credited for their development of the psychotherapy and behavioural change field from their studies investigating the existing stages of change. That is behavioural changes are not instantaneous events but processes that evolve and develop as time passes. Prochaska and Diclemente are known for describing this process in a series of stages:

- Precontemplation: a lack of perceived need or intention for change.

- Contemplation: an awareness of the problem yet a lack of decisive action or commitment to take necessary actions for change.

- Preparation (decision making): a decision to change as evidence by taking small behavioural and mental actions necessary for change.

- Action, overt behaviours: the motivation to take such steps is evidenced over time, effort and commitment.

- Maintenance: the continuation of necessary actions that must be met for the desired change to be sustained.

- Termination: no further temptations remain and there is a sense of total self-control.

Based on the research examining at the stages of change process, it has been determined that when people are further along in the process and come to therapy, their results are better than those clients who are in the early stages of the process. That is not to say therapists should not accept clients into treatment until they are further along in the process. It does mean, however, that the therapy would be most beneficial if it were specifically tailored to which stage of change the client is at (Cooper, 2008).

MORE CLIENT FACTORS

Another client factor that has been seen to contribute to therapeutic outcomes is psychological functioning. The level of psychological functioning is defined; clients with higher levels of psychological functioning regularly benefit more from therapy then the clients with a lower level of psychological functioning. It also is noted that clients who are not diagnosed with personality disorders, have secure attachment styles and good interpersonal functioning, have lower levels of perfectionism, are ready to change, and receive high levels of social support have better therapeutic outcomes (Cooper, 2008).

CLIENT FACTORS IN ADVENTURE THERAPY

As we have seen, when people are not motivated to be in treatment, their outcomes are not as good as those clients who are motivated. Adventure therapy that uses intentionally designed adventure activities is a good way to foster clients' using motor skills and cognitive skills. These activities are used to facilitate skill development, which has been connected to developing motivation to be engaged in treatment (Gass, et al., 2012).

In a study by Russell (2008) most of the clients were seen as being partially coerced into entering an adventure therapy treatment program, whether it was from influences such as their parents, school officials, mental health professionals or a judicial system. Interestingly, there was a 93% completion rate, despite the fact the majority of the clients were originally rated as unmotivated to be in treatment at admission (determined by analyzing the stages of change profile). At post-treatment, the clients were seen to have developed a marked aspiration to continue improving and working on their development.

This can be similarly related to preferences, where if the client is in a treatment that they prefer, their outcomes tend to be positive. For clients who may be resistant to traditional forms of therapy, adventure therapy can be an influential tool, if, for example, a client is participating in a multi-day canoe trip in which they are acquiring useful skill development without it being forced.

The design of adventure therapy programs increases the motivation for clients to participate and engage in therapy. The design of adventure therapy programs integrates evidence-based treatment strategies with exciting and fun adventure experiences to facilitate the therapeutic experience and to engage clients. "In fact, many times clients forget they are in treatment as they are focused on accomplishing meaningful tasks" (Gass et al., 2012, p. 82).

Of course, when considering these separate common factors, such as client factors, it is important to remember correlation does not mean causation. There may, in fact, be other contributing factors, which are responsible for the outcomes, meaning that these client factors are not the only cause for the positive change in their lives. This leads to the next three common factors, therapist factors, relational factors and technical factors.

THERAPIST FACTORS

When looking at the combination of factors found across the bona fide therapies and the essential elements of adventure therapy, it is important to consider the therapists and what they bring to the process. According to Corsini and Wedding (2011), the success of therapy is a function of the experience, practice and knowledge of the therapist. This includes their beliefs, values and demographic characteristics as well as the importance of therapist–client match in relation to the clients' outcomes.

From studies that have focused on therapist factors there have been varying results, with some results showing that therapeutic outcomes do significantly differ among therapists, while others show that they do not. In general, however, there are some therapist factors that have been associated with positive outcomes (Cooper, 2008).

It would be reasonable to assume that therapists who themselves are in good mental health and have high levels of psychological function are more likely to produce positive client outcomes. There is research that supports this assumption. For example, "a meta analysis of nine studies, found a significant positive relationship between therapists' well being and clients' outcomes" (Cooper, 2008, p.82).

This brings up the interesting question of whether therapists should be participating in therapy for themselves. Norcross (2005) has combined 25 years of research looking at the effects of personal therapy for mental health professionals. All the results show that personal therapy is mentally, emotionally, interpersonally significant and an influential experience that should be important to health care professionals for their own healthy development. It is often seen in adventure therapy that practitioners themselves are participating in the experiential activities they are providing to their clients.

For this reason it would seem that adventure therapy is on the right track to being applied by therapists with high levels of psychological functioning. For one, adventure therapists commonly become interested in using adventure-based activities because of the passion that they themselves have for these activities. They recognize how influential and powerful adventure activities can be. Thus, they want to share them with others. The inherent benefits of experiencing nature and participating in such activities is often discussed and applauded. Of course, these adventure activities are not psychotherapy on their own, but may be viewed more as a personal "therapy," a way in which the adventure therapists are taking care of themselves, making sure they are mentally, spiritually and physically healthy.

THERAPIST FACTORS – TRAINING

It would be assumed that professional training would improve overall therapeutic outcomes. From the research it can be concluded that when therapists are better skilled, it relates to positive outcomes for clients (Cooper, 2008). In a meta-analytic study, Stien and Lambert (1995) divided therapists into groups based on their levels of training. They then compared the treatment outcomes between the groups. Supporting the idea that therapists with more training provide better client outcomes, Stien and Lambert (1995) found "a modest but fairly consistent treatment effect size associated with training level for a number of measures of client improvement" (p. 192). It was also seen that higher dropout rates were associated with therapists who had not attended graduate school compared to their colleagues who had received extra training through graduate school.

It is also important to remember that not only do adventure therapists need to have training in mental health, but also in outdoor adventure skills. Thus, it would make sense

if the field of adventure therapy wants to provide positive therapeutic outcomes that adventure therapists ensure that they are receiving training and continually developing their outdoor adventure competencies as well as their therapeutic competencies. The techniques and applications of adventure therapy have a foundation in psychotherapeutic theory. Yet adventure therapy has still been criticized for discrepancies compared to standard mental health practices. For example in a study done by Berman (1995), the adventure therapists were lacking therapeutic skills. Berman asked adventure therapists from different programs what their former training levels were. The results showed that several adventure therapy employees in the United States were not trained in the techniques and applications of psychological interventions. Ltin (1995) points out that "adventure therapy practitioners may include people with extensive wilderness or adventure training but limited formal human service training or individuals with extensive training in one of many human service professions but with limited adventure experience" (p. 8). It would be obvious, then, to have practitioners proficient in both adventure and human service training, to have better treatment outcomes (Ltin, 1995). Efforts towards creating a standard for adventure therapists are being made.

ADVENTURE THERAPIST COMPETENCIES

Gass et al. (2012) make an important effort to distinguish between competencies and skills. They note that skill development is limited to the gaining of certain aspects of competency obtained for training means, and misses the background knowledge, theory and value elements that require one to be competent. Competency is defined as "the capacity to integrate knowledge, skills and attitudes reflected in the quality of clinical practice that benefits others, which can be evaluated by professional standards and

developed and enhanced through professional training and reflection" (Sperry, 2010, p.7).

To illustrate the difference, consider the disputed statement of adventure professionals:

"Is the purpose of teaching rock climbing to teach people to be better rock climbers, or to

teach people to be better people?" If the goal is to teach people to be better rock climbers

it will require teaching necessary skills in order to appropriately manage risks and

physically rock climb. If the goal is to use rock climbing to teach people how to be better

people, it will require the skills necessary to rock climb, and also require further emphasis

on knowledge, frameworks, ethics, the added meeting of professional standards and

thoughtful reflection required to enhance rock climbing to more than only teaching a skill

(Gass et al., 2012, p. 210). So when considering the characteristics of competent

adventure therapist, we must explore the competencies of the disciplines which make up

adventure therapy. This includes adventure programming competencies and mental health

therapist competencies.

ADVENTURE PROGRAMMING COMPETENCIES

The competencies found in adventure programming are made up of hard skills, soft

skills, and abstract skills. The hard skills include the technical aspects—being competent

in the adventure activities, whether it is rock climbing, whitewater kayaking or a ropes

course—as well as safety skills and environmental skills including being competent in

risk management, decision-making and leave no trace practices.

The soft skills of adventure include aspects of facilitation, being competent in

assisting group dynamics, and creating interpersonal and intrapersonal experiences. They

also include instructional skills where it is required to be competent in demonstrating

skills, describing tasks, giving feedback and enabling clients and leaders.

The abstract skills are the combination of skills that relate to other skills. This includes being effective in communications, being a competent leader, and being a flexible leader in order to meet client objectives. Having judgment and professional ethics are also integral abstract skills (Gass et al., 2012). Other competencies that are identified for adventure programming, such as effective listening, debriefing, transfer of learning, client assessments, and integration strategies, often overlap with those of mental health professionals.

MENTAL HEALTH THERAPIST COMPETENCIES

There are many approaches to mental health such as social work, couples counseling or psychotherapy to name a few. With so many different approaches there are competencies that are the same amongst them as well as some that vary. For the purpose of this discourse the focus will be on the competencies found in psychotherapy.

Sperry (2010) describes six core competencies common to all the major psychotherapeutic orientations. These are as follows:

1. Conceptual foundations. This is the conceptual and theoretical framework involved in psychotherapy; therapists must be grounded and competent in the theories of the field.

2. Therapeutic relationship. Here the therapist must be capable and have the ability to build and maintain effective therapeutic relationships.

3. Intervention planning. Emphasis is placed on therapists being competent at forming concepts for the therapeutic case. They must be competent in assessing the client and creating a treatment strategy.

4. Intervention implementation. Therapists must be capable of taking the strategy and putting it into practice. This includes being competent in the therapeutic strategies, having the ability to recognize and resolve issues that interfere and have strategies for coping with unsuccessful treatment.

5. Evaluation and termination. Here the therapist must evaluate the progress throughout the treatment and be able to determine when and who to terminate. Thus, this includes having the capability to prepare the client to maintain treatment gains.

6. Cultural and ethical sensitivity. Throughout the process, a competent therapist will have integrity and demonstrate respect for others. Therapists need to be proficient in cultural assessment and formulations as well as making ethically appropriate decisions.

Based on competencies from the field of adventure and mental health, a schema can be created focusing on the areas of professional practice for adventure therapists. These include:

1. Technical competencies: the adventure therapist's proficiency in instructional knowledge of adventure programming skills in the areas of adventure activities; risk management competencies relating to adventure activities and specific therapeutic populations. These encompass emergency medical skills, risk management plans, procedures, documentation, and expertise of drug/environment contraindications (factors/circumstances which serve as a reason not to provide or use a certain technique or treatment). One must also maintain competence in environmental practices such as leave no trace.

2. Facilitation and processing competencies: the adventure therapist's ability to apply skills and knowledge in effective listening, goal setting, monitoring, providing feedback, debriefing, transferring client change, experiential learning methodologies, processing skills, group development, conflict management, challenge by choice, facilitation models and methods.

3. Organizational and administrative competencies: the adventure therapist's ability to apply skills and knowledge contributing to the structure and organization of the adventure/therapeutic experiences. This includes skills in logistical planning, knowledge of industry standards, policies and procedures, necessary protocols, and accreditation.

4. Conceptual knowledge competencies: the adventure therapist's ability to conceptualize and put into practice the models and philosophies of adventure therapy. The adventure therapist should be proficient in the foundations, theoretical models, the change process, the independent and interdependent use of the environment and activities for specific populations and therapeutic techniques.

5. Therapeutic alliance building competencies: the adventure therapist's ability to create an efficacious therapeutic alliance with clients. Competencies in this area include emotional validation techniques, creating a supportive and secure environment, managing counterproductive behaviour in the therapeutic process, building rapport, creating a beneficial and positive connection of trust and confidence in clients' belief of the positive outcomes to follow, and

knowing how to use the natural environment and natural consequences to contribute to the therapeutic relationship.

6. Assessment competencies: the adventure therapist's skill in examining clients' mental health prior to, during, and post treatment. An exemplary adventure therapist will have knowledge and the ability to use the assessment procedures, create multiple theories regarding client response, analyze and interpret data, collaborate with other professionals to confirm assessments and understand the wide range of contributing factors in a client's life.

7. Intervention competencies: the adventure therapist's ability to implement and use treatment strategies to produce positive client outcomes. The competent adventure therapist develops the adventure therapy experience to be a culturally relevant intervention for clients while creating challenges specific to and individualized for clients' needs and integrating client changes into their future development as well as their life outside therapy.

8. Therapeutic monitoring competencies: the adventure therapist's ability to oversee client progress, determine whether the treatment and techniques are effective or if changes are needed, document the process, continually assess the process, evaluate effectiveness and create follow up strategies.

9. Documentation competencies: the adventure therapist's aptness in recording and assessing the entire adventure therapy process. This means recording anything and everything from admissions, where a client's strengths and weaknesses are assessed, to the screening and intake of clients, participant

forms, waivers and medical information as well as progress reports, referrals and termination records.

10. Professionalism competencies: the adventure therapist's ability to meet and surpass the level of professionalism required in the field of adventure therapy. The behaviors of a professional adventure therapist will be culturally and ethically appropriate. The therapist should be competent in empirically based research methods and program evaluation, should adhere to high ethical standards, and continuously pursue personal development and training (Gass et al., 2012).

THERAPIST FACTORS – PROFESSIONAL STATUS

While there is a relationship seen between a therapist's level of training and positive client outcomes, it would be reasonable to assume that professionally trained therapists would produce better client outcomes than "paraprofessional" therapists. A paraprofessional is described as "a mental health care worker, paid or voluntary, who is not formally qualified in the psychological treatment of mental distress" (Cooper, 2008, p. 92). This is an important consideration when looking at adventure therapy practices because, as mentioned earlier, adventure therapists may not be professionally trained in techniques and applications of psychological intervention. For this reason, it can be beneficial to have teams of professionals from different fields come together to meet the requirements needed to provide adventure therapy. For an example, see Figure 3.
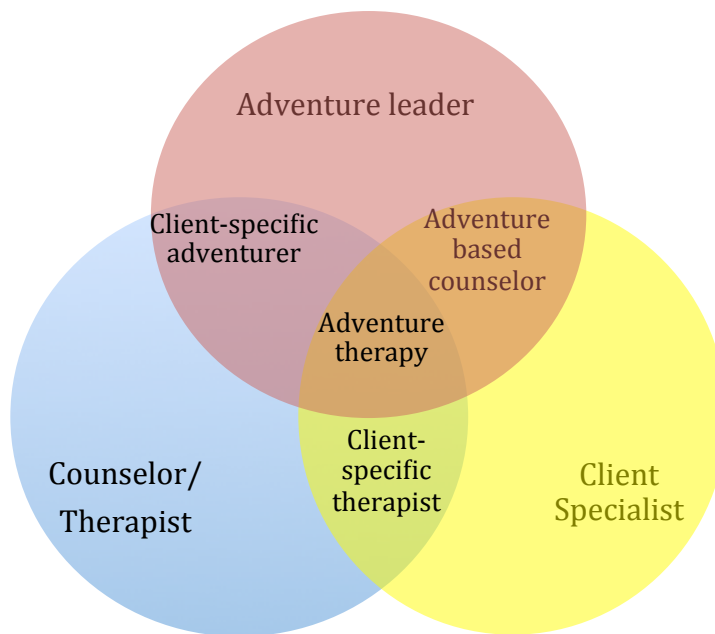
Figure 3. Adventure therapy team make up (Gass et al. 2012).

Let us compare the Enviros Shunda Creek adventure therapy team to Figure 3. The

Shunda Creek program is an adventure-based wilderness treatment program that

addresses addiction-based issues for males aged 18 to 24 years old. Enviros Shunda

Creek adventure therapy team is made up of a program director who could be considered

the adventure leader from Figure 3. This person runs and oversees the overall facility and

adventure therapy process. Next, one main therapist and a part-time therapist, who are

comparable to the counselor/therapist from Figure 3, oversee the treatment aspects. The

rest of the staff are addiction support workers similar to the client specialist from Figure 3

and take care of the delivery system.

Despite the fact that the Shunda Creek adventure therapy team looks as though it

meets the design of Figure 3 made up of specific specialists, Jeff Wilson (2013), the

program director of the Shunda Creek program, says that when hiring employees they

look for generalists. The key attribute is the ability to connect with clients—relationship being the main treatment modality. Enviros staff obviously come with varying degrees and depths of experience in the outdoors as well as the addiction-specific realms. By encouraging generalists, they are looking for staff to constantly be developing professionally and personally. This foremost provides relationship building and role modeling as they work with clients on their own paths of development. Each staff member has additional accreditation courses to do, such as suicide intervention, therapeutic crisis intervention, aboriginal awareness, diversity training, and outcomes training, for example. As well, every staff member must complete 12 professional hours of addiction-specific training every year, hence looking for generalists. Of course, to meet industry standards for the more technical outdoor skills, especially in climbing and whitewater, some staff must have some specialty in addition to those of the generalist.

In early studies examining the connection between professional status and client outcomes, the results show that paraprofessionals were actually more likely to resolve the problems of their clients compared to professionally trained therapists. These findings were disputed when Berman and Norton (1985) claimed that the conclusions were based on inappropriate studies and statistical analyses. They conducted a meta-analysis to provide valid statistical conclusions. Their results showed that paraprofessional and professional therapists were mostly equivalent in effectiveness.

On the other hand, however, there is research to support that clients treated by professionals do better than clients treated by paraprofessionals. For example, Bright, Baker and Neimeyer (1999) compared the outcomes of depressed clients after receiving cognitive behavioural therapy and mutual support group therapy from either a

professional or a paraprofessional. Clients from both groups made equal improvements in symptom reduction. However, there were more clients who received treatment from the professionally trained therapists who were classified as non-depressed at post-treatment compared to the clients who were treated by the paraprofessionals. There is also good evidence in support of professionals specifically trained in mental health compared to more generally trained medical professionals (Cooper, 2008).

There are training programs and certifications being developed in an effort to have qualified professionals with a high level of training and standards in the industry. Of particular note is the Australian Wilderness Adventure Therapy Accreditation scheme created by Neo. This was the world's first accreditation scheme in an annualized, evidence-based treatment called Wilderness Adventure Therapy (WAT). The accreditation scheme is comprised of introduction to WAT courses, psychological first response courses, WAT practicums, intermediate WAT courses, advanced courses in WAT, and exams for adventure facilitators and clinical facilitators (Crisp, 2002; Neo psychology, 2005).

Now that we have looked at client factors and therapist factors individually, we can look at the relationship between the two of them and how this relationship contributes to the therapeutic process.

RELATIONAL FACTORS

Relational factors are the sentiments and attitudes of the client and therapist toward one another. These include the approach that is used to express these feelings. Relational factors are known as important factors in therapeutic success regardless of therapeutic orientation. Contributing to this is the therapeutic alliance, "the quality and the strength

of the collaborative relationship between therapist and client" (Cooper, 2008, p. 103). The therapeutic alliance is seen as one of the significant predictors for therapeutic outcomes (Norcross & Lambert, 2011). Research has shown that the therapeutic alliance is related to continuation in counseling, changes in clients' symptoms and distress. It has also been rated as a demonstrably effective component of the therapeutic relationship along with cohesion in group therapy, empathy and goal consensus, and collaboration (Ackermen et al., 2001).

Bohart and Tallman (1999) found that clients viewed the relational factors as the most important aspects of therapy. This includes having a place and time to talk with someone who listens, cares, understands and is capable of giving support and advice. This may be contributed to the client feeling relieved after emotionally unloading whatever has been troubling them. These relational factors are frequently evident in relationally oriented or humanistic therapies such as client-centered therapy. They are also just as important in non-relationally oriented therapies such as cognitive behavioural therapy. Also, from a client's perspective an equal power balance, in which the client and therapist work together, is perceived as being helpful. There are fewer dropout rates when the therapeutic alliance is perceived as being positive. Some research shows that it is particularly important to build a strong collaborative relationship early in the therapeutic process (Cooper, 2008).

RELATIONAL FACTORS – GOAL CONSENSUS AND COLLABORATION

This aspect of the therapeutic relationship, the mutually laid out goals and expectations of the therapeutic process, relates to the therapist–client agreement,. Client and therapist agreement of therapeutic goals has been related to positive outcomes and

client satisfaction. On the other hand, if there is disagreement regarding goals, and a failure to be open and to discuss the roles and expectations of the therapeutic process, it is related to client dissatisfaction (Cooper, 2008). Also, as previously mentioned, Ackermen et al. (2001) included goal consensus and collaboration in the demonstrably effective components of the therapeutic relationship.

CORE CONDITIONS OF CHANGE IN THE THERAPEUTIC RELATIONSHIP

Carl Rogers described six necessary and core conditions for therapeutic change to occur. These conditions are present within the therapeutic relationship (Corsini & Wedding, 2011). They include:

1. Therapist-client psychological contact. A relationship must exist between the therapist and client, a relationship in which each person is important.

2. Client incongruence. Incongruence must exist between the clients' experiences and their awareness. These include feelings of anxiety and tension which will motivate them to stay in the relationship.

3. Therapist congruence. The therapists' experiences must match their awareness, meaning the therapist is able to trust his own feelings, making the therapist deeply involved in the relationship, not faking it. This allows for the therapist to be open and model.

4. Unconditional positive regard from the therapist. The therapist accepts the client without judgment, disapproval or approval and accepts the client for who they are. This is used to counteract any conditional worth the client has received in the past.

5. Therapist empathic understanding. The therapist is able to put himself in the shoes of the client, providing the therapist with a cognitive and effective frame of reference. Accurate empathy helps the client see the therapists' unconditional positive regard.

6. Client perception. The client comes to perceive that the therapist is congruent, genuine and is showing unconditional positive regard and empathy.

Research looking at these necessary conditions described by Rogers suggests a strong relationship between empathy and outcomes. A therapist's empathic understanding may actually be more related to positive outcomes than specific techniques and even therapeutic alliances (Bohart, Elliot, Greenberg & Watson, 2002). Also from clients' perspectives, a therapist's empathic understanding is rated as one of the most helpful elements. Paulson and Worth (2002) used "concept mapping" to enhance the understanding of what was helpful in counseling. The clients described what therapeutic processes they believed contributed to overcoming their suicidal thoughts and behaviours. Clients rated being understood by their therapist as one of the four most important aspects contributing to their positive outcomes. "The existence of empathic and validating relationships was identified as a critical factor for clients" (p. 89).

Other notable conditions of change described by Cooper (2008) include self-disclosure and feedback. A therapist's self-disclosure is the therapist being open and real with their clients. This is controversial because, on the one hand, some practitioners feel that sharing statements that reveal something personal about the therapist is unprofessional and should not be involved in the therapeutic process. On the other hand, self-disclosure has been credited with building and enhancing the therapeutic

relationship. In relation to therapeutic outcomes, self-disclosure has been seen to significantly decrease symptom distress in clients. Feedback is the information that therapists provide to their clients, reflecting their behaviour and the effects of their behaviour. There are four types of feedback seen in therapy as described by Claiborn, Goodyear, and Horner (2002).

1. Observation or description of clients' behaviours.

2. Emotional reactions to client behaviours.

3. Inferences about something not directly observable.

4. Mirroring, providing clients with a sample of their behaviour.

Feedback research has shown that when clients are provided with precise feedback on performance, their rates of improvement were dramatically increased. Rapee and Hayman (1996) found that when clients were able to view themselves on video, they could make more positive assessments of their performance.

THE THERAPEUTIC RELATIONSHIP IN ADVENTURE THERAPY

The therapeutic alliance has been demonstrated to be an important part of psychotherapy for treatment outcomes. Thus, it makes sense that it is also an important element contributing to the process of change for clients in adventure therapy. The therapeutic relationship in an adventure therapy setting is unique because of the many different conditions created with the use of adventure activities. It has been reported that there is the potential for the therapeutic relationship to be developed more quickly and more powerfully in adventure therapy than in other therapeutic methods (Gass et al., 2012).

One reason the therapeutic relationship in adventure therapy is unique is the amount of time the client and therapist spend together. Instead of the typical 60-minute sessions conducted in an office, in adventure therapy the client and therapist are spending multiple days on end together, participating in the regular day-to-day experiences that are a part of a wilderness-based trip. When the design of an adventure therapy program such that the clients are out in the wilderness, hiking or canoeing for a month, the therapist and client are together almost constantly; this would constitute 360 hours of therapeutic contact, assuming an average of 12 hours of the day are spent together for approximately 30 days. Of course, it is not only the amount of time that a client and therapist spend together that contributes to a strong therapeutic relationship; it does, however, provide plenty of opportunity for the relationship to develop.

A second reason why the therapeutic relationship is unique in adventure therapy is the type of contact that is created between the client and therapist. When the therapist and client are together days on end, it allows the therapist to observe the client and the client's behaviors' in real life situations and often in strategically designed scenarios to stimulate certain behavioral patterns and emotional responses. Such scenarios create an opportunity for the therapist to detect what these responses and patterns are, and another opportunity to immediately address them.

The client also has the benefit of a unique experience that may not be present in traditional psychotherapy. That is, the client is able to see the therapist in a different light, meaning they are capable of viewing the therapist as a real person rather than only seeing them as a title, "the therapist," and the preconceived notions that are attached to it. This can help equate the client and the therapist; the client can observe how the therapist also

struggles in situations, how they face challenges, become frustrated and communicate with others. This could constitute a modeling process (Gass et al. 2012).

A third dynamic that contributes to the strong therapeutic relationship in adventure therapy is fact that clients and therapists often will need to work together in the adventure activities. Continuing with the example of a month-long adventure therapy canoe trip, the client and therapist must work together to safely navigate across the waterways. They both need to contribute and learn to live together over an extended period of time, often in situations that are less than pleasant or in activities where trust is essential. These unique factors contribute trust and mutual respect, which are fundamental in a powerful therapeutic relationship. The therapeutic relationship and its effect on outcomes is quite a new area of study in the field of adventure therapy. The previously mentioned study by Russell (2008), which looked at outdoor behavioural health care programs for treating adolescent substance abuse, found the therapeutic relationships to be perceived as strong by the clients because of the trust and the competency of the therapist.

CORE CONDITIONS OF CHANGE APPLIED TO ADVENTURE THERAPY

Therapists and leaders of the adventure therapy experience must be capable in facilitating the development and change of their clients. As Rogers has mentioned, there are six conditions necessary for therapeutic change to occur. Therefore, it becomes the responsibility of the therapists in adventure therapy programs to contribute their half of the necessary conditions in the therapeutic relationship. This means the therapist must help create a relationship between the client and themselves, they must be congruent, show unconditional positive regard and be empathic.

Walsh and Golins (1976) support that in adventure therapy, the therapist "requires the ability to be empathic, genuine, concrete and confrontive when necessary" (p. 11) as well as demonstrate the qualities of "reflection, openness, esteem and acceptance of others" (p. 12). Though the words are not exactly the same, they do seem very similar to the necessary conditions described by Rogers and the other relational factors in traditional psychotherapy. For an example, see Figure 4.

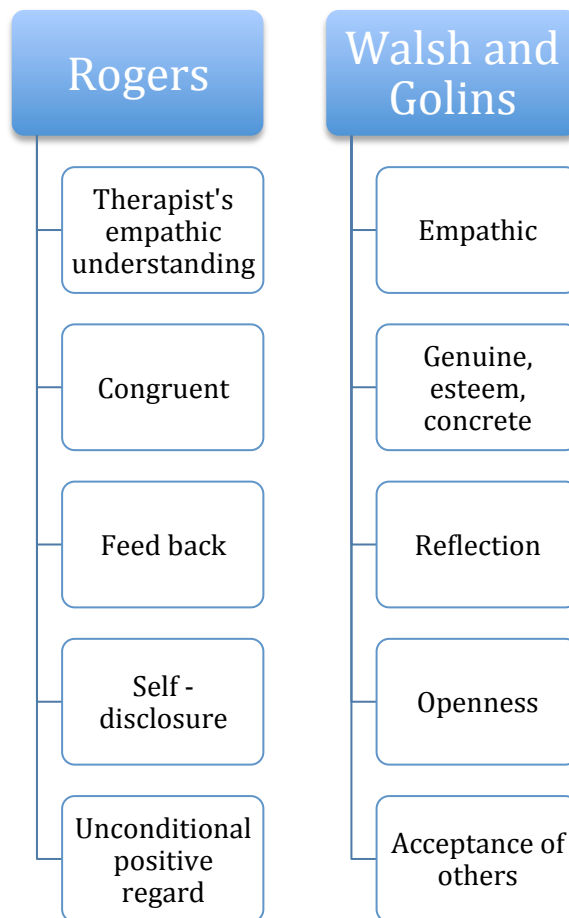| Rogers	Walsh and Golins
Therapist's empathic understanding	Empathic
Congruent	Genuine, esteem, concrete
Feed back	Reflection
Self - disclosure	Openness
Unconditional positive regard	Acceptance of others

Figure 4. Comparing relational factors of Rogers to Walsh and Golins.

Again a key factor is that in adventure therapy, a client and therapist are not only together for therapy sessions but also in the daily routines involved with wilderness trips. A unique opportunity for the client to see the therapist as congruent, genuine, and

showing unconditional positive regard in normal interactions is provided, as opposed to the therapy session where clients may feel the therapist is pretending to be genuine because it is the therapist's job. Situations where a therapist and client share experiences, such as enduring a 24-kilometre hike in the pouring rain, provide the therapist with the opportunity to model behaviours, emotions and cognitions, which in turn contribute to their congruence and genuineness (Gass et al., 2012).

The extended time period in adventure therapy can also help the development of unconditional positive regard. The extended time periods as well as the group living situations in wilderness environments provide the therapist with an opportunity to monitor behaviours and interactions of the clients. By observing the clients first-hand, therapists can develop a full understanding of the circumstances connected to client behaviours and emotions. Gass et al. (2012) believe that these conditions help facilitate therapists' unconditional positive regard for clients because "assumptions do not need to be made to address certain therapeutic issues" (p. 85).

The same can be said for empathy. With the almost constant interaction between the therapist and client, a therapeutic moment can present itself at any time, not just during specifically scheduled times. This means, for one, that the therapist must constantly be ready for such moments in order to make them relevant and meaningful. Secondly, it creates a good and instantaneous opportunity for the therapist to demonstrate empathic understanding.

Finally, the natural environment provides a great environment of concreteness. Carl Rogers described concreteness as the therapist's ability to focus the client on specific and distinct events, thoughts and feelings, instead of abstract and generalized ones (Singh,

2007). Concrete therapeutic experiences allow the client to relate the learning and transfer it to their daily lives. The wilderness offers a great environment for concrete experiences because it is a very physical environment, where the action–reaction response is instantaneous. When the activity is something such as rock climbing, the rock face is there to be climbed, and this is very straightforward. If a client is struggling with the task of climbing and begins to catastrophize the event, assuming conclusions that they are a failure at life and have no skills that are applicable to accomplish anything, the therapist can jump in immediately to challenge this kind of thinking. The therapist takes the opportunity to explain how they themselves learned the technique of a skill such as rock climbing, outlining that the client may not learn the skill immediately, showing them examples of people who have spent years of practicing, and explaining that it is something that must be continually worked upon. Such challenges can be related and compared to the clients' daily lives as well as their past, where they have skills and have accomplished things by working at them.

In summary, this section has demonstrated the importance of having quality therapeutic relationships wherein the therapist and the client can agree and work together on goals, and where the therapeutic process has been related to positive therapeutic outcomes. The ability of the therapist to contribute to congruence, empathy and positive regard in the therapeutic relationship has also been demonstrated to be valuable in the development and maintenance of quality therapeutic relationships. Next, the techniques of therapy will be explored; that is, what therapists do and the way they do it.

TECHNICAL FACTORS

Technical factors are the techniques and practices used by therapists in treatment. Techniques can be described as the deliberate methods that therapists use in order to reach a specific goal or produce specific outcomes. The technical factors are being included as part of the common factors seen in bona fide psychotherapies because bona fide psychotherapies use well planned and thought out techniques. However, it is important to consider that often, specific techniques being used are synonymous or closely related to specific therapeutic orientations.

Cooper (2008) points out how "evidence in support of specific techniques tend to support the differential effectiveness position rather than the dodo bird one" (p. 128). Even so techniques are important factors of treatment. The value of what a therapist does can be seen throughout numerous comparative studies looking at specific techniques. For example, studies which compare an experimental group (where clients are exposed to the specific therapeutic techniques) and a control group (where the clients are not exposed to the techniques) show that clients in the experimental groups make significant improvements when compared to the clients in control groups (e.g., Gloaguen et al., 1998; Hollon & Beck, 2004).

Still the question as to which specific techniques are best employed or which are most effective is debated. Psychotherapy research demonstrates that even within therapies known to be effective, there are minimal differences between the efficacies of the specific techniques used (Cooper, 2008). Furthermore, Ahn and Wampold (2001), using component studies to examine specific aspects of therapy either by adding or

removing a specific technique, have shown that using or not using specific techniques does not make a significant difference on the therapeutic outcomes.

Despite the fact that many techniques are specifically related to certain forms of therapy, there are also generic techniques and practices used across all therapeutic orientations which contribute to client outcomes. One important technique used in all forms of psychotherapy is case formulations.

CASE FORMULATIONS

All psychotherapies will begin with a case formulation. Each case formulation is individualized to every client. This is important to consider because some techniques may be more effective with some clients than with others, and case formulations help identify a client's specific psychological problems, thus allowing for better patient–treatment matching. Case formulations are useful in building an individualized treatment plan for each client, describing what interventions to use. They function as a blueprint to guide psychotherapy, they help in symptom reduction, prevent relapse and remove obstacles to more effective functioning. The roles of case formulations are to:

- Understand relationships among problems, because there is usually more than a single problem and they are interconnected.

- Choose a treatment modality, the paradigm or school of thought that will be used in treatment.

- Choose an intervention strategy.

- Choose an intervention point. From a full understanding of the client it is possible to determine where the problems develop and find a point to start from.

- Predict behaviours. Based on the theories of personality, the origin of the problem, and the client's characteristics, behaviours can be predicted; that is, how they should react to what treatment/techniques and what blocks they may try to put up.

- Understand and manage non-compliance based on the school of theory being used.

- Understand and work on relationship issues, based on the school of thought being used.

- Make decisions about extra therapy issues, for example if a client does not pay.

- Redirect unsuccessful treatment. If treatment is not working, the clients' best interests should be kept in mind and they should be redirected as necessary (R. Webster, personal communication, September 5, 2012).

Case formulations are designed to gather as much information as possible to provide a full and holistic picture of the client. The therapist uses case formulation to create a description of the client. The therapist elicits the presenting complaints, why the patient is coming for treatment at this time, and what are their major concerns. The therapist will try to determine how they think, feel and behave. The therapist will look for the date of onset; when did the problem arise? Have there been multiple occasions? Particular attention should be given to the most recent onset. What are the precipitating events? What was happening when the problems started; what were the circumstances at the time? What are the predisposing causes? The therapist will look at family history, past experiences and any medical issues. From this, the therapist will develop an

explanation of the central problems; what are the origins of the difficulties and the hypothesized mechanisms of the problem? They will try to determine what the defenses will be; what are the defense mechanisms or any resistance that may need to be addressed? From the case formulation, the therapist can determine the conditions for which help is needed, addressing specific problems. Then, the treatment goals can be made, and it will be decided what type, intensity and frequency of treatment will be used and what the plan of action will be, providing the client with a sense of what will happen and identifying the sequence of treatment. Case formulations are also useful for determining the criteria of progress, deciding on what signs will indicate progress; will they be subjective or objective? Case formulations may not provide information on everything and there could be unanswered questions or information that the therapist still wants to collect. Thus, case formulations can constantly be updated as treatment progresses (R. Webster, personal communication, September 5, 2012).

Adventure therapy programs should include case formulations as a necessary technique in the process of treating clients effectively. This is supported in the literature by Cline (1993) and Tippet (1993), who state that adventure therapy programs need to assess clients before accepting them into treatment. These assessments can be used to match the strengths of the programs with the requirements of clients. This is key to providing effective treatment especially because some adventure therapy programs are not designed to work with clients presenting certain problems while others specialize in working with specific clients.

CASE FORMULATIONS IN ADVENTURE THERAPY

Gass and Gillis (1995b) have described a model know as *CHANGES* as a way to obtain client information and review it in such a way so it can be used to enhance the positive development of the client. The acronym *CHANGES* can be broken down into:

- Context

- Hypothesis

- Action

- Novelty

- Generating

- Evaluation

- Solutions

This model seems to share the same or similar elements seen in psychotherapy case formulations including diagnosis, treatment design/plan, delivery, continuous evaluation and proper termination/debriefing. Looking at the context, this is where the therapist needs to be gathering as much information about the client as possible. Why are they coming to treatment? Why now? What are their goals? Gass et al. (2012) state that the therapist should go even further in this part of the model by asking questions such as "am I competent and am I able to be competent with this client or group given the parameters of the situation" (p. 139). Once there is a well-developed understanding of the context, adventure therapists can create a plan of action and speculate about what can be expected from the client in certain situations, or with specific techniques. The action stage of this model is where therapists can implement the treatment plan based on the information they have gathered in the two previous steps. Therapists are able to see if clients'

responses and actions are what were expected in the hypothesis. The novelty part of the model is an aspect that is used to develop a deeper, more realistic understanding of the client; this creates a situation where the client does not know the socially accepted way to act. This provides the therapist with more information on a client's true behaviour, feelings, and ways of thinking. Next comes generating, where, from observing the clients responses from the action and novelty of the *CHANGES* model, they can establish behavioural patterns, thinking patterns, and functional or dysfunctional emotional responses.

When the observations have been made they can be evaluated; that is, they are assessed and a plan can be developed on what actions need to be taken next to lead to the clients' positive development. Lastly, when complete evaluations of the clients' issues are determined, the therapist can develop solutions to manage such issues. The *CHANGES* model is not a one-time technique to evaluate clients but rather a continuous process throughout treatment. As more information is gathered, new hypotheses are developed and re-evaluated so appropriate actions can be taken (Gass et al., 2012).

OTHER GENERIC TECHNIQUES

These are some of the techniques, along with case formulations, that are found across all established psychotherapies and, therefore, should also be used in adventure therapy programs. First, let us explore the technique of listening and, even more, active listening. The term "active listening" can be defined as genuinely participating in trying to hear and understand what is being communicated. This can be contrasted to passive listening in which the listener accepts what is being said without actively responding and partaking in the communication; the listener is non participative.

Rogers and Farson (1979) demonstrate how "active listening is an important way to bring about changes in people" (p. 1), saying how it is effective for individual personality change as well as group development. Listening can strengthen the therapeutic relationship, which is one of the reasons why it may be an effective technique (Cooper, 2008). To be effective at active listening, Rogers and Farson (1979) suggest avoid passing any judgment, regardless if it is positive or negative. This is because judgment can make it difficult for the client to freely express himself or herself. However, they do suggest a therapist should respond in such a way that shows the client that they have heard and understand what's being said. The therapist must be capable of responding to feelings; that is, they must be able to determine the feeling of what is being said, not only the content. Finally a good active listener will not only hear the verbal communication but also pick up on other cues. These can include facial expressions, body language, or the way in which clients are expressing themselves; for example, are they hesitant or distracted?

Next we can look at paraphrasing, which may be considered an aspect of active listening. It is a way in which the therapist can demonstrate to the client that they understand what is being said. Paraphrasing is a technique in therapies that, apart from listening, is probably the most used. From both a client's perspective as well as a therapist's, research has shown paraphrasing to be one of the most helpful ways to respond. However, there has not been any substantial proof that paraphrasing improves therapeutic outcomes (Cooper, 2008).

Another technique, which has been seen to contribute to the positive outcomes in therapy, is encouragement. This may be due to the relation between outcomes and what

clients expect to gain from therapy. Again, clients rate encouragement as being an important aspect of therapy (Cooper, 2008).

It can also be seen that the common components in social skills training and problem solving techniques are applicable to the technical factors contributing to positive outcomes. These include providing instructions—letting the client know what they will be doing and the value of it; modeling—where the therapist models appropriate behaviours, responses or how to perform a certain task; role-playing and rehearsal—where controlled situations can be set up in order to practice specific skills; praises and prompts—which may be similar to encouragement; coaching and providing feedback about what's working and what's not as well as finding where improvements can be made; and homework assignments. Homework assignments are specifically designed tasks for clients to engage in between sessions. Some examples of homework assignments may include "practicing relaxation exercises, confrontation feared situations, keeping a journal or practicing interpersonal skills" (Cooper, 2008, p. 149).

Research looking at the effects of homework on therapeutic outcomes shows support for its use. Hlavaty, Brown and Janson (2011) examined the relationship between the participants' treatment engagement through the completion of homework on treatment outcomes. They found that when clients completed all of the homework assignments they made greater improvements in role, social and mental health functioning. Even though such techniques may be highly evident in cognitive behavioural therapies, they are easily incorporated into many other forms of therapy.

SPECIFIC TECHNIQUES USED IN ADVENTURE THERAPY

Within adventure therapy programs, the approach tends to be a behavioural form of intervention. The behavioural approach uses the physical environment and the social environment to create psychological and routine consequences for the clients' inadequate or inappropriate behaviours. The theory is that clients will assimilate new behaviours, attitudes and problem solving skills. These are accepted and will be continued when they complete the program (Miles & Priest, 1999). Even though behavioural techniques lend themselves easily to adventure therapy, most programs use a multidisciplinary approach applying aspects from different psychological orientations, including cognitive therapy techniques and humanistic techniques (Gillis & Ringer, 1999).

The behavioural techniques are based on the learning principles of classical and operant conditioning. Behavioural techniques attempt to address clients' current problems by dealing with the contemporary environmental forces that maintain them. Behavioural approaches may use techniques such as self-monitoring, which is a way to keep track of how often a behaviour occurs. This also allows the client to observe the consequences of the behaviour or emotions. Another technique is to get clients using skills that they may lack and teach new productive behaviours to replace harmful ones (Wade, Tavris, Saucier & Elias, 2012). Solely using behavioural techniques has been criticized for ignoring the relational factors including judgments for not talking with clients, not developing awareness or insight into the problems, or not concerning themselves with how clients feel (Masters, 2004). However, using behavioural techniques does not mean the therapeutic relationship must be disregarded; instead, it is used to aid therapy in creating

a supportive and productive context (R.Webster, personal communication, October 29, 2012).

Cognitive techniques are closely related to behavioural techniques and are often used together. This is because, like behavioural techniques, cognitive techniques are learning-based and educational in style. As described by Aaron Beck, the origins of a person's psychological problems are their learning history and early life experiences (Morris, 2003). Cognitive techniques are established on the idea that in order to change dysfunctional personal characteristics, core beliefs that predispose the person to future distress must be modified, and irrational and unproductive ways of thinking need to be identified and changed. This is accomplished with the help of the therapists' teaching clients how to replace thinking errors with reasonable thoughts. (R.Webster, personal communication, November 14, 2012).

There are various cognitive and behavioural techniques. Of particular note are those that have been associated with positive therapeutic outcomes. These include exposure techniques, which are based on extinction (the un-training of a conditional response). Exposure techniques are when the therapist intentionally puts the client in situations that create fear or anxiety. This is done in order to teach the client that they are capable of coping with the situation and the fear affiliated with it. Exposure techniques are known to be highly effective for anxiety-based problems, as well as for treating obsessive-compulsive disorders and panic disorders (R.Webster, personal communication, November, 14, 2012). Forms of exposure techniques include:

- "In vivo (in life): actual exposure to the feared situation.
- Imaginal: actively visualizing the feared situation.

- Virtual reality: simulated exposure, for instance through a flight simulator.

- Interoceptive: generation of bodily symptoms (e.g., feelings of choking, dizziness) that accompany the feared situation.

- Exposure and response prevention: in addition to exposure, encouraging clients to resist from engaging in ritual or compulsive behaviours (such as checking and re-checking that they have locked their front door).

- Cue exposure: exposure to stimuli associated with substance-use behaviours (for instance, presenting a problem drinker with a whiskey bottle), while addressing and attempting to reduce their desire to use.

- Systematic desensitization: general exposure to a feared stimulus, generally in imagination while in a state of deep muscle relaxation" (Cooper, 2008, p.130).

Other behavioural techniques include reinforcement and punishment. Reinforcement is supposed to increase behaviours, while punishment is supposed to decrease behaviours. These can both be negative or positive. When behaviour is followed by a positive outcome, the behaviour becomes more likely; when behaviour is followed by a negative outcome, it will become less likely. Therapists may also use:

- Time outs: the client is removed from the situation that is reinforcing the undesired behaviour and makes sure not to relate it to the clients' personality.

- Grandma's rule: the client is required to engage in a less desirable behaviour before they can take part in a more desirable behaviour. A higher-level behaviour is used to reinforce a lower-level behaviour.

- Token economies: getting clients to participate in behaviour for a token.

- Contingency contracting: a contract is created describing what will happen if the client engages in a certain behaviour or fails to engage in a certain behavior.

- Shaping behaviour: this is a way to get clients to learn a whole new behaviour. This is done by rewarding behaviour that approximates the target behaviour. A list of successive approximations to the target behaviour is created. Then the list is worked through to accomplish each aspect by positively reinforcing it until the frequency is stable (R.Webster, personal communication, October 29, 2012).

The cognitive techniques that are related to positive therapeutic outcomes include Socratic dialogue, which are questions designed to help the client identify their automatic thoughts that influence behaviours and emotions. By doing this, the clients' thinking, self-awareness, and ownership increases. They can then be helped to evaluate the costs of maintaining these thoughts. Other cognitive techniques include guided discovery, which is the process of the client changing maladaptive thoughts, with the therapist acting as the guide. Together with the therapist, the client works on gaining new skills and is pushed out of their comfort zone. Automatic thoughts are directly challenged with evidence or analyzed logically. De-catastrophizing, or the what-if technique, where the client learns to lessen the catastrophizing thoughts by learning realistic ways of talking to him- or herself, is helpful in decreasing avoidance when combined with coping skills. Additionally, the technique of reattribution is used to help the client find new reasons for why things happened by challenging and then replacing the dysfunctional thoughts with realistic ones. Furthermore, redefining is a technique used to mobilize the client, showing

them that they do have control over their problems. Finally, de-centering is used to show clients that they are not the focal point of everyone else (R.Webster, personal communication, November 14, 2012).

There is research supporting these cognitive techniques, which identify and challenge clients' dysfunctional beliefs. These techniques have been seen as important and contributing to clients' positive outcomes, especially for clients with depression as well as other psychological problems (Cooper, 2008). Interestingly a study by Marks, Lovell, Noshirvani, Livanou, and Thrasher (1998) demonstrates that the value of cognitive techniques appears to be comparable to the use of behavioural techniques. Furthermore, the addition of cognitive techniques made no difference on the effectiveness of a behavioural approach and vice versa. Thus, the combination of the two may not be necessary.

Adventure therapy programs also use rational emotive behaviour techniques, such as those conducted by Albert Ellis. These techniques are a way in which the clients' unrealistic thoughts are challenged using rational arguments. Some of these techniques are similar to the cognitive–behavioural techniques such as role-playing, desensitization, humor, operant conditioning, suggestion and support. These techniques are used to target and to dispute irrational beliefs. The client learns to actually challenge their irrational beliefs and substitutes or replaces them with rational beliefs. This must be practiced repeatedly so the rational beliefs become automatic. These rational beliefs must be assimilated in order for the client to respond effectively to activating situations (Corsini & Wedding, 2011).

Even humanistic techniques are intertwined in the use of adventure therapy programs. Humanistic techniques emphasize the here and now. A big part of the humanistic techniques include the techniques previously mentioned which contribute to the therapeutic relationship, such as using unconditional positive regard and providing empathy. Client-centered techniques are based on the belief that the person seeking help is the best judge of the direction that will lead to growth. The goal of such techniques is to help the client be free to experience whatever their inner inclinations point toward and to foster self-actualization (Corsini & Wedding, 2011).

This brings up an interesting issue of taking a non-directive stance, where the therapist will try not to direct their client in any particular way. However, as seen in Cooper (2008), there does not seem to be any research exploring how this non-directive technique relates to therapeutic outcomes. This is because the definition of non-directivity is seen as an attitude, making it difficult to be empirically tested. Yet there is evidence on the relative benefit of using directive or non-directive techniques. Overall, the findings are split with some supporting directive techniques, compared to a non-directive control group, while others have proved established non-directive therapies to be as effective as directive therapies (Cooper, 2008).

UNIQUE TECHNIQUES TO ADVENTURE THERAPY – NATURE

Some authors in the field of adventure therapy have argued that nature is the key therapeutic influence in adventure therapy programs that take place outside. Even if this is not the case, nature does play a unique role in adventure therapy and it provides important implications. There has been an increasing growth of literature regarding the

argument that a growing separation between people and nature is negatively impacting our overall health.

Louv (2006) discusses a concept he calls nature deficit disorder, which is described as the human cost of alienation from nature. Among the costs are a diminished use of the senses, attention difficulties, and higher rates of physical and emotional illnesses. One woman Louv interviewed on the subject of nature deficit disorder said, "we've become a more sedentary society" (p. 11). Evidence of nature deficit disorder and the sedentary society that contributes to the disorder can easily be seen by looking at the epidemic of children who are considered overweight and obese (Louv, 2006). Evidence is also seen with the number of children that are now being diagnosed with attention deficit disorders, type 2 diabetes, and other psychosocial problems (Louv, 2006).

Adventure therapy creates an opportunity where the effects of using nature for therapeutic means can be researched and evaluated. It is interesting to see that one of the reasons why nature works therapeutically is because in our western industrialized society, it seems we are continuously being drawn away, isolated and protected from the natural environment, meaning we are missing out on the health benefits associated with it. It would make sense that reconnecting people with nature would naturally have a restorative, healing effect on humans. Gass et al. (2012) describe how people are reacting to this separation as a "projection of their suppressed unconscious needs and desires to reconnect with nature" (p. 99). This idea is grounded in the work of Edward O. Wilson (1984) who believed that the natural environment has become a hard-wired aspect of humans' cognition and affect because of the millions of years spent adapting and

surviving in the natural environment. In today's day and age, where humans are more alienated from the natural environment, they feel a longing to be connected with nature.

The way in which therapists use nature begins with eliminating the stimulations of everyday life. Research shows that people who visit natural areas do so to get away and feel a sense of escape. This helps reduce what Kaplan and Kaplan (1999) call mental fatigue. The natural environment is used as a milieu for change in the therapeutic process. Louv (2006) states that some of the utilitarian values of nature are that "nature offers healing for a child living in a destructive family or neighborhood and nature inspires creativity in a child by demanding visualization and the full use of the senses" (p. 7). Adventure therapy uses the challenges of the natural environment. These challenges can then be used to create a metaphor for the problems individuals face and the challenges can be connected to the clients' natural world. This connection with the natural world can deepen the personal growth of participants and lead to positive therapeutic outcomes. With proper facilitation, nature can be used to change the effects of alienation from nature that are restricting the person from living a full and healthy life.

There is evidence that supports the therapeutic abilities of nature to restore physical, psychological and emotional development. In a study by Chalquist (2009), therapies that use the natural environment were examined. These included horticultural therapy, wilderness excursion work, time stress management, and animal-assisted therapies. The evidence shown in this study suggests that using the natural environment does, in fact, contribute to clients' positive outcomes. The positive outcomes are contributed to spending time in the natural environment. Through reconnecting with the

natural environment, clients are also reconnecting with themselves and each other (Gass et al., 2012).

UNIQUE TECHNIQUES TO ADVENTURE THERAPY – RISK

The technique of using risk where it is perceived or real is an important aspect in adventure therapy. First of all, what is risk? Risk has been defined in many different ways. Curtis (2007) provides a good working definition which can be applied to risk in adventure therapy. He says "risk is both the potential of losing something of value and also the potential of gaining something of value" (p. 2). This definition provides us with an understanding that someone's actions or inactions can lead to either positive or negative outcomes. Risks are inherent in adventure activities, meaning they are essential to the activity; if risk was removed it would no longer be adventure. For example, "whitewater rafting cannot happen without running whitewater. Heli-skiing only happens in avalanche-prone terrain" (Jackson & Heshka, 2011, p. 27).

It is important to realize that the risks involved in adventure therapy are not only physical; they include social and emotional risks. When these risks are applied appropriately they can promote interpersonal and intrapersonal relationships for clients (Bosch & Oswald, 2010; Gillis & Ringer, 1999) and can lead to positive functional change. Appropriately using risk in adventure therapy requires being skilled at properly managing what risks, and the number of risks, clients are exposed to. On one hand, too much risk can be harmful; on the other hand, not enough risk may limit achieving the desired effect. Thus, the therapist must be competent at tailoring the physical, psychological, emotional, and social risks to each individual client or group. Interestingly, clients do not actually have to be exposed to risks in order to achieve the

desired effects. In fact, the perception of risk can often be enough to motivate clients to change dysfunctional behaviours or develop new perspectives (Gass et al., 2012).

DISCUSSION

In this study, I attempted to explore what the elements in established therapies are, how these elements contribute to the therapeutic process and lead to positive changes in clients' lives, as well as whether or not these elements could be found in adventure therapy, thus providing support for the field of adventure therapy as an established and legitimate form of therapeutic treatment. It was found that the principles of change that contribute to the therapeutic outcomes in clients included client factors, therapist factors, relationship factors and technical factors. These elements were found to be important aspects in bona fide forms of psychotherapy, regardless of the theoretical orientations.

From exploring the field of adventure therapy, it does seem reasonable to say that adventure therapy shares common factors found throughout established psychotherapies, yet there is still a lack of standardization similar to what is found in bona fide psychotherapies. The lack of such standardizations and governing bodies to monitor those who practice adventure therapy can be harmful to establishing the field as an equally legitimate form of mental health treatment. The ways in which adventure therapy contributes to these common factors has also been recognized. For example, as with client factors and, in particular, motivation, the use of adventure activities which are fun and novel may increase a client's motivation compared to traditional therapeutic activities. Adventure therapists, like all therapists, must consider the question posed by Paul (1967) "What treatment, by whom, is most effective for this individual, with that specific problem, under what circumstances?" (p. 111).

In studying adventure therapy it was determined that therapist factors are important in creating psychological change. As mentioned, competence, training and clinical experience are key therapist factors. Historically in adventure therapy, however, this has not been the case. Little formal training in mental health was seen. Thankfully, today, standards are being formulated to insure the competence of adventure therapists. This includes being competent in both the mental health field as well as the outdoor adventure field.

The relational factors may be closely considered with therapist factors, as the therapist must be capable of contributing the feelings of warmth, care and openness. The client factors are also important aspects that adventure therapists must take into consideration. Depending on the client, their specific problems, and other contributing factors, the therapist can make decisions about which approaches to take, including specific techniques. The beauty of adventure therapy is that it does not exclusively practice psychodynamic approaches, humanistic approaches, or any of the other psychotherapy techniques. It is possible to apply any one of these approaches, or all of them, to adventure therapy.

ISSUES WITH BEING CONSIDERED EQUAL

From reviewing the literature, there seems to be an agreement that there are truly some benefits that could be derived from using adventure therapy. Yet, the field as a whole has a lot of work ahead of it if it wants to go through a renaissance and reach a point where it is recognized as a common practice for treating mental health issues. One of the major weaknesses includes the lack of consensus amongst definitions; it is difficult to communicate to others what is done in adventure therapy. The lack of definitions

creates a bad reputation for the field of adventure therapy, because people do not understand the therapeutic intentions and practices, and there is confusion with what is done in the programs. This misinformation leads to people associating adventure therapy programs with boot camps or scared straight programs, which, in turn, weakens the field's reputation and creates stereotypes of adventure therapy programs as being scary (Gass et al., 2012).

Adventure therapy also has a weak research base and a lack of researchers within the field. When comparing adventure therapy to other modalities, there are minimal empirically supported research results and a lack of ongoing projects. The professionals in the field are not contributing to the advancement of the field, evidenced by a lack of empirically sound research being conducted and the same points continuously being argued with no evidence supporting them or testing their validity (Gass et al., 2012).

Another big area of weakness in the field of adventure therapy in comparison to the field of psychotherapy is a lack of licensed programs and a lack of regulating/governing bodies. Adventure therapy programs are not being held to levels of standardization, and lack regulation for what is acceptable and unacceptable when practicing adventure therapy (Gass et al., 2012). In the overall health care field and, specifically, the field of psychology, there are governing bodies and associations that oversee health and social care professions, and they ensure those who are providing such care meet the professional standards. Of note are the Canadian Psychological Association (CPA), the American Medical Association (AMA), the American Psychological Association (APA), the Health and Care Professions Council (HCPC) and the National Association of Social Work (NASW). In Canada, to practice psychology, like all other health care professions,

requires being licensed. The CPA recommends, "when considering the services of any professional, it is always wise to seek the services of someone who is licensed" (CPA, 2013). Being licensed in Canada helps protect the public by ensuring that the professionals have met the standards and are accountable for their practice (CPA, 2013). The professional organizations in the field of adventure therapy, such as the Outdoor Behavioral Healthcare Industry Cooperative (OBHIC), the National Association of Therapeutic Wilderness Camping (NATWC) and the Association for Experiential Education, fall short of being the licensures and governing bodies compared to the AMA (Gass, et al. 2012). The lack of staff adequately trained in mental health can be directly linked to the need for such organizations. As it has been mentioned, there are many programs that say they are offering adventure therapy, yet their program staff are not trained to the same levels as those providing traditional therapy and are not licensed to do so (Gass et al., 2012).

THE PATH TO BETTER ADVENTURE THERAPY

There is no doubt that adventure therapy has its weaknesses, but the biggest issue is what will be done next to solve the areas of weakness. If the field of adventure therapy wants to progress and stand a chance of being recognized as an effective means of therapy, there are changes that must occur throughout the field. There needs to be a governing body developed, an association who can provide licensing and oversee and uphold those who wish to practice adventure therapy to a set of rigorous standards. Having a governing body can also solidify and set agreed upon definitions for the profession. Having clear definitions will make it easier to communicate to the public and other health care providers exactly what it is that adventure therapists do. Having clear

definitions will also allow for better research to be produced, because it will allow for researchers to clearly define which practices are effective, for which populations, in which environments. With a governing body in place it would be important for the programs practising adventure therapy to regulate themselves and the profession. This way they can help adventure therapy programs offer the best care possible for patients, instead of making things worse. A possibility would be to require programs offering adventure therapy to provide evidence of their efficacy, and to close programs if they cannot do so.

There also needs to be well-grounded research exploring the efficacy of adventure therapy. Determining what is effective, with what populations, and their presenting factors in what environments will help define the standards that programs should be held to. Conducting good research will benefit the field by being able to share findings with the public and funding agencies to gain support. If the word is spread about what is being done in adventure therapy, with supporting evidence of its benefits, it has the potential to create a name for itself and build good public relations (Gass et al., 2012).

In health care systems and policy as well as the field of psychology there have been a movement towards evidence-based practice (EBP). EBP is the combination of the best research evidence, the clinical expertise and the clients' characteristics and values (Edwards & Rawson, 2010). The integration of these three aspects into EBP allows programs, clinicians and program directors to implement efficacious and effective assessments and treatments. To look closely at what EBP means, we can look at each aspect of EBP individually, starting with the best research evidence described as several clinical research studies showing that the treatment was efficacious and effective. The

research evidence will have a strong empirical foundation, with a variety of sources from which data can be collected and used for clinical decision making (Edwards & Rawson, 2010). Such data can be collected from randomized clinical trials, quasi-experimental investigations, correlation studies, field studies, case reports and clinical guidelines based upon professional consensus. These studies are needed to evaluate the effectiveness of existing practices; this is supposed to help clinicians make empirically formed treatment decisions. The clinical expertise is the scientific competence that guides evaluation and the use of research evidence as well as awareness of the individual client's characteristics as they influence treatment. It is the practitioner's ability to be aware of personal skills and restrictions that affect clinical decision-making. The client's characteristics and values are the individual patient's and family's unique beliefs, cultures, expectations, and concerns that are integrated into clinical decision making (Edwards & Rawson, 2010).

The field of adventure therapy should be striving to achieve EBP. Edwards and Rawson (2010) demonstrate "if clinical and decision making and practice are informed by experimental studies that have established effectiveness of particular interventions for specified clinical populations this should increase effectiveness, facilitate consistency in practice, establish accountability of health service providers to funding sources, increase cost effectiveness of treatment and improve the overall quality of treatment" (p. 94). Adventure therapy as an EBP would enhance program delivery to clients and benefit all those involved, from researchers and practitioners to policy makers. It would also help determine if the right person is doing the right thing at the right time, in the right place, in the right way, to produce the right results.

There is also a great need to improve the training and required qualifications of those providing adventure therapy. It may be possible to create courses and university-level programs that have a mental health focus, where a student can become a licensed practitioner while also gaining skills and certifications in outdoor adventure. One option could be to introduce and offer outdoor adventure training to individuals who are currently in a mental health program. Training people to be adventure therapists starting from a mental health base and teaching them the outdoor adventure competencies would serve more effectively than having individuals competent in adventure trying to provide mental health care. The best option may potentially be a team-based approach where it becomes standard practice to have an adventure therapy team made up of individuals with competencies in mental health and adventure working together to provide the best care for clients. As stated by Gass et al. 2012, "the bottom line is that to call oneself a therapist, one must have a degree that leads to a mental health license in the state where one is working" (p. 316).

FUTURE RESEARCH POSSIBILITIES

After exploring the common factors in adventure therapy from use of secondary sources, it would be of interest and value to conduct primary research in this area. We could be asking adventure therapists if they themselves find these factors useful and important components that bring about change in clients. Do they find these to contribute at all? To what extent do they contribute? We could attempt to ascertain what aspects the clients found helpful. What value, if any, do the common factors contribute in adventure therapy from the clients' perspectives?

Another key area of note where future research could be performed is the success of adventure therapy. To be considered an effective form of therapeutic treatment, adventure therapy programs need to be put through randomized controlled trials. Such trials are considered the gold standard of research. Gass et al. (2012) point out that, to date, there have not been any randomized controlled trials. If adventure therapy wants to continue its growth and establish its credibility within the field of psychotherapy, this needs to be an area of future research.

CONCLUSION

In conclusion, the importance of the common factors being included in adventure therapy has been demonstrated. Common factors will help establish adventure therapy as an effective form of treatment. When the common factors, which are known to bring about positive change for clients in traditional psychotherapies, are also being applied in adventure therapy, it has been demonstrated that the common factors also contributed to the desired therapeutic outcomes.

This study has looked at the different common factors, which helped to provide a description of the process of adventure therapy. The common factors were broken down into client factors, therapist factors, relational factors, and technical factors. Via analysis, it was concluded that these factors contribute to therapeutic outcomes. Next, the common factors were examined in the field of adventure therapy. That is, I concerned myself with identifying whether the literature has shown that the common factors are present and important aspects of adventure therapy; how they can be integrated, and how adventure therapy can enhance such common factors. From this literature review, I determined that indeed these common factors are found in adventure therapy. There is also support for

recognizing adventure therapy as an actual means of therapeutic treatment in relation to already established forms of psychotherapy. Yet, there are still areas in the field of adventure therapy where improvements can be made. For example, therapist factors including training and accreditation require further evaluation and improved educational criteria and field standards.

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