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# Adventure Therapy Best Practices

**Last updated in 2018*

AEE's Therapeutic Adventure Professional Group(TAPG) has been engaged in efforts to produce a statement of best practice for adventure therapy (AT) since 2001, with writing beginning in 2007. TAPG has coordinated Adventure Therapy Best Practices conferences that have, and continue, to serve as catalysts for this effort. The intent of this effort is to identify, establish, and promote appropriate AT practices. The following is to be considered a working document in its attempt to provide preferred programming standards for the administration of adventure and wilderness therapy programs. This statement will reside on the TAPG website and be updated as the field grows in knowledge and understanding. Please click the highlighted text above to access the sitemap.

Best practices are the elements and activities of intervention design, planning, and implementation that are recommended based on the best knowledge available. Historic precedent, practitioner experience and judgment, theoretical developments, and empirical and basic research results inform them. This template for best practices will continue to be informed by research with the intent to establish adventure therapy as an empirically validated treatment. It is designed to inform practitioners, administrators, consumers, and policy makers on theory, process, and outcomes guiding AT.

These best practices are currently in draft form, and we are seeking feedback from you about its contents. The website provides definition and structure, with bibliographies indicating where the reader can get more detailed information.

It is proposed that this template for best practices could integrate the various approaches of AT into a common body of knowledge that can then be presented as best practices to the Association of Experiential Education (AEE) and it's associated professional group, the Therapeutic Adventure Professional Group (TAPG), as well as the Outdoor Behavioral Healthcare Industry Council (OBHIC), the National Association of Therapeutic Wilderness Camps (NATWC), the National Association of Therapeutic Schools and Programs (NATSAP) and others. The information on this website is

designed from a U.S. perspective, but may have utility for other countries engaging in AT.

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# Foundations of Adventure Therapy

Foundations of Adventure Therapy are the fundamental influences and principles on which the field of adventure therapy was established. The intent of the Foundations section is to review and discuss the development and creation of the practice of adventure therapy in the United States.

**History of Adventure Therapy in the United States**

The historical foundations of practice highlight the beginning of AT as an eventual merging of adventure programming and psychotherapy (Gillis & Priest, 2003). This section includes a historical review and timeline of the influences on AT in the United States. The scope of the historical review encompasses influential developments related to AT in the United States and is not intended to include all developments related to experiential education, adventure education, etc.

**Defining Adventure Therapy**

Defining AT presents many challenges, as the field is quite diverse in how AT is conceptualized and applied. This section explores the varying definitions found in the literature and provides a definition.

**Foundational Concepts**

There are several foundational concepts that are central to AT. Examples include challenge by choice, negotiating risk and stress, using natural-logical consequences, and experiential learning. Although these concepts are not universally utilized in AT, they exist as prevalent constructs impacting practice. This section explores these concepts and their influence on current practice.

**Professional Organizations**

This section provides an overview of professional organizations and their current activities and contributions to the AT field. Professional organizations play an important role in developing and maintaining the quality, integrity, and professionalism of AT.

# History of Adventure Therapy in the United States

**Camping Movement**

Before 1800, the Friends Hospital opened in Philadelphia and incorporated the use of the natural environment as a major component of treatment for the mentally ill. Then, in 1901, Manhattan State Hospital East introduced "tent therapy" to isolate TB patients from other patients and found unexpected health benefits for patients related to being outside. This was the first documented case of utilizing the outdoors as a healing factor in the United States. In 1906, the San Francisco Psychiatric Hospital moved patients into tents after an earthquake and again noted dramatic improvements, indicating that the patients demonstrated improved social interactions. These events mark historic beginnings of the idea that there is a mental health benefit to being in natural environments. (Davis-Berman & Berman, 1994; leegillis.com).

The camping movement identified the use of camping as a therapeutic milieu, making initial attempts at integrating outdoor experience with therapeutic intent. This form of intervention was first seen through Camp Ahmek in 1929. This program identified socialization of the camper's behaviors as one of its primary goals, indicating the beginning of a therapeutic approach to camping (Davis-Berman & Berman, 1994; Russell & Hendee, 2000). The second program emerged in 1946, created by Campbell Loughmiller, as part of the Salesmanship Club of Dallas. This program represents the beginning of the therapeutic camping movement. (Loughmiller, 1965; Russell, 2005; Davis-Berman & Berman, 2008; Russell & Hendee, 2000; Davis-Berman & Berman, 1994; Schoel & Maizell, 2002).

**Progressive Education Movement**

The Progressive Education Movement also had significant impact on the development of AT. This movement was largely championed by John Dewey, considered to be one of the founders of experiential education. This philosophy holds that experience is a central means to broaden a student's knowledge and, thus, experience must form the

basis of a student's curriculum (Mitten & ?, 2008). In the view of the Progressive Education Movement, the learner is also a participant and more can be learned by struggling with a problem than by being provided with a solution. Experiential learning is active and may encourage the learner to become intrinsically motivated. The learner has the freedom to make choices and take responsibility. The philosophy of experiential education highlights the use of natural and logical consequences to provide feedback to the learner and incorporates reflection on the experience as a critical component of the learning process. (Gass, ; Stanchfield, ).

**Adventure Movement**

The catalyst for the development of the adventure education movement was the development of Outward Bound by Kurt Hahn. The Hahnian approach to education included concepts such as journey, expedition, and challenge. This approach was not only experience-centered but also value-centered. Learning through doing was not developed to facilitate the mastery of academic content alone, but was oriented toward development of character and maturity (Russell & Hendee, 2000). Bacon (1983) published The Conscious Use of Metaphor in Outward Bound integrating outdoor expeditions, personal change, and the conscious use of metaphor, which advanced the concept of intentional use of outdoor experience to foster personal growth and change.

Kurt Hahn opened the first Outward Bound program in 1941 in Aberdovey, Wales with Lawrence Holt and Jim Hogan (Miles & Priest, 1999). In 1950, the second Outward Bound school opened in England. In 1962, the first American Outward Bound school opened in Colorado. By 1984, Colorado Outward Bound had opened a treatment program. The influence of Outward Bound can be seen in the practices of the National Outdoor Leadership School, the Teton Science School, and Project Adventure.

A number of theoretical perspectives influenced Outward Bound in the development of their mental health curriculum. These include humanism, T-group movements, structural therapy, and strategic therapy. This was an important point in the history of AT because it was the first concrete shift from the camping movement to adventure therapy. These theories were applied alongside the adventure education movement's philosophies related to challenge and stress. Early approaches to AT viewed risk and stress as a pre-requisite for growth and held to the idea that people grow by getting out of their "comfort zone." These concepts are controversial today, as there is a movement away

from the use of intentional risk and stress by many practitioners who prefer an approach based on individual assessment of client needs rather than assumptions regarding the value of stress.

The adventure movement was also influenced by individuals previously serving in the British and American military. While these perspectives aided in the evolution of adventure work, they have also led to the development of coercive models that utilize a philosophy of "breaking someone down to build them back up." This approach is not consistent with current ethical guidelines or best practice in AT.

Project Adventure, begun in 1971, had a significant impact in developing the use of experiential programs to effect positive growth and change for clients. Key constructs in the adventure movement were promoted by PA including challenge by choice and the use of full value contracts.

To view a timeline and detailed synopsis of the Significant Events in Adventure Therapy, visit Lee Gillis's website at http://leegillis.com/AT/2IATC/advthe.htm.

## Definition of Adventure Therapy

Current preferred practice acknowledges that adventure therapy can occur indoors or outdoors as well as in urban or rural settings. It also uses games, trust activities, initiatives, high and low challenge course, high adventure and wilderness based programming. All are powerful tools, although they may be quite distinct in practice. (See the Treatment Applications section for further explanation) For example, the healing power of wilderness and the outdoors is well-acknowledged, however, we also recognize that AT can occur effectively without exposure to the outdoors.

Several definitions exist in the adventure therapy literature. In order to explore a definition of adventure therapy, we explored each definition and identified the components that were common to each. It is important to note that the following guidelines were applied to the development of a generalized definition for adventure therapy.

- Specific interventions or optional practices are not included. For example, issues related to facilitator choice of intervention style (e.g., whether to use isomorphic frontloading or what level of challenge to incorporate in an activity).
- It reflects a flexible environmental context, such as wilderness, outpatient or residential.
- It reflects a flexible interpersonal context, such as individual, group, or family.
- It focuses on the unique aspects of adventure therapy superimposed on a general therapy definition. For example, therapy, whether adventure or other form, is always provided by a certified or licensed mental health professional or its equivalent in the state, province or country in which the practitioner operates. Similarly, the expectation that interventions will be prescribed by an assessment of client needs and general functioning is universal.

The following were found to be common facets in the reviewed definitions as well as additional current thoughts.

Adventure Therapy:

- Utilizes active (kinesthetic) experiential methodology[1] to engage clients and establish an identical or parallel process[2] between the client's life experience and the client's therapeutic experience and enhances the transfer of learning from the therapeutic context to the client's life.
- Focuses on therapeutic goals[3], possibly including the cognitive[4], behavioral[5], affective,[6] physical and spiritual facets of the person.[7] This differentiates adventure therapy from uses of adventure for recreational, education, or physical health purposes.
- Involves a dynamic therapist-client relationship[8] enhanced through the shared experience and the active involvement of the client in the creation and maintenance of an effective therapeutic environment, such as goal setting[9], personal decision-making[10], and achieving outcomes.[11] The therapist is intentional[12] in facilitation of process, the selection and

design of the intervention, and about the role of the environment. This process may, but does not always, include real or perceived, physical or psychological stress or discomfort.[13]

- Incorporates a dynamic use of the environment and often the role of nature.[14] This may include exposure to unique environments or environments with adaptive dissonance for the client.[15]

The following definition is an example that reflects the most current professional perception of adventure therapy.

*AT is the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels." (Gass, Gillis, and Russell, 2012)*

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[1] Gass, Gillis, & Russell (2012); Friese (2006); Neill (2004); Alvarez and Stauffer (2001); Gillis & Ringer (1999); Gillis, Ringer, Priest (1999); Crisp (1998); Thomsen & Gillis (1996); Gillis (1995); Gass (1993)

[2] Thomsen & Gillis (1996)

[3] Gass, Gillis, & Russell (2012); Berman & Berman (2008); Neill (2004); Alvarez and Stauffer (2001); Itin (2001); Priest (2006); Gillis & Ringer (1999); Gillis (1995)

[4] Gass, Gillis, & Russell (2012); Schoel & Maizell (2002); Neill (2004); Schoel & Maizell (2002); Itin (2001); Thomsen & Gillis (1996); Gillis (1995)

[5] Gass, Gillis, & Russell (2012); Neill (2004); Schoel & Maizell (2002); Itin (2001); Thomsen & Gillis (1996); Gillis (1995)

[6] Gass, Gillis, & Russell (2012); Neill (2004); Schoel & Maizell (2002); Itin (2001); Thomsen & Gillis (1996); Gillis (1995)

[7] Wedding & Wedding *(? - ask tiffany wynn)*

[8] Norcross (2011); Berman & Berman (2008); Thomsen & Gillis (1996)

[9] Crisp (1998)

[10] Crisp (1998)

[11] Crisp (1998)

[12] Gass, Gillis, & Russell (2012); Berman & Berman (2008); Neill (2004); Alvarez and Stauffer (2001); Itin (2001); Gillis & Ringer (1999); Thomsen & Gillis (1996)

[13] Crisp (1998); Thomsen & Gillis (1996)

[14] Gass, Gillis, & Russell (2012); Neill (2004)

[15] -

## Foundational Concepts

Adventure therapy (AT) practitioners utilize a wide range of theoretical approaches, philosophies and concepts when providing services. In determining which concepts should be considered "foundational," it was important to consider which of these are unique and primary to AT, as opposed to those of which are found in other treatment modalities.

Each of these foundation concepts are rooted in the principles of experiential education, as well as a belief in the value of action and kinesthetic engagement of the client to create opportunities for change.

### The Use of Environment and Nature

The treatment environment is a critical component of AT. Practitioners of AT engage and manage the environment as part of the treatment process, attending to the foundational concepts described here.

***Involvement of risk and stress***

Possibly the most controversial concept is the use of risk and stress. Risk is inherent in the natural environment, as it is in any endeavor. Even in activities in which risk is perceived as minimal, basic movement can be considered to carry some risk. This is

obviously increased by moving outside, where inherent risks occur, such as weather. Understandably, the nature of the activity itself determines the baseline level of risk, and engaging in adventure activities will inevitably produce some level of risk and stress for participants.
In practicing AT, it is the assessment and appropriate use of this risk that are foundational, not simply the presence of risk alone. Effective practitioners manage risk and stress in a manner that best supports a change process for each client, including making decisions about engagement, sequencing, client choices, framing and reflection, client risk appraisal, and others. There should be a dynamic risk assessment before and during the activity that incorporates plans to adjust levels of risk/stress as needed. The use of risk and stress becomes harmful when practitioners do not adequately assess the client and environment and engage in practices that denigrate a person's mental health or cause harm to clients rather than creating positive change (*Mitten, DATE*). From this perspective, of crucial consideration is the client's perception of the risk and care should be taken that all activities are evaluated from this perspective.

Understanding the appropriate use of risk and stress can lead to positive change for clients when effectively managed. Participating in adventure activities provide opportunities for clients to work through challenges, develop and implement effective coping strategies, build resilience, and increase the ability to manage stressors effectively. In order to effectively facilitate that process, the practitioner is responsible for monitoring levels of risk and stress, maintaining a safe therapeutic environment, and supporting clients in applying what they've learned outside of the treatment environment.

***Natural and Logical Consequences***
As clients engage in adventure activities, they experience the positive and negative consequences of their choices. This allows clients to increase in their level of self-awareness about their behavior choices, based on immediately occurring tangible and concrete feedback. This can lead to a different level of motivation to change or provide useful information for clients about their strengths and weaknesses. The use of natural and logical consequences is a standard practice in AT. Natural consequences are a natural outcome of a behavior without any enforcement on the part of the practitioner. Logical consequences, on the other hand, involve action taken by the practitioner.

Using the dynamic of natural consequences removes the practitioner as an enforcer or rescuer, which can create a more level power differential. For example, if a group of clients are camping, everyone is experiencing the same weather conditions and the choices made (put on a rain coat, set up a group shelter, leave important clothing out in the rain, etc.) give feedback to the client that would be received differently if just delivered by a practitioner without the same experience.

A logical consequence, on the other hand, does require the practitioner to enforce the consequence. For example, the consequence of the client choosing not to wear a helmet while climbing, means that the client does no longer gets to climb.

When using natural and logical consequences, practitioners must monitor the level of stress experienced by clients in order to prevent doing harm as well as monitor for potential safety issues and adjust accordingly.

***Healing Power of Nature***

The dynamic climate for change present in AT is created in part due to participation in the natural world and in part due to the experiential, adventure-based activities that occur in the natural environment. The therapeutic benefits of being in the outdoors are well documented and they are enhanced when combined with facilitation that utilizes dynamics in nature to provide immediate and non-judgmental feedback to clients (Berman, 2008; Groenewegen & Ven Den Berg, 2006; Mitchell & Popham, 2008).

**The Shared Experience of the Practitioner**

The dynamic role of the practitioner also differentiates AT from other forms of therapy. Practitioners of AT engage with clients in a shared experience that allows for several dynamics to emerge Muran & Barber). These include:

- Increased pace of therapeutic relationship development (Harper, 2009)
- Enhanced reflection due to in-moment events, multiple access points for reflection, and a strong connection to the client's current functioning.
- Being present in the here-and-now shared experiences (Wright, 1997; Norton & Hsieh, 2011)

- Opportunity to revisit dynamics and determine whether or not gains have been integrated.
- A leveling of the power dynamic, which minimizes existence of a counter-therapeutic hierarchy (cite).
- Increased likelihood of countertransference as well as different opportunities and risks associated with use of self. Maintaining appropriate boundaries becomes of vital importance - this is explored in more depth in the Ethical Considerations section.

**The Actively Engaged Client Experience**

In AT, clients are invited to engage in action and interact with the activity the same way they would with any other personal life experience. This process results in the client revealing who they are in an authentic manner as they participate in experiences. This authentic participation enhances development of the therapeutic contract and engagement in the development of treatment alliance through the active, concrete and analogous creation of it.

Clients often experience a parallel process where the dynamics of the adventure experience are reflective of the dynamics of the client's life experience. For example, a client's approach to solving an initiative problem will likely mirror his or her approach to solving problems in other places. If the client implements more effective strategies while working through an initiative, he or she will likely be more able to implement the same strategies at home. An important foundational concept for AT is the idea of client empowerment, freedom and responsibility. Often referred to in adventure education as "challenge by choice," this foundational concept emphasizes the idea that clients are responsible for choosing what learning or type of change they want. Clients are given the freedom to make choices and with that, the responsibility for the change or learning is theirs. This enhances the treatment process and allows clients to engage in self-directed, positive risk taking. In addition to this, the foundational belief in client responsibility enhances the client's accountability for treatment outcomes.

AT provides a wide range of options for reflection as experiences are engaged in on physical, emotional and cognitive levels. Clients are able to use all of their senses and

experience a kinesthetic opportunity for reflection that is active and flexible (Norton, 2010).

The dynamic involvement in an experience that is shared by the practitioner and client described earlier also has significant ramifications for the client in AT, including:

- The client is presented with an increased sense of vulnerability by the mere fact that their actions in the moment are in plain view of the practitioner. It is the difference between the client telling a practitioner about an embarrassing moment and a client doing something that embarrasses him/her in front of the practitioner.
- A related concept is the fact that shared experience results in an increased likelihood for transference.
- The shared experience provides an opportunity to give and receive help which enhances the development of empathy and altruism within the context of AT.

**The Active Process as the Vehicle of Change**

The active process as the vehicle for change is at the very core of AT. Practitioners of AT use concrete, real-life, kinesthetic experiences as therapeutic interventions to address client goals. A misconception that is sometimes made is that the activity selected creates the opportunity for therapeutic change. In AT, the opportunity for change is really created by the connection between the clinical assessment and the clinical intervention and the practitioner's translation of the client's issues into an activity intentionally designed to explore those issues. This is often referred to as a "kinesthetic metaphor." The treatment goal is more important, and more of a focus, than the specific tasks of the activity.

AT often incorporates the fun of the activity and the value of play as a part of the change process. The role of fun and play in AT is to enhance engagement with the client, offer a respite from negative and inhibiting affect, and to open the client's perception of the multiple possibilities for growth. It is theorized that the client's “resistance” to change and fear of taking risks will be decreased through play.

The opportunity for clients to practice new skills and experiment with managing life experiences in new and healthier ways is enhanced through AT. Practitioners who recognize that the client has moved along in the process of change (through recognition of their need to change and preparation for new behavior) can present activities that offer the client an opportunity to test what they are learning. Additionally, the practitioner can provide immediate feedback in the here-and-now context. This opportunity for practice is significant to help clients integrate learning.

A central component of almost all AT application is the phenomenon of parallel process. This refers to how the process unfolding in the therapy session mirrors the client's actual functioning in life. It is almost as if the activity becomes a projective technique in which typical behavioral patterns, thought processes, cognitive structures, affective responding, and physiological reactions are displayed for the client and practitioner to evaluate and explore for meaning. These complex intrapersonal processes are readily accessible and transparent in the context of AT.

There is also the thought that AT can be used to create an identical process, opposed to one we would label as parallel. When working with young children, for example, the practitioner may choose to present activities requiring social skills that are exactly the same as those required to meet treatment goals.

# Professional Organizations

### Association for Experiential Education (AEE)

- Please refer to www.aee.org for this and more information regarding AEE, its professional groups, conferences and upcoming events.
- Primary purpose is to expand educators' and practitioners' capacities to enrich lives through the philosophy and principles* of Experiential Education. The association is committed to connecting educators in practical ways so that they have access to the growing body of knowledge that fuels their growth and development; publishing and providing access to relevant research, publications and resources; raising the quality and

performance of experiential programs through its accreditation program; and increasing recognition of experiential education worldwide.
- Serves challenge course operators; school, college, and university staff and faculty; therapists; outdoor education practitioners; expeditionary learning, wilderness, outdoor behavioral health agencies; organizational development specialists; experience-based professionals working in the nonprofit, private, and academic arenas; and membersof many other areas of experiential education internationally.
- Provides networking, training, education; develops accreditation standards; accredits programs; and supports research and political action.
- Publishes the Journal of Experiential Education.
- A member association governed by a volunteer board of program directors.
- Brief History: In the early 1970s, a group of educators assembled in Boone, North Carolina, USA, to discuss ways in which education could be made more relevant for students. This group believed that the core of learning is greatly enhanced by experiential forms of education. Now, AEE has more than 1,200 members in over 30 countries around theglobe are part of that discussion.
- The following are significant historical events in AEE as they relate to AT Best Practices:
- In 1980 AEE determined a need for a specialized professional group that focused on therapeutic intervention. Thus, was born Adventure Alternatives in Corrections, Mental Health and Special Populations.
- In 1991 an Ethical Code was adopted by AEE AACMH & SP. Just after, in 1992, AEE created an online list serve that is still a primary form of communication for members. Lastly, in 1995, the AT list serve was created to encourage and provide a forum for dialogue regarding adventure therapy specifically.
- Please see (http://leegillis.com/AT/2iATC/advthe.htm) for these and many other significant dates in adventure programming.
- Therapeutic Adventure Professional Group (TAPG)
- www.tapg.aee.org
- Primary purpose is the "development and promotion of adventure-based programming and the principles of experiential education in therapeutic settings and to the professional development of our members and the profession as a whole." Furthermore, TAPG "facilitates networking for

professionals within our various fields and shares information, techniques, and concerns regarding the therapeutic use of adventure.
- Serves AEE members who work within the fields of health, mental health, corrections, education, and other human service fields.
- Provides networking, training, education; code of ethics; develops best practices documentation; and supports research.
- Publishes the Insight newsletter.
- A volunteer professional group under the Association for Experiential Education.
- A Leadership Council structure is intended to afford the most representation of membership possible, supporting the membership and mission and purpose of TAPG. The Council coordinates activities and provides direction for the professional group. Leadership Council members serve for a term of 3 years.
- Code of Ethics: Since therapeutic adventure programs profoundly affect individual lives, it is the purpose of these guidelines to advocate for the education, empowerment, and safety of those who participate in these programs by establishing a minimum standard of ethical care and operation. Individuals who adhere to these guidelines will be considered as upholding, contributing to, and promoting a high standard of operation and service by the Therapeutic Adventure Professional Group of the Association for Experiential Education.

**Asia Association for Experiential Education *(waiting for information)***

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- Vision: Learning by doing on reflection, with giving, with sharing.

**The Association for Challenge Course Technology (ACCT)**

- www.acctinfo.org

- Primary purpose is to "to promote the use of Challenge Courses Technology and to set minimum standards for Challenge Course and Aerial Adventure Course installation, operation and inspection."
- Represents and serves challenge course builders, facilitators, insurance representatives, attorneys, course managers and owners, university professors, K-12 school teachers, park district personnel, camp personnel, and others interested in challenge courses internationally.
- Provides networking, training, education; sets minimum standards for developing and running challenge course programs; accredits programs and vendors; and supports research and political action.
- Publishes the Association for Challenge Course Technology Standards.
- A trade association governed by a board of program directors.

**The Canadian Adventure Therapy Symposium (CATS)**

- Primary purpose is to share resources, develop standards of practice, and gather collaborative input for those using adventure therapy in Canada.
- Serves practitioners, academics and students from across Canada engaged in the health, mental health, substance abuse, education, justice and related human service fields have been in attendance at each symposium.
- Provides training, education, and networking.
- CATS views itself as an adhocracy, a volunteer organized gathering.
- Next Symposium is scheduled for Spring 2013

**International Adventure Therapy Conference (IATC)**

- Primary purpose is to build an international network of relationships between people through the exchange of ideas and the growth of purposeful and friendly relationships" (Ringer: in Itin, 1998:2)
- Provides an International Conference every three years

- Serves an international audience of adventure therapy professional who have a commitment to developing theory, research and practice in the field.
- The 6th IATC Conference will be held in Czech Republic in September 2012.
- Publications
    - **1IATC**: Itin, C. (1998). Exploring the boundaries of adventure therapy: International Perspectives. Proceedings of the First International Adventure Therapy Conference, Perth, Australia. Association for Experiential Education: Boulder, Colorado.
    - **2IATC**: Richards, K, & Smith, B. (Eds.) (2003). Therapy within adventure. Proceedings of the Second International Adventure Therapy Conference, Augsburg, Germany. Zeil: Augsburg.
    - **3IATC**: Bandoroff, S., & Newes, S. (Eds.). (2005). Coming of age: The evolving field of adventure therapy. Proceedings of the Third International Adventure Therapy Conference, Vancouver Island, Canada. Association for Experiential Education: Boulder, Colorado.
    - **4IATC**: Mitten, D., & Itin, C. (2009). Connecting with the essence: Proceedings of the Fourth International Adventure Therapy Conference, New Zealand. Association for Experiential Education: Boulder, Colorado.
    - **5IATC**: Pryor, A. et all (in print). 5IATC proceedings. European Science and Art Publishing.

**The National Association of Therapeutic Wilderness Camping (NATWC)**

- www.natwc.org
- Primary purpose is to "support the establishment and continuation of therapeutic wilderness camping organizations; with the attendant responsibility to educate the public as to the existence of such organizations and their success in helping troubled young people change their lives for the better."
- Represents therapeutic wilderness programs for young people across the United States.

- Provides networking, training, education, counselor certification; and supports research and political action.
- Serves as a reference for parents and professionals searching for appropriate programs.
- Publishes the Journal of Therapeutic Wilderness Camping.
- A member association governed by a volunteer board of program directors.

**The National Association of Therapeutic Schools and Programs (NATSAP)**

- www.natsap.org
- Primary purpose is to "serve as an advocate and resource for innovative organizations which devote themselves to society's need for the effective care and education of struggling young people and their families. Our vision is a nation of healthy children. We are the voice inspiring, nurturing, and advancing the courageous work of our schools and programs."
- Serves therapeutic schools, residential treatment programs, wilderness programs, outdoor therapeutic programs, young adult programs and home-based residential programs in the United States working with troubled teens and troubled adolescents.
- Provides networking, training, education, and supports research.
- Publishes the Journal of Therapeutic Schools and Programs.
- A member association governed by an elected, volunteer Board of Directors.

**Outdoor Behavioral Healthcare Research Cooperative (OBHRC)**

- http://obhrc.org/
- Primary purpose is to "administer and deliver an active, comprehensive research program on outdoor behavioral healthcare programs operating in North America." They strive to "conduct multiple ongoing research projects on OBHRC issues; increase accessibility to wilderness & adventure therapy

research, and inform the public and professionals outside of OBHIC on the true value of wilderness and adventure therapy.
- Represents Wilderness & Adventure Therapy Programs.
- Provides research and evaluation.
- A member organization overseen by a director.

## Ethical Guidelines for the Therapeutic Adventure Professional

**Statement of Purpose**

Since therapeutic adventure programs profoundly affect individual lives, it is the purpose of these guidelines to advocate for the education, empowerment, and safety of those who participate in these programs by establishing a minimum standard of ethical care and operation. Individuals who adhere to these guidelines will be considered as upholding, contributing to, and promoting a high standard of operation and service by the Therapeutic Adventure Professional Group of the Association for Experiential Education.

**A. Definition of Professionals**

The term "professional" that is used in these ethical principles represents individuals who are members of the AEE Therapeutic Adventure Professional Group. These guidelines may have application to other members of the AEE, but the items contained in these ethical principles only pertain to Therapeutic Adventure Professional Group members of the AEE.

**B. Applicability**

The activity of professionals subject to these Ethics Principles may be reviewed under these Ethical Principles only if the professional is identified as a member of the Therapeutic Adventure Professional Group of the Association for Experiential

Education. Purely personal activities having no connection to or effect on these professional roles are not subject to the Ethics Code.

**C. Related Ethical Principles**

Professionals subscribing to this ethical code must be aware of other ethical codes and laws that intersect with the statements in this Ethical Code.

**D. Ethical Principles of the Therapeutic Adventure Professional Group of the Association for Experiential Education**

**1. Competence**

Professionals strive to maintain high standards of competence in their work. They recognize the boundaries of their particular competencies and understand the potential limitations of adventure activities. Professionals exercise reasonable judgment and take appropriate precautions to promote the welfare of participants. They maintain knowledge of relevant professional information related to the use of adventure experiences and they recognize their need for ongoing education. Professionals make appropriate use of professional, technical, and administrative resources that serve the best interests of participants in their program.

**1.1. Boundaries of Competence**

(1) Professionals provide services only within the boundaries of their competence, based on their education, training, supervision, experience, and practice. (2) Professionals provide services involving specific practices after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas or practices. (3) In those areas where generally recognized standards for preparatory training do not yet exist, professionals take reasonable steps to ensure the competence of their work and to promote the welfare of participants. (4) Professionals seek appropriate assistance for their personal problems or conflicts that may impair their work performance or judgment.

**1.2 Continuing Training**

Professionals are aware of current information in their fields of activity and undertake ongoing professional efforts to maintain the knowledge, practice, and skills they use at a competent level.

### 2. Integrity

Professionals seek to promote integrity in the practice of adventure programming. In these experiences, they are honest, fair, and respect others. In describing or reporting their qualifications, services, products, fees, and research, professionals do not make statements that are false, misleading, or deceptive. Professionals strive to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work.

### 2.1 Interaction with other Professionals

In deciding whether to offer or provide services to those already receiving services elsewhere, professionals carefully consider the potential participant's welfare. Professionals discuss these issues with participants in order to minimize the risk of confusion and conflict, consult with other professionals when appropriate, and proceed with caution and sensitivity. Professionals do not engage, directly or through agents, in uninvited solicitation of services from actual or potential participants or others who, because of particular circumstances, are vulnerable to undue influences (e.g., respecting client relationships).

### 2.2 Supervision

Professionals delegate to their employees, supervisees, or students only those professional responsibilities that such persons can perform competently. Within the limitations of their institution or other roles, professionals provide proper training or supervision to employees or supervisees. Professionals also take reasonable steps to see that such persons perform these services responsibly, competently, and ethically.

### 3. Professional Responsibility

Professionals uphold ethical principles of conduct, clarify their roles and obligations, accept responsibility for their behavior and decisions, and adapt their methods to the

needs of different populations. Professionals consult with, refer to, and cooperate with other professionals and institutions to the full extent needed to serve the best interests of participants. Professionals are concerned about the ethical professional conduct of their colleagues. When appropriate, they consult with colleagues order to avoid unethical conduct. Because of its direct negative influence on participants as well as the field, professionals are strongly urged to report alleged unethical behavior to appropriate and prescribed channels. Professionals are ethically bound to cooperate with professional associations' inquiries concerning ethical misconduct.

### 3.1 Basis for Professional Judgments

Professionals have an adequate basis for their professional judgments and actions that are derived from professional knowledge.

### 3.2 Initiation and Length of Services

Professionals do not begin services for individuals where the constraints of limited contact will not benefit the participant. Professionals continue services only as long as it is reasonably clear that participants are benefiting from that service.

### 3.3 Concern for the Environment

Professionals conduct adventure experiences in a manner that has minimal impact on the environment. Professionals do not conduct adventure experiences where permanent damage to wilderness environments will occur as a result of programming.

### 4. Respect for People's Rights and Dignity

Professionals respect the fundamental rights, dignity, and worth of all people. They respect the rights of individuals to privacy, confidentiality, and self-determination. Professionals strive to be sensitive to cultural and individual differences, including those due to age, gender, race, ethnicity, national origin, religion, sexual preference, disability, and socioeconomic status. Professionals do not engage in sexual or other harassment or exploitation of participants, students, trainees, supervisees, employees, colleagues, research subjects, or actual or potential witnesses or complainants in investigations and ethical proceedings.

### 4.1 Policy Against Discrimination

Professionals do not discriminate against or refuse professional services to anyone on the basis of age, gender, race, ethnicity, national origin, religion, sexual preference, disability, and socioeconomic status.

### 4.2 Ethic of Empowerment

Professionals respect the rights of participants to make decisions and help them to understand the consequences of their choices. Professionals assist participants in charting the course of their own lives. They respect the rights of participants to make decisions affecting their lives that also demonstrate an equal concern for the rights of others.

### 4.3 Describing the Nature and Results of Adventure Programming

When professionals provide services to individuals, groups, or organizations, they first provide the consumer of services with appropriate information about the nature of such services and their rights, risks, and responsibilities. Professionals also provide an opportunity to discuss the results, interpretations, and conclusions with participants.

### 4.4 Informed Consent

Professionals respect participants' rights to refuse or consent to services and activities. Participants must be well informed of the fees, confidentiality, benefits, risks, and responsibilities associated with these services and activities prior to participation. Professionals make reasonable efforts to answer participants' questions, avoid apparent misunderstanding about the service, and avoid creating unrealistic expectations in participants. Professionals inform participants of the relevant limitations of confidentiality as early as possible and the foreseeable uses of the information generated through their services. In the case of participants who are minors, parents and/or legal guardians must also give informed consent for participation. Professionals obtain informed consent from participants, parents, or guardians before videotaping, audio recording, or permitting third-party observation.

### 4.5 Fees

Professionals charge appropriate fees for services. Fees are disclosed to participants at the beginning of services and are truthfully represented to participants and third-party payers. Professionals are not guided solely by a desire for monetary reimbursement. They are encouraged to contribute a portion of their professional time for little or no personal advantage.

### 4.6 Advertisement

Professionals accurately represent their competence, training, education, and experience relevant to their practices. This practice includes using: (1) Titles that inform participants and the public about the true and accurate identity, responsibility, source, and status of those practicing under that title. (2) Professional identification (e.g., business card, office sign, letterhead, or listing) that does not include statements that are false, fraudulent, deceptive, or misleading.

### 4.7 Distortion of Information by Others

Professionals make efforts to prevent the distortion or misuse of their clinical materials and research findings. Professionals correct, whenever possible, false, inaccurate, or misleading information and representations made by others concerning their qualifications, services, or products.

### 4.8 Public Opinions and Recommendations

Professionals, because of their ability to influence and alter the lives of others and the field, exercise special care when making public their professional recommendations and opinions (e.g., public statements and testimony).

## 5. Concern for Welfare

Professionals are sensitive to real and ascribed differences in power between themselves and their participants, and they avoid exploiting or misleading other people during or after professional relationships.

### 5.1 Professional Relationships

Professionals provide services only in the context of a defined professional relationship or role.

**5.2 Dual Relationships**

Professionals are aware of their influential position with respect to participants and avoid exploiting the trust and dependency of such persons. Because of this, professionals make every effort to avoid dual relationships with participants that could impair professional judgment (e.g., business or close personal relationships with participants). When dual relationships exist, professionals take appropriate professional precautions to ensure that judgment is not impaired and no exploitation occurs.

**5.3 Sexual Relationships**

Sexual intimacy with participants is prohibited during the time of the professional relationship. Professionals engaging in sexual intimacy with past participants bear the burden of proving that there is no form of exploitation occurring.

**5.4 Physical Contact**

Adventure activities often include various forms of physical contact between professionals and participants or among participants (e.g., spotting, checking climbing harnesses, holding hands). Professionals are sensitive and respectful of the fact that participants experience varying degrees of comfort with physical contact, even when it is offered for safety, encouragement, or support. Whenever possible, professionals inform, explain, and gain consent for usual and customary forms of physical contact. Professionals are aware of individual needs when initiating physical contact, especially if the contact is meant to communicate support (e.g., hugs, pats) and is otherwise not required for a particular activity. Except when safety is a factor, participants have the right to limit or refuse physical contact with professionals and participants.

**5.5 Behavior Management**

Each program and professional will approach the topic of managing behavior with a concern for dignity and safety for both participants and professionals. Definitions of appropriate and inappropriate behaviors of participants should be made clear to

participants before any adventure programming commences. Professional responses to inappropriate behaviors should be clearly understood by both professionals and participants and carried out in an appropriate manner. There should be clear documentation of staff training and awareness about program policies concerning the management of unsafe behavior. Policies should never advocate the use of restraint unless participant(s) impose a threat to themselves or others. Restraint should never be used as a punishment or as a means to frighten, humiliate, or threaten a participant. Whenever possible, restraint should be avoided and as passive as possible. All behavior management should be accurately documented.

### 5.6 Physical Needs of Participants

Participants will be provided with the necessary water, nutrition, clothing, shelter, or other essential needs they require for the environment they are living in, unless there is a prior mutual consent between participants and professionals and it is recognized that this will serve a valid purpose (e.g., solo). At no time during any program will the withholding of these needs be used as a punitive measure.

### 5.7 Physical Treatment of Participants

At no time will participants be asked to perform excessive physical activity as a means of punishment. There should be a direct relationship between the amount of participants' physical activity levels and the objective of the experience.

### 5.8 Appropriate Use of Risk

The amount of actual emotional and physical risk participants experience in adventure activities will be appropriate for the objectives and competence level of participants. Professionals use appropriate judgment when choosing activities that expose participants to actual or perceived physical and emotional risks.

### 5.9 Assisting Participants in Obtaining Alternative Services

Professionals assist participants in obtaining other services if they are unwilling or unable, for appropriate reasons, to provide professional help. Professionals will not unilaterally terminate services to participants without making reasonable attempts to

arrange for the continuation of such services (e.g., referral). Experiences are planned with the intent that decisions made during and after the experience are in accordance with the best interest of participants.

**5.10 Confidentiality**

Professionals respect the right of participants to decide the extent to which confidential material is made public. Professionals may not disclose participant confidences except: (a) as mandated by law; (b) to prevent a clear and immediate danger to a person or persons; (c) where the professional is a defendant in civil, criminal, or disciplinary action arising from services (in which case participant confidences may be disclosed only in the course of that action); or (d) if there is a waiver previously obtained in writing, and then such information may be revealed only in accordance with the terms of the waiver. Unless it is contraindicated or not feasible, the discussion of confidentiality occurs at the onset of the professional relationship.

**5.11 Use of Case Materials with Teaching or Professional Presentations**

Professionals only use participant or clinical materials in teaching, writing, and public presentations if a written waiver has been obtained in accordance with guideline 5.10 or when appropriate steps have been taken to disguise participant identity and assure confidentiality.

**5.12 Storage and Disposal of Participant Materials**

Professionals store and dispose of participant records in ways that maintain confidentiality. Records should be maintained for a minimum of seven (7) years.

**6. Social Responsibility**

Professionals are aware of their professional responsibilities to the community and society in which they work and live. Within the limitations of their roles, professionals avoid the misuse of their work. Professionals comply with the standards stated in the AEE Safety Practices in Adventure Programs book as well as with the particular laws in their particular geographical and professional area. Professionals also encourage the

development of standards and policies that serve the interests of participants and the public.

## Footnotes

### 1. Background of Ethical Guidelines

At the 19th Annual Conference for the Association for Experiential Education in St. Paul, MN, one of the critical needs identified by the Therapeutic Adventure Professional group was the establishment of a set of ethical guidelines for adventure therapy. At that time, a committee was formed to: 1) examine the feasibility of such a development, 2) help to research ethical guidelines used by other professionals, and 3) serve as a "conduit" to help synthesize the input of others. Input for the initial creation of these documents was from a number of sources, which included: 1) the 1991 draft of the American Psychological Association (APA) ethics code, 2) the 1991 revised code of ethics of the American Association of Marriage and Family Therapy (AAMFT), 3) the 1986 ethics code for therapeutic recreation specialists, 4) Jasper Hunt's work in the second edition of "Ethical Issues in Experiential Education" (1990), and 5) Tim Marshall's work on these guidelines from the Aspen Achievement Academy guidelines (1991), which have become part of the licensing standards for the State of Utah under the "Outdoor Youth Programs" section. The work of this committee was presented at a Pre-Conference session of the Therapeutic Adventure Professional Group at the 1991 AEE Conference at Lake Junaluska. During this session, these guidelines were revised by a group of 27 invested professionals. During the Conference, the Therapeutic Adventure Professional Group voted to accept these guidelines given that we notify organizations like the APA and AAMFT that we were using portions of their ethical codes and that we would recognize their input into our work. The AAMFT and the APA after consultation with their legal counsel, have given the Therapeutic Adventure Professional Group permission to use portions of their ethical code. Since their approval at the Conference, the guidelines have been reviewed and commented on by more professionals. Most of these comments have been extremely positive, a number of individuals thinking that the entire Association should establish such guidelines. Some of the perplexing issues (i.e., areas where we could make these guidelines even better) that have been brought up include:

(1) **A. Definition of Professionals** - "This raises interesting issues. Does paying $35 to the AEE make one a professional?" "Who is going to police programs that are unethical? Is this 'policing' this part of being a professional?"

(2) **C. Related Ethical Codes** - "This section is too vague to be useful. What do I have to know about the Islamic Fundamentalist codes? It would be better if it was more explicit."

(3) **3.3 Concern for the Environment** - Some people felt this section was too vague to be helpful. "Do you mean 'legal wilderness only?" "How about bolts in rocks?"

(4) **4.1 Policy against Discrimination** - (Note: this section has drawn the most attention.) Some people challenged this statement as an effort to be "politically correct" and it was "troublesome." Specific questions in this policy were: (a) with gender, does this imply that "women" or "men" only groups would be discriminatory?, (b) with ethnicity, does this mean that not choosing to provide services for a Ku Klux Klan group would be discrimination?, (c) with religion, does this mean that Christian programs must include satanists? Some of these arguments may be for exceptional circumstances, but they do raise attention to areas that need to be addressed.

(5) **4.4 - Clarify the "limitations of confidentiality"** - one person thought this should be clearer.

(6) **6 - Social responsibility** - One person stated that something needs to be said about a professional's primary responsibility being the welfare of the client before the institution. Other ideas that have been raised include: -the need for specific negative rights that clients possess -something about the importance of empirical research to undergrid the practice and implications for scanty or non-existent research for practice -something about marketing materials accurately reflecting the practice (e.g., the pictures used to show only smiling facesrarely crying, hurt, or enraged faces). -something about separation of powers (i.e., some form of court of appeals for clients to turn to for aid against an organization or specific practitioner). Ideas like these will serve to further the evolution of these guidelines. Other future areas of development include a clearer definition of particular principles, the establishment of a collection of ethical dilemmas and scenarios in adventure therapy that help to further define these practices, and a decision on how such guidelines will be regulated and monitored.

**2. Acknowledgments**

The Therapeutic Adventure Professional Group acknowledges the use of the ethical guidelines from the American Psychological Association (APA) and American Association of Marriage and Family Therapy. It also greatly appreciates the support of the American Psychological Association (APA) and American Association of Marriage and Family Therapy (AAMFT) in the development of these ethical standards and their current evolutionary process.

# Competence and Scope of Practice

AT practitioners should have adequate knowledge/training upon which to make sound professional judgments. AT practitioners should also provide services only within the boundaries of competence; based on their education, training, supervision, experience, and practice.

Considerations related to this include:

1. It is essential that practitioners understand the potential limitations of adventure activities. These include:

- Limitations of practitioner inherent ability
- Appropriate choice of activity, matched with client assessment/needs.

2. Supervision/Training issues - relevant training and quality supervision are essential elements of competence and crucial aspects of appropriately managing risk.

**Supervision**

- Supervision must be provided at the level required based on the practitioner's training/certification.

- Supervisors should maintain awareness of whether the practitioner has demonstrated ability to manage risk and safety issues associated with any activity/intervention/setting chosen.
- Supervisors should remain aware of and be engaged in ongoing efforts at maintaining the knowledge, practice, and skills required for competency; particularly as related to current information, research, legislation, trends, preferred practices, etc..
- Supervisors should attend to the balance of abilities found in the staff/instructor team. For example, some clients/groups and/or activities require a staff team with demonstrated competence in both technical and therapeutic skills. Issues to consider include whether all staff need to be competent to lead in all areas, or whether it is appropriate for different staff to lead in different areas (e.g., someone who is technically trained to backpack, but not necessarily clinically trained to lead a therapeutic group; vice versa). In that case, supervisors have a responsibility to be certain that co-staff be at least a level of competence to support primary activities. The necessary balance may differ based on factors such as activity, client needs, make-up of the group, staff experience; and supervisors should be aware of these factors.
- Supervisors should be aware that individual client/ group therapeutic needs are directly related to the levels of supervision, as well as the type.
- Supervisors should attend to issues of secondary traumatization or vicarious traumatization; efforts should be made to attend to and prioritize the self-care needs of the practitioner (Bunce, 1 IATC).

## Training

- Practitioners should have access to qualified supervision and consultation, particularly in the field. Reasonable efforts should be made to provide resources (e.g., technological, time in schedule) to allow for this, and careful consideration of the rationale should be given to activity/setting choice that does not allow for this.

- Practitioners should have relevant and adequate training to work with the particular client populations they are engaged with ("soft skills"); based on their specified role *(LINK)*.
- Practitioners must have demonstrated capability in the technical skills ("hard skills") necessary to facilitate the activities particular to their setting and to function effectively in all environments in which they work; at the level to which they are responsible (i.e., lead staff vs. support staff).
- In areas or activities where generally recognized standards for training do not yet exist, practitioners must take reasonable steps to ensure the competence of work and promotion of the welfare of participants. (e.g., tree climbing).

**Issues for consideration**

1. Issues arise when supervisors are not skilled in the competencies required for activities, but still responsible for the oversight of the practitioner. While recognizably all supervisors may not be competent in all activities found within a program, it is essential that supervisors be aware of the issues that can arise, be able to recognize both problems and practitioner skill in each area, and have resources/support available to address particular issues that arise.

2. How do we define a competent practitioner? Questions to consider might include:

- "What makes someone a professional?"
- "How do we know they can do what is needed for this role?"
- "How does this change based on setting/client need?"
- "How much dual training (clinical/field) is needed to facilitate therapeutic outcomes?"
- "Is there a need for some sort of certification?"

(Johnson & Johnson, Joining Together textbook)

3. Different training protocols across settings lead to differences in service provision and contribute to definitional inconsistencies in the AT field. Is there a need for standardized training protocols? If so, in what areas?

4. Due to safety and risk management issues, the field of AT has largely focused on "hard skills" training. However, given that field/direct care staff are in direct relationship with clients, what degree of clinically-oriented training is necessary in order to effectively work with therapeutic populations?

# Client Welfare

Regardless of ethical governance, practitioners should hold client welfare as a primary ethical consideration at all times.

- Practitioners should develop and maintain working definitions of appropriate and inappropriate behaviors of clients, including behaviors related to physical *and* emotional safety (e.g., climbing commands, hurtful communication).
- Practitioners should be skilled at the application of consequences to client behaviors. There should be an emphasis on the use of natural and logical consequences ***(LINK)*** and practitioners should avoid consequences that are shaming to clients (e.g., making the group or client sing because of a "mistake" during the activity). There should also be a direct relationship between clients' physical activity levels and the objective of the experience; i.e., practitioners must refrain from asking clients to perform excessive physical activity as a means of punishment. As a side note, this tenet is a central factor which differentiates AT from "boot camps," which tend to rely on these sorts of consequences.
- At no time during any program will the withholding of the means to meet physical needs be used as a punitive measure. Physical needs of clients must be met at all times (e.g., necessary water, nutrition, clothing, shelter, or other essential needs they require) and accommodations be made for the environment they are living in. Exceptions to this may be made if there is a prior mutual consent between clients and professionals and it is

recognized that this will serve a valid purpose (e.g., solo); although again these factors must be adequately attended to.

- Careful consideration should be given to the use of deceiving the client or secrecy in an activity frame or for emphasis of lesson (e.g., if a client has a certain cognitive schema about his/her climbing ability and a practitioner creates a situation where s/he is climbing a greater level of difficulty). Concerns include the impact on trust/rapport and the use/misuse of power in relationships. Secrecy carries similar consideration (e.g., problem solving activities). ***(??? Can you expand on this example?)***
- Appropriate use of risk: the amount of actual emotional and physical risk clients experience in adventure activities will be appropriate for the objectives and competence level of clients. Levels of risk should also be in line with the therapeutic goals of the activity, and careful consideration should be given as to whether clients are likely to *benefit* enough from a higher level of risk to warrant such a choice. Along these same lines, it is essential to highlight that higher levels of *perceived* risk (whether it is *actual risk* or not) can trigger anxiety and other client reactions that may adversely impact the treatment process (e.g., PTSD reactions may be triggered which could have a negative impact on multiple aspects of ongoing treatment). Practitioners must also be certain that they have realistic expectations for levels of client performance, and that performance expectations are associated with treatment goals. Additionally, it is important to consider what level of choice clients have in assuming risk.
- Assisting clients in obtaining alternative services: As is common to all therapeutic settings, practitioners assist clients in obtaining other services if the practitioner is unwilling or unable (for appropriate reasons) to provide skilled professional help. Practitioners will not unilaterally terminate services to clients without making reasonable attempts to arrange for the continuation of such services (e.g., referrals to other professionals). Experiences are planned with the intent that decisions made during and after the experience are in accordance with the best interest of clients.
- Fixed length of stay (program) vs. achievement of maximum therapeutic value: Practitioners continue services only as long as it is reasonably clear that clients are benefiting from that service. Issues to consider include activities with a fixed time of participation (e.g., a 30 day trip), or when curriculum completion is a required to complete the program (e.g., Johnny

is refusing to complete the curriculum, yet appears to have gained the maximum treatment benefit that the program can reasonably be expected to provide, under the current circumstances). Other considerations might include if /when paternalistic actions are justified in the best interest of the client.

- It is essential that activities be chosen based on client need and assessment vs. practitioner enjoyment (e.g., climbing because it is something you like to do vs. in line with client needs).

# Confidentiality

Practitioners are bound to the levels of confidentiality required by their licensure, setting, community, state, and client group. This is a central consideration, yet it is also important to highlight that the unique circumstances and settings of AT may lead to situations in which confidentiality *could* be compromised. Regardless, it is essential that practitioners not assume that these circumstances allow for less attention to the issue and reasonable efforts to protect confidentiality should be made at all times, regardless of circumstance.

- It is important to recognize situations that might compromise confidentiality in this context (e.g., meeting outside of an office may limit the ability to maintain confidentiality due to the fact that other people may be encountered, registration of a group at a public campsite, use of public lands by non-program clients).
- It may be useful to disclose to a client how confidentiality may be compromised due to the inherent services (e.g., medical services, nature of activity site). Informing them that third parties may be encountered during the course of an activity helps uphold the standard.
- AT interventions are often incorporated as part of a broader treatment system, which often requires more collateral communication than is found in other settings. This creates scenarios in which breaches of confidentiality can occur more easily and it is essential that practitioners maintain ongoing awareness of whether or not appropriate consents have been given to allow for client-related communication (i.e., it is illegal to talk

to another professional about a client when consents have not been signed, even if it is obvious that the other professional knows the client well). It may be useful to review the bounds of confidentiality and procedures necessary to procure confidentiality with less experienced practitioners.

- Education about HIPPA standards and organizational efforts to be in line with these regulations should be provided to all practitioners. These standards may be applicable to other areas as well, and organizations are encouraged to continually remain cognizant of the ways in which they are maintaining HIPPA compliance.

## Informed Consent

Clients should be adequately informed as to risks associated with any activity or program component.

1. Due to the nature of the inherent risks, it is important to provide the client with appropriate information about the nature of such services and their rights, risks, and responsibilities. Under circumstances when clients are in program involuntarily, appropriate communication regarding these issues must remain as a primary consideration. It may not be appropriate to withhold information regarding risk-related factors from clients due to concerns that he/she may refuse to participate.

2. The client's ability to understand the informed consent must accurately be taken into account. This may also warrant additional considerations with non-voluntary clients, or situations when an adult enrolls a child/youth in a treatment program without their consent. Specific factors to consider might include whether a youth can really understand the risk involved or does a parent/guardian want a minor in treatment more than they want to truly understand the risks. As a side note, this is a crucial risk management issue and a lack of attention to informed consent makes programs more vulnerable to adverse litigation.

3. Challenge by (of) choice - ***(LINK)*** it is important to respect the rights of clients to make decisions and help them to understand the consequences of their choices. Careful consideration to this issue is particularly warranted when participation in an activity is contingent on program completion.

4. It is also appropriate to maintain a *therapeutically relevant* balance between answering clients' questions and allowing for the "discovery aspect" of adventure (e.g., some clients will benefit from having more information about an activity, whereas others may benefit from less). The crucial piece is that this consideration be based on individual client need, whereas overall program policies to this end may be less useful (e.g., a programmatic mandate of allowing clients "no future information" may be harmful to some clients, particularly those with PTSD and other anxiety-related issues).

5. Use of jargon (e.g., with initiatives) can get in the way of client understanding. It is important to consider whether clients truly understand the language being used and adjust language choice accordingly.

6. Clients must be informed as to the consequences of particular behaviors/types of behaviors prior to the experience. This also helps to provide a foundation for ongoing intervention.

7**.** The use of secrecy must be considered carefully. Practitioners should have clearly explored the potential benefits ahead of time and its relation to learning/growth (e.g., problem solving activities).

*8. "Activity captivity" particularly if a client has not participated in the activity previously. Idea of paternalistic actions - justified in the best interest of the client? (???)*

9. Clients should be informed of the multiple roles of the practitioner (e.g., does the practitioner also talk to parents?). See Dual Relationships section for more specific information.

10. Program advertisement: Pictures and descriptions included in advertising materials must accurately reflect and be congruent with the activities in practice. Programs promoting themselves as adventure therapy are expected to be in line with Preferred Practices (e.g., include a licensed practitioner).

# Boundaries

An emphasis on the need for appropriate physical, emotional, cultural, relational boundaries is found in all therapeutic environments and AT practitioners should draw

association for experiential education

from these general standards. However, the unique nature of the AT intervention creates a number of situations that are outside of the bounds of what is typically encountered in other settings, and therefore additional considerations are necessary (Newes, 2000).

**Dual Relationships and Conflict of Interest**

This tenet involves avoiding relations where there may be the potential for participants to be exploited or misled, typically based on the power differential between staff/client. It also speaks to the need to intentionally avoid dual relationships that may impair judgment.

The nature of AT interventions by nature creates a wider range of client/staff relationships than are found in more traditional settings, creating particular ethical conundrums when practitioners are held to the aforementioned dual ethical standards (Newes 2000). Particular factors to consider include:

- Proximity - Staff and clients often spend extended periods of time together; often in close proximity as well. This is particularly prevalent on expeditions or in other situations where staff and client share the same living space (e.g., cabin, tents, etc.). Care must be taken to fully consider the impact of this, as well as any ways that this might adversely impact treatment outcomes.
- Practitioners are often in multiple roles that expand the typical client staff relationships. For example, during a climbing activity, staff may be responsible for belaying and spotting a client, as well as facilitating outcomes. In addition, many activities warrant full staff participation with clients, so they are also personally responsible for their individual performance.
- Sexual/romantic relationships: As in all therapeutic settings, sexual relationships are *always* inappropriate between client and staff; regardless of setting. However, the intensity of the experience, along with the degree of time spent together, close living situations, etc. tend to create situations where sexual/romantic relationships between staff flourish. While at first glance, it may seem fairly straightforward to allow or not allow such relationships; this has implications not only for staff but also longer-term

consistency of programs. Again, there are no clear answers but factors to consider include the impact on staff of the lack of time off and privacy during course, the degree of freedom staff have to pursue other relationships (this is particularly salient for expedition-oriented and wilderness therapy programs), the fact that clients are not paying for staff time spent on their personal relationships, the potential impact on clients/groups of conflict that may occur between involved staff, potential differences between adult/youth groups, potential differences between groups with different stated goals (e.g., mutual aid or self-help vs. therapy) and length and stability of staff involvement. What is recommended is that staff and supervisors carefully consider where the practitioner's primary responsibility lies, and look to the guidelines (both formal and informal) adhered to in other professions.

**Self Disclosure**

This refers to staff disclosing to clients about personal experiences or knowledge, such as previous life experiences, emotional states or reactions, or current life circumstances (e.g. marital status, parental status).

- What is most important to consider is the reason behind the desire to disclose. Typically, these reasons include the desire to build rapport, the desire to prove competence, and the related issue of informed consent (e.g., when a client asks, "Do you know how to climb?" or "Do you know how to canoe?").
- Supervision on this issue is important, and the ability to differentiate the value of disclosing different types of information for different reasons is crucial. For example, there may be great benefit in assuring a client that you know how to climb, while disclosing about more personal issues in an attempt to create rapport/shared understanding has a high potential to negatively impact staff/client relationships.
- When relationship and/or rapport building is the goal, it may be useful to consider other ways to achieve the same effect.

**Physical Touch**

Adventure activities often include various forms of physical contact between professionals and participants or among participants (e.g., spotting, checking climbing harnesses, holding hands, touch due to activity structure, sharing small spaces during river crossings).

- Practitioners are sensitive and respectful of the fact that clients experience varying degrees of comfort with physical contact; even when it is offered for safety, encouragement, or support.
- Whenever possible, inform, explain, and gain consent for usual and customary forms of physical contact. It is essential that practitioners be aware that some clients (e.g., those struggling with PTSD) may react to physical touch/proximity in ways that can adversely impact the treatment process (that may extend beyond the particular activity), and facilitate activities in a way that maintains a high degree of sensitivity to this. This should also include allowing clients the choice not to participate. This should be done in a way that allows for the maintenance of client dignity, as well as for participation in another way that does not entail physical contact. Careful consideration should be given to circumstances when specific activity completion is thought to be necessary for program completion. NOTE- blindfolded activities in particular can trigger PTSD reactions in clients, and it is essential that sensitivity to this and associated factors be maintained in such cases. Some clinical supervision may be necessary.
- Participants should be given the right to limit or refuse physical contact with professionals and participants except when safety is a concern (e.g., essential spotting, medical - first aid response).
- It is important that practitioners maintain awareness of their own individual need when initiating physical contact with clients, especially if the contact is meant to communicate support (e.g., hugs, pats) and is otherwise not required for a particular activity. Care must be taken to differentiate touch that is in the client's best interest from that which mainly serves the needs of the practitioner.

- Practitioners should be aware of the effect of close physical proximity between clients and/or practitioner (s) during activities where that is inherent to the activity itself, and use that awareness to inform into their activity choice.

**Emotional Boundaries**

It is important to recognize that clients have a right to maintain emotional boundaries that are appropriate to their treatment goals and the goals of the particular situation.

- Practitioners should be trained in appropriate sequencing of activities in order to not push clients too quickly into emotional areas that they may be unready for. Training is also necessary on the potentially adverse treatment impact on clients of not maintaining emotional boundaries appropriate to the situation at hand, as well as the potentially detrimental effect on practitioner/client relationships.
- Practitioners should also have the level of training necessary to be able to make judgments about when it is appropriate to respect a clients stated emotional boundary and when it might be useful to encourage a deeper level of sharing/emotional openness.
- Constant awareness of the emotional safety of a group is paramount, and practitioners must intervene when this safety is compromised; either by a situational factor or another group member/staff.
- Practitioners must be aware of the impact on clients of disclosing about core therapeutic issues (e.g., trauma) at less optimal points in treatment or in less optimal situations; and take care to support clients to disclose at a time that is deemed most appropriate based on individual treatment goals. When less optimal disclosures occur, staff must take care to act in ways that maintain emotional safety while also helping to create a more appropriate emotional boundary. This must be done in a sensitive manner, and training/supervision on this is essential.
- Practitioners must maintain awareness of the stated goals of the group, and maintain emotional boundaries that are in line with these goals (e.g., an

intact therapeutic group vs. a group that participates in a personal growth oriented one-day experience).

## Cultural Considerations

It essential that practitioners maintain awareness of appropriate cultural considerations for the client groups they are working with. According to the TAPG ethical code, "Professionals respect the fundamental rights, dignity, and worth of all people. Professionals strive to be sensitive to cultural and individual differences, including those due to age, gender, race, ethnicity, national origin, religion/spirituality, sexual orientation, ability level/disability, and socioeconomic status."

While not all of these are unique to AT, particular considerations include:

- Awareness of particular factors regarding culture/ethnicity that may be related to a particular setting/environment (e.g., African Americans from Washington, D.C. going to a wilderness area near a white supremacist community in West Virginia).
- Given the ease with which practitioners and organizations in all professions assume cultural biases unknowingly, it is essential to continually ask "What do culturally competent/appropriate/responsive practitioners and/or organizations look like?" or is it more "What is a definition of cultural competence for practitioners?" (CITE- Skye and Nina 2008 TAPG pre-con).
- It is important that awareness be maintained of the potential cultural parity of practitioners in comparison to clients.
- It is important that practitioners understand the disparities of cultural representation in adventure activities; and that different cultural groups have very different perceptions of the same activities/environments. Central to this is that practitioners continually examine their own biases and those that might be embedded into an AT activity, particularly assumptions about client reactions to particular activities and how those may/may not be associated with positive/culturally relevant therapeutic outcomes. Additional information regarding these issues and factors to consider might include demographic changes/trends in the U.S., current US

Institute of Medicine data on health disparities and reasons for their existence, American Camping Association has information about widely differing participant experiences with camping/the outdoors and how this relates to comfort levels). (Richards, Peel, Smith, & Owen, 2001), there are also many other cites for this in the AEE world- Karen Warren, Nina Roberts have written a lot about this; there is a whole book about women in the Outdoors somewhere........)

- Practitioners should continually challenge themselves to understand how cultural beliefs about adventure or environment shape experiences, for both themselves and clients. Although there are many, areas to explore might include how cultural values and beliefs are shaped, identification of relevant cultural barriers, skills that enhance open communication, culturally appropriate assumptions regarding levels of self-disclosure, effective techniques for particular client populations (e.g., working with interpreters, considerations, etc.), role of cultural upbringing and how that relates to communication style/conflict resolution, etc..
- Practitioners should continue to educate themselves about culturally relevant outcomes, in order to avoid making what may be misassumptions about treatment success or non-success.

## Environmental Impact

Environmental impact refers to practitioners' attitudes and behavior regarding environmental values that are transmitted during the course of an activity.

- Practitioners should consistently model concern for the environment, and conduct adventure experiences in a manner that has as little impact as possible (e.g., bolts in rocks, teach Leave No Trace principles and methods).
- Practitioners should access national or state lands using appropriate channels (e.g., procuring permits from appropriate government agencies prior to using public lands). Activities should be conducted in line with applicable regulations (e.g., obeying fire bans, packing out human waste, etc.).
- It is important to maintain awareness that there are different cultural concepts of environment values.

- ***NOT SURE WHAT THIS MEANS???*** Environmental value conflicts with human value (e.g., ability level access to water).

# Links to Professional Ethical Codes

There are many Codes of Ethics that inform and guide the AT practitioner. Links to several ethical codes are provided below. It is impossible for this list to be comprehensive, but if there are additional relevant ethical codes to be considered, please contact TAPG and this list can be updated.

**Adventure Professional Codes of Ethics**

Therapeutic Adventure Professional Group of AEE
Ethical Guidelines for the Therapeutic Adventure Professional
National Association of Therapeutic Schools and Programs
Ethical Principles and Principles of Good Practice
National Association of Therapeutic Wilderness Camping

**American Therapeutic Codes of Ethics**

American Psychological Association
APA Ethics Code
American Counseling Association
ACA Code of Ethics
National Association of Social Workers
NASW Code of Ethics
American Association of Marriage and Family Therapy
AAMFT Code of Ethics
American Therapeutic Recreation Association
ATRA Code of Ethics
American Mental Health Counselors Association
Code of Ethics of the AMHCA
School Social Work Association of America
SSWAA Ethical Guidelines

**International Therapeutic Codes of Ethics**

Australian Psychological Society
APS Ethics Code
British Association for Counselling and Psychotherapy
BACP Ethical Framework
Canadian Psychological Association
CPA Code of Ethics

# Theory

Theory is of vital importance to informing the practice of adventure therapy (Ringer & Gillis, 1996; Hoyer, 2004). Adventure therapy is a rapidly developing, multi-disciplinary, multi-theoretical modality of treatment (CITE) that incorporates elements of more well-established theories from a range of diverse perspectives. Drawing from the fields of psychology, education, sociology, outdoor education, and a number of others, the central question of "what makes adventure therapy work" continues to be debated in the literature, as well as in both formal and informal gatherings of adventure therapy practitioners (links to AEE, IATC, etc).

Similar to more eclectic views of traditional psychotherapy, it may well be that no single psychological, sociological, or spiritual model can fully explain the complex forces at work in adventure therapy (Boudette, 1989). This theoretical pluralism is reflective of the diversity of the field, thus it is important to avoid elevating one theory over another. However, it is critical to articulate the theoretical perspectives that are currently assumed to be at the core of explaining the process of adventure therapy, while still allowing for the flexible application of a range of additional perspectives. As with other forms of therapy, this tends to be based on the unique lens of the practitioner, program, client needs, and treatment setting.

In many ways, adventure therapy is early on in its theoretical development. There are multiple, and at times divergent, perspectives from practitioners on what the theoretical foundations of adventure therapy consist of. It is an important evolutionary era in the field, as practitioners work toward increased theoretical understanding and generate new areas of understanding that inform the process. Below, five core perspectives are presented as supporting theories underpinning the adventure therapy process.

**Experiential Learning Theory/Experiential Education Philosophy**

The inter-relationship between psychological, sociological and educational theories has long been discussed, especially in the domain of learning (Breunig, 2009; Delay, 1996; Quay, 2003). Experiential learning theory and experiential education have long been considered core perspectives informing adventure therapy (Breunig, 2005; Dewey, 1938; Itin, 1999; Seaman, 2008). Experiential education focuses on the intentional transactive relationship between practitioner (teacher) and client (student) around common and often shared experiences (Cassidy, 2009; Itin, 1999). Central to the theory is the recognition that the learning must be tangible for the client, and involves an ongoing process of creating and associating meaning to the experience. This occurs through intentionally facilitated opportunities for reflection and processing (Breunig, 2005; Dewey, 1938).

**Systems Theory**

Adventure therapy seems to draw heavily on a systems perspective, including but not limited to general systems theory, social systems theory, ecological systems theory, and family systems theory (Hoyer, 2004). An adventure therapy practitioner utilizing systems theory incorporates an understanding of individual functioning, the complex social and environmental context, and the interactions between these 2 systems. Adventure therapy interventions in this context are structured to create systemic change in a parallel social or environmental context, such as home or school (Hoyer, 2004).

**Existential Theory**

Choice and exploration of the unknown are often considered to be important components of the learning associated with adventure therapy. Adventure therapy draws heavily upon exploration of the choices clients make, their approach to the challenges posed, and the meaning attached to activities or interactions. Existentialism and related constructivist perspectives inform the client's creation of meaning and interpretations related to their experience.

**Behavioral/Cognitive Behavioral Theory**

Adventure therapy draws heavily on the action orientation of behavioral perspectives as well as the development of increased awareness of thought processes and the role of cognition in the change process. In this perspective, change in behavior is the ultimate

goal thus special attention is paid to what clients actually do in activities and associated self-talk. Where a peer group is involved, social learning (Bandura) and modeling (both individual and group) are considered to be a crucial part of the adventure therapy process and practitioners draw attention to this process through the use of natural consequences and reflection.

**Psychodynamic Theory**

Adventure therapy practitioners tend to focus on a here-and-now orientation, which is similar to process-oriented psychodynamic therapy and Yalom's Social Microcosm theory (Newes & Bandoroff, 2004). From this perspective, practitioners maintain awareness of the historical elements that impact and inform current relationships and assess the underlying dynamics revealed in the therapy process. When appropriate, adventure therapists work directly with the historical elements to address current behavioral elements (Ringer & Gillis, 1996) although the focus tends to be on those seen in the context of the experience.

**Conclusion**

Adventure therapy practitioners draw from a diverse range of theoretical perspectives to guide their practice. Although several core perspectives are identified above, numerous other theoretical orientations are utilized and it would be impossible to name all of them. In addition to drawing from established theoretical orientations, many people question if there is a theory of adventure therapy that is unique and distinct from these core perspectives, if the "whole" is not just the "sum of the parts." Experts continue to debate whether or not it is useful or even possible to articulate "the theory of adventure therapy" in addition to debating which theories are considered to be core perspectives informing our practice. However, whatever theoretical orientations are utilized, it is considered to be best practice to have identified theoretical perspectives that guide adventure therapy practice.

# Practitioners

Practitioners who work with clients directly have a variety of roles and responsibilities in the practice of AT. Each role represents an important component of the overall

treatment process. Some practitioners operate as independent professionals, while others exist within complex program and organizational structures. Whether a practitioner is independent or part of a larger program or organzation, he or she must ensure that standards of competence and scope of practice within the identified role or roles are met.

**Practitioner Roles in Adventure Therapy**

Practitioners in adventure therapy operate in many different roles, such as an individual therapist providing AT in an office, a multi-disciplinary treatment team member facilitating adjunctive experiences on a climbing wall or high ropes course, or a program consisting of guides and therapists providing AT in a wilderness setting. This section explores the multiple roles and structures found in AT settings.

**Training in Adventure Therapy**

AT practitioners need to have a well-developed skill set to provide quality client care. Training expectations vary considerably to accommodate for the diverse range of processes and activities employed in the application of adventure therapy. This section explores the training in clinical skills, adventure tools and techniques, and theoretical and practice work involved in integrating both clinical and adventure skills sets. For more information on ethics related to training, refer to the Ethics section on Competence and Scope of Practice.

**Supervision in Adventure Therapy**

Supervision is a critical component of effective AT practice and is explored in relation to how supervision occurs in AT settings. For more information on ethics related to supervision in adventure therapy, refer to the Ethics section on Competence and Scope of Practice.

# Practitioner Roles

Adventure therapy is a dynamic and diverse field, with practitioners from many different educational and training backgrounds. The field of medicine provides a useful metaphor

in considering the variety of practitioners in adventure therapy. In medicine, providing medical care is different than practicing medicine. There are many roles in the provision of medical care (doctor, nurse, physical therapist, etc.). Clinicians and paraprofessionals provide adventure therapy collaboratively. It is important to consider multiple practitioner roles and how these roles operate together when AT is provided with a multi-disciplinary team. The provision of adventure therapy is accomplished through many roles - administrators, supervisors, doctors, therapists, direct care/field staff, and many others.

In this section, we look at practitioners, defined as the individuals engaging in direct service with clients in settings where adventure therapy is offered. We identify roles and explore the interplay between them. There are a number of roles and responsibilities in the practice of AT and organizations must consider who does what within their organization and assist practitioners in maintaining the competence and scope of practice of their identified role. This is further addressed in the training section.

Practitioner roles can be categorized in the following manner:

- Adventure Therapist - a clinician with a graduate level degree in a mental health field who has additional training, education and experience in the application of adventure tools and techniques in a treatment setting. An adventure therapist is expected to effectively integrate their clinical and adventure training. Adventure therapists are licensed or certified to provide mental health services by appropriate governmental agencies, such as mental health or licensing boards.
- Clinician - a person with a graduate level degree in a mental health field, training and experience that is have licensure (or its equivalent) according to the requirements of governmental agencies, such as state departments of mental health or licensing boards. Clinicians who have little or no training in adventure or adventure therapy are expected to collaborate with other adventure therapy professionals in the provision of adventure therapy.
- Paraprofessional - a person that provides adventure therapy under the supervision of a clinician. The terms used for this role are diverse and include field staff, line staff, guide, direct care, or residential staff. In fact,

within this category, the exact role played will vary considerably depending on the organization or program.

Each role requires different competencies in order to be effective; the clinical oversight is provided by practitioners with clinical training, the oversight of adventure activities and facilitation is provided by practitioners with adventure facilitation training, and the adventure therapist has competency in both. However, even where competencies are absent, the clinician should know enough about the adventure activity to support the paraprofessional and the paraprofessional should have enough clinical training to support the clinician. This categorization of practitioner roles reflects that when adventure therapy services are delivered to clinical populations, it is best practice to have clinical oversight provided by trained and licensed mental health professionals.

Many organizations utilize a treatment team in their work that may include collateral professionals, such as doctors or nurses. As with treatment teams in other settings, attention to appropriate roles and effective collaboration is critical. Each practitioner role provides an important piece of the overall service. Practioner roles have distinct, although often overlapping and interconnected functions. As part of best practice, when treatment teams are utilized, the delineation of function, responsibilities, and roles should be carefully considered. The training required for each role may vary considerably depending on the organization, environmental context, and types of services provided.

Adventure therapy is practiced in many settings, including but not limited to private practice, schools, residential treatment, outpatient therapy, inpatient psychiatric treatment, wilderness therapy, or community-based services. The adventure therapy practitioner may operate as an individual therapist, school counselor or social worker, guide or direct care staff, as part of a treatment team, or in a variety of combinations of these and other roles.

The range of potential settings present additional challenges in sorting out what the appropriate roles may be for whom. Most importantly, it is critical to remain aware of issues of competence and scope of practice when working with clinical populations, including maintaining quality clinical oversight. Each of the elements described (practitioner roles, competence and scope of practice, and collaboration among

treatment team members) are of central importance to providing effective adventure therapy.

# Supervision

Practitioners of adventure therapy work with populations that require special consideration and a careful approach to treatment services. People receiving adventure therapy services struggle with significant challenges in their lives such as substance abuse, physical or sexual abuse, isolation, depression, and many other mental health issues. It is critical that adventure therapy is provided in a manner that accounts for the intense needs of our client populations.

Supervision provides the oversight and safety net for our clients. Supervision supports practitioners by providing professional development, gaining an outside perspective, keeping practitioners focused on client needs and goals, maintaining a reflective and ethical practice, managing risk, and coping with the personal responses of practitioners to client issues.

The best practice is that all practitioners seek out and utilize supervision or peer consultation in their practice and that practitioners comply with governmental rules and regulations related to supervision and service provision. Adventure therapy practitioners are responsible for ensuring that quality clinical oversight is provided.

**Types of Oversight**

Clinical oversight may be provided through supervision, clinical review or peer consultation, depending on the practitioner's level of experience and training or the organizational structure. Clinical supervision is often required by state licensing boards for new therapists, who are not permitted to practice without the supervision of an independently licensed, more experienced practitioner. Most adventure therapists will require clinical supervision in order to be consistent with best practices and licensing standards. Supervisors have a level of professional accountability related to their role that provides a safety net for practitioners and clients.

In addition, the work of paraprofessional staff may be supervised or reviewed by a clinical supervisor hired to provide clinical oversight for decisions made related to

provision of adventure therapy services. This type of oversight may exist where the clinical supervisor maintains responsibility for the clinical oversight, but the paraprofessional staff are directly supervised by some other person. In this situation, clinical supervisors may be responsible for tasks such as completing diagnostic assessments, reviewing client cases, making clinical recommendations and developing treatment plans, or supporting staff in responding to crisis situations effectively.

Adventure therapists with independent licensure or adequate experience will often continue to engage in supervision through the use of peer consultation, drawing on other experienced peer practitioners to answer questions, gain an outside perspective, and provide oversight for client care. Using peer consultation has a different level of accountability than providing or utilizing supervision, as peers providing consultation are not directly accountable as there is not a hierarchical structure to peer consultation.

### Qualifications of Supervisors

The best practice for professionals providing clinical supervision or oversight for adventure therapy practitioners is to have training and experience in both clinical mental health and adventure therapy practices. Supervisors providing clinical supervision of adventure therapy services should have a minimum of 2 years post-graduate experience and, ideally, will have this level of experience in practicing adventure therapy as well. Due to the diverse nature of adventure therapy settings, it may not always be feasible to meet these standards for supervision. For example, a school social worker in a rural setting may be supervised by someone with the mental health qualifications but limited adventure experience. This practitioner may be able to engage in peer consultation or contract with a different supervisor to oversee the adventure components of his or her practice. It is important that practitioners work to attain the appropriate level of supervision in order to provide the best client care.

### Standards of Supervision

Clinical supervision needs to occur regularly and be documented. The frequency and duration of supervision will vary widely in terms of settings, but needs to ensure that practitioners have access to clinical supervisors, especially during times of client crisis. The standards outlined for adventure therapy practitioners are consistent with those found in most mental health treatment contexts; the difference is that in AT, the best

practice is for practitioners to be supervised by professionals with adequate depth of experience and knowledge with the use of adventure to maintain safe and ethical client care.

**Experiential Models of Supervision**

As the field of AT is experiential in nature, it is no surprise to find that supervisors have developed experiential approaches to supervision. The work of Lee Gillis and Mike Gass on the CHANGES model of supervision and numerous presentations at professional trainings and conferences is noteworthy and the reader is referred to their work (CITE) for more information about application of experiential models of supervision.

## Training

AT practitioners need to have well-developed competencies and skill sets to provide quality client care. Training expectations vary considerably to accommodate for the diverse range of processes and activities employed in the application of adventure therapy. Significant training in clinical skills, adventure tools and techniques, and the theoretical and practice work is involved in integrating both clinical and adventure skill sets. These competencies and skill sets include but are not limited to clinical, medical, wilderness/environmental, technical/activity, and interpersonal (working effectively on multi-disciplinary teams, etc.). Which competencies and skill sets are required of an AT practitioner depends greatly on his or her role in the delivery of client services.

While not unique to AT, a typical progression of training involves going through the initial training, participating in periods of observation, engaging in supervised practice, and then achieving competence to practice more independently. Organizations, programs, clinical supervisors and AT practitioners providing AT are accountable for ensuring that training meets industry standards and is completed adequately to provide quality client care. This is true of both clinical and technical skills, as well as aspects of organizational philosophy and mission. It is also important in managing risks associated with providing AT services.

For mental health skills, information about industry standards can be found through professional organizations, governmental standards, professional publications, and universities. For standards related to technical skills used in adventure activities,

practitioners can explore professional publications, accreditation standards, and training or certification programs related to the particular activities to be facilitated. In addition to this, attendance at conferences and participation in professional groups provides an important avenue to maintaining current knowledge of best practices in AT.

The various practitioner roles identified require differing types of training. Adventure therapists are trained in mental health practices through graduate coursework in a mental health field and required to attain licensure (or the equivalent in their location) and maintain education through continuing education programs. They are also expected to have some level of training in the integration of their mental health training and adventure therapy. While adventure therapists have the combined clinical and adventure skills, there are clinicians providing AT services who have the mental health training but not the accompanying training in integrating adventure and adventure activities. Paraprofessionals do not have the graduate training but may be trained in a variety of mental health or adventure activities as required by their particular practice settings. To provide adventure therapy, both the clinical and adventure skill sets should be represented in the practitioners on the treatment team. The training required for each role will be dependent on the setting in which the AT practitioner is working.

In addition to considering these skill sets separately, training in the integration of mental health practices and the use of adventure is an important component of the training process. Best practice is to have training that addresses mental health, facilitation of adventure activities/technical skills, and the integration of these in the clinical context. Organizations, practitioners and programs need to consider which licensures and certifications are appropriate for their settings and are in line with industry standards. Where multiple roles exist, some cross-training among specializations in encouraged in order to effectively work together as a treatment team.

There has been debate in the AT field regarding whether or not a certification for AT practitioners should be established. While this debate has continued, graduate and post-graduate programs with a focus on the clinical use of adventure have emerged as well as opportunities to participate in training from experts in the field. University-based and private training resources are available for new and advanced practitioners to meet the best practice standard for training for an AT practitioner. In addition to this, accreditation standards from organizations such as AEE, COA, The Joint Commission and others provide insight into required competencies and adventure therapy

publications outline recommended training, competencies and skills (Gass, Gillis, Russell 2012).

## Treatment Applications

This section addresses how the concepts of adventure therapy are implemented in treatment. The material in this text is primarily focused on describing what is specific to adventure therapy (AT). It is expected that currently accepted best practices in mental health will be observed and implemented in adventure therapy programs, and as such, are not specifically addressed in this document. Practitioners are encouraged to consider ways that traditional clinical theory and method inform an AT process.

In all treatment contexts, the following guidelines of AT apply:

- Client safety, physical and emotional, is always in the forefront of practitioner considerations. Practitioners also attend to their own safety (Gass, 1993; Priest & Gass, 1999; Lung, Stauffer, Alvarez, 2008).
- The practitioner is expected to explore and continually educate him or herself about relevant theoretical or systemic perspectives on human growth, development, and change; and to develop an ever-expanding knowledge base that informs their practice of adventure therapy (Newes, 2000; Berman & Davis-Berman, 1994; Gass, 1993).
- Clients are invited to actively engage in experiential activities that serve as a primary catalyst for behavior change through the assumed activation of underlying issues and the associated observed behaviors (Newes, 2000; Berman & Davis-Berman, unknown).
- Clinical observations about client functioning are taken from the current experiential activity occurring in the treatment context.
- Specific interventions are chosen after a thorough assessment of client needs and treatment context. This includes an identification of the problem(s) to be addressed (Berman & Davis-Berman, unknown; Lung, Stauffer & Alvarez, 2008).
- Individual treatment plans are developed that identify client issues, goals, and interventions clearly. Interventions are intentionally designed to address identified issues and documented appropriately (Berman &

Davis-Berman, 1994; Berman & Davis-Berman, unknown; Lung, Stauffer & Alvarez, 2008; Newes, 2000; Russell, 2003; Russell & Phillips-Miller, 2002; Russell, 2001; Russell, 2000).

- Issues that unfold during the process of the activity are the primary focus of each treatment intervention. The practitioner is expected to maintain the flexibility to deal with spontaneous issues that arise in the moment (Newes, 2000; Lung, Stauffer & Alvarez, 2008), and to continually remain aware of ways in which behaviors initiated during the activity are representative of client functioning in other areas. While the emphasis remains in the here-and-now, opportunities to help clients recognize these parallels should be created; either at a later point in the activity or in follow-up sessions.
- Adventure therapists are expected to be involved in a process of self-assessment and awareness during the delivery of services, as well as professional supervision to help navigate the therapeutic situations that arise during adventure therapy interventions (Lung, Stauffer & Alvarez, 2008).
- Any organization or partnering agency that is involved in client care should be educated and informed about the process of AT to support effective AT application.
- Adventure-based practice can be used as a primary treatment modality or used as an adjunct to other mental health interventions grounded in accepted counseling practice theories and modalities. For more information about integration of mental health theories and adventure therapy, the reader is referred to the Theory section.

The Treatment Applications section identifies the environmental and interpersonal contexts in which adventure therapy is applied, how the adventure therapist implements assessment and intervention methods, and unique issues existing within AT. The material is contained in the sections outlined below:

**Environmental Contexts** are explored in this section to help the reader understand the venues through which AT may be used. These settings include schools, outpatient, inpatient, residential, and wilderness settings.

association for experiential education

**Interpersonal Contexts** are explored in this section including individual, group, and family applications of adventure therapy. This section discusses interpersonal context as an important consideration for treatment.

- Group Adventure Therapy
- Family Adventure Therapy
- Individual Adventure Therapy

**Assessment** is explored in terms of how it guides effective practice, enhances facilitation, and is implemented using adventure tools and techniques.

**Intervention-Treatment Outcomes** describes treatment outcomes that are commonly sought through adventure interventions.

**Intervention-Facilitation Skills** are examined in relation to the development of the therapeutic process. The primary focus of this section is to articulate how practitioners work intentionally to achieve the most effective treatment results.

- Therapeutic alliance
- Matching interventions to enhance the therapeutic intent
- Therapeutic environment
- Treatment skills
- Processing

**Intervention-Adventure Activities** are described by the types listed below. The primary focus of this section is to identify intended treatment outcomes and practitioner guidelines for using these activities in a treatment context.

- Cooperative activities
- Initiative activities
- Trust activities
- High constructed element activities
- Service Learning

- Solo
- High adventure and Natural Environment activities
- Expeditions

# Environmental Context of Treatment

Diverse applications and settings for the use of adventure therapy are utilized within the United States (Gass, 1993; Newes & Bandoroff, 2004; Russell, 2002). This section explores environmental contexts through which AT may be applied. These contexts range from offering individual counseling in an office to spending 2 months on a wilderness expedition. The context selected will vary depending upon the initial and on-going assessment of the client. Environmental contexts are explored in this section to help the reader understand the venues through which AT may be used (Berman & Davis-Berman, 1994; Berman & Davis-Berman, unknown; Newes, 2000; Russell & Hendee, 2000; Gass, 1993; Gillis & Ringer, 1999).

Practitioners are required to observe state and national regulations related to their environmental contexts. Individual practitioners are expected to maintain state certification or licensure in their area of training. A practitioner providing mental health treatment is expected to be appropriately trained and licensed according to state requirements for the services being rendered.

It is important to note that this list is not exhaustive in terms of the wide range of environmental contexts used in adventure therapy. Home-based services, group homes, or more long-term care facilities are examples of contexts not described in detail but in which AT applications are being utilized. The intent is to demonstrate a variety of treatment contexts in which AT applications are found.

**Schools**

Numerous types of educational settings exist that utilize AT approaches to working with clients. Examples include traditional schools, day treatment programs, or therapeutic boarding schools. Applying AT in a school setting allows practitioners to address client issues in an environment clients are in on an almost daily basis. Clients are accessible

in this environment and practitioners also have access to other important figures in the client's world, such as teachers, coaches, or peer groups.

### Outpatient Treatment

Outpatient therapy is the treatment of an individual who does not reside in the setting where they are receiving treatment. The client is engaged in treatment sessions and then returns to his or her home system to test the skills learned within the outpatient context. This return to system allows the client to integrate treatment progress immediately into the home setting. Outpatient contexts are excellent venues for AT because the participant can return to the outpatient context and identify successes and failures of AT with his or her clinician. An advantage of AT is the richness of the parallel process that is possible between the action in the outpatient context and what occurs in the participant's real life (systemic context) (Lung, Stauffer & Alvarez, 2008).

### Inpatient Treatment

A client in inpatient treatment remains in a closed controlled system and receives services under the direction of a physician for at least 24 hours. This is often an intensive process whereby the participants are immersed in their treatment or recovery process. It is important to note that inpatient treatment is often focused on managing acute issues and is therefore a shorter process where the clients concentrate on stabilization. This is important because AT can support the clients in identifying acute stage issues and heighten awareness that are germane to their treatment. Due to the fact that inpatient work occurs in a closed controlled system, a therapeutic milieu can be developed with the potential to become a primary agent of change. AT can aid in the development and use of this milieu (Berman & Anton, 1988; Stich & Senior, 1984; Voight, 1988 in Gillis, 1992; Doherty, 1996; Gass, 1993)

### Residential Treatment

Residential treatment is a structured out of home placement for clients experiencing behavioral and or emotional problems. Residential treatment facilities provide 24-hour care with trained staff offering mentorship, counseling and therapy. A client may need residential treatment for their own safety or the safety of others. As opposed to inpatient treatment, this environmental context generally provides a lower level of

confinement and longer term of stay. Similar to inpatient treatment, AT is often used to develop the treatment milieu as a primary agent of change.

Residential treatment as an environmental context for AT can allow the practitioner to develop a deeper, longer term relationship with participants through the therapeutic milieu and extended stay. This structure allows for greater control of the treatment environment, which can enhance desired results. AT applications exist in residential facilities and in residential wilderness programs.

**Wilderness Treatment**

Wilderness treatment refers to using the outdoors and outdoor activities as an important context in the treatment process. This context is used within residential treatment programs, outpatient programs, schools, and stand-alone wilderness treatment settings. Clients may be traveling and immersed in the wilderness context or may be involved in a more base-camp focused experience. There are diverse program structures for using wilderness or the outdoors, but a key distinguishing factor for this context is that the outdoors or outdoor activity are specifically used to support the desired client change and that interventions are based on sound mental health practices. In wilderness treatment, work with clients is done in compliance with ethical standards and is not designed to be punitive in nature. The outdoor environment is utilized in creating a place for healing and healthy change (Miles, 1987).

The term "outdoor behavioral healthcare" has been used to describe wilderness treatment programs that are committed to upholding standards common to established mental health practice (Newes & Bandoroff, 2004; Russell, 2003). Outdoor behavioral health programs are designed to help participants change destructive, dysfunctional or problem behaviors through clinically supervised individual and group therapy, and an established program of educational and therapeutic activities in outdoor settings (Russell & Hendee, 2000). These programs utilize elements of wilderness treatment to focus client behavioral assessment and intervention by immersing participants in an outdoor environment involving group living, along with the above mentioned clinical oversight. They are designed to address problem behaviors by fostering personal and social responsibility and emotional growth (Russell, Hendee & Phillips-Miller, 2000). Although this setting has primarily been used with groups, there are also practitioners using this context for working with individuals and families (Bandoroff, 2005; Russell,

2000; Russell & Hendee, 2000; Russell, Hendee & Phillips-Miller, 2000; Newes, 2000; Friese, Hendee & Kinzinger, 1998; Rozak, 1992; Rozak, Gomes & Kanner, 1995).

## Interpersonal Context of Therapy

This section addresses the application of adventure therapy within individual, group, and family contexts of treatment. There are a number of theories and models of treatment applicable to these interpersonal contexts, which are described in the Theory section. This section explores considerations regarding use of adventure therapy for different modalities of treatment, including explaining why the interpersonal context is an important consideration for treatment and to identify currently accepted best practices.

The decision to use a particular treatment modality is based on a clinical assessment of the client. Please refer to Operational Guidelines for Clinical Practice and Assessment for more information related to that assessment process. Adventure therapy can be successfully incorporated into any of the contexts referenced. As a starting point, it is assumed that the adventure therapist will have a working knowledge of the basic clinical skills inherent in more traditional applications of the interpersonal context as derived from social work, psychology, and counseling literature. Non-clinical staff involved in the process should also be provided with clinically-relevent training to increase their ability to effectively identify and address ongoing therapeutic issues. For example, it is assumed that a practitioner engaged in adventure-based individual therapy will understand the conventional clinical disorders his or her clients may present and that he or she will utilize accepted and applicable clinical methodology, such as clinical interviewing, to complement the use of adventure-based activities. Non-clinical staff are expected to be working as part of a treatment team which includes a clinician.

Specific interpersonal contexts are:

- Group Adventure Therapy
- Family Adventure Therapy
- Individual Adventure Therapy

# Group Adventure Therapy

This section is intended to discuss the use of group treatment and the application of AT to this type of treatment context, which is the most commonly utilized treatment format within the AT realm. Specifically, in this interpersonal context, adventure activities are used as the catalyst for the development of the group into a functional, effectively performing team. The group therapy context allows opportunities for group and individual goals to be addressed concurrently. Group members are provided the opportunity to work toward mastery in a variety of areas, such as addressing social or behavioral problems, self-efficacy, problem solving skills, modes of coping, communicating with others, or self-acceptance. Broadly, the group social context is thought to provide an opportunity for development of improved relational skills through shared experience, mutual goal accomplishment, the experience of authentic community, the experience of giving and receiving support, and the opportunity for immediate and ongoing feedback from others (Yalom, 1995 ; Berman & Davis-Berman, 1994; Corsini & Wedding, 2004; Neri, 2003; Newes, 2000; Newes & Bandoroff, 2004;Schoel & Maizell, 2002; Gillis, 1998; Gillis & Gass, 2003; Russell, 2004; Russell, 2003a; Newes, 2000). The majority of these principles are directly in line with established group psychotherapy theory and method and practitioners are encouraged to consider ways in which the process may be quite similar to group processes that occur in other contexts (Newes, 2000).

**Practitioner Guidelines**

1. The basic tenets of standard group practice (e.g., social work, psychology, and counseling literature) also apply to adventure group therapy (Russell, 2003a; Newes & Bandoroff, 2004, Newes, 2000; Ethical Guidelines for Social Work, Counseling, Psychology and Mental Health literature).

2. The issues that unfold during the process of the activity are the primary focus of each treatment session. Adventure group therapists attend to the process and issues that unfold during the group session, not the pre-designed or desired plan of the facilitator. This guideline requires that the facilitator maintain the flexibility to deal with spontaneous issues that arise in the moment. Adventure group therapists intentionally focus on the dynamic issues during the course of an activity rather than exclusively

attending to the concrete results, such as success or failure, of the group efforts (Lung, Stauffer & Alvarez, 2008; Itin, 2003). See the Treatment Applications section for more information regarding this.

3. Use assessment data to inform and guide treatment decisions. Engage in activities with the intention of gathering assessment data about individual clients, as well as about the functioning level of the group and the nature of the group environment (Russell, 2003a; Russell, 2003b; American Psychiatric Association, DSM-IVTR (2000); Schoel & Maizel, 2002; Gass & Gillis, 1995; Hoyer, 2004; Alvarez & Stauffer, 2001; Nadler & Luckner, 1992; Kimball, 1993; Russell, 2004; Schoel, Radcliffe & Prouty, 1988; Russell, 2001; Priest & Gass, 1999; Gillis & Thomsen, 1996; Gillis, 1998; Gillis, 1992; Gass, 1993; Itin, 2003). See Assessment for more information.

4. Apply a "theory of use" (Stanchfield, 2007) to the practice of adventure group therapy. That is, practitioners are urged to apply a preferred theory of human growth and change to their practice of adventure group therapy. It is the application of this theory and the connection to individualized treatment goals that differentiates adventure *therapy* from related fields such as recreation, education, outdoor education or youth development. For example, it is the practitioner's choice of theory that will move the group sessions into addressing change at a meta-process level, which considers behaviors, cognitions, and unconscious processes that impede or support therapeutic change. (Itin, geocites_definitions web page, 2008; Newes & Bandoroff, 2004; Gillis, 1992; Hoyer, 2004; Ringer, 1994; Gerstein, 1992; Itin, 1999, 2001, 2003)

5. Attend to issues related to group composition.

- Client Safety: The expectation that clients in an adventure therapy group will engage in self-disclosure during group sessions requires that facilitators vigilantly attend to safety issues throughout the process. This includes issues that arise within the session, as well as things such as appropriate group composition, the establishment of group norms and cooperatively developed decisions about what constitutes group safety in each activity (e.g., safe communication patterns, spotting, feedback).
- Gender issues: Consider potential gender issues in both mixed and same-gender groups.

- Homogeneity versus heterogeneity: in terms of descriptive factors of group members. Groups may be homogenous in relation to treatment issue, gender, age, etc. Group practitioners make intentional decisions about this aspect of group composition and plan corresponding interventions.
- Size of the group: safety issues as well as type of activity and facilitation tasks are all affected by the sheer size of the client group. The group psychotherapy literature has identified group sizes from 6-12 as being the most effective (Yalom, 1994).
- Personal and physical boundaries: issues related to boundaries are necessary to vigilantly attend to in order to create a safe environment that is conducive to change and growth. A lack of attention to this crucial issue can inadvertantly create situations that may be harmful to client's emotional and psychological well-being.
- Diversity: factors of age, class, race, religion, gender identity, sexual orientation, and ability.

6. Attend to issues related to the structure of the group, including closed versus open-ended enrollment, frequency and duration of the intervention, supervision expectations, and staffing.

7. Use activities to establish desired group norms and beliefs within the therapeutic environment. The beliefs and norms desired will vary depending on the developmental, emotional, and cognitive level of the clients, as well as the specific goals of the intervention. Refer to the Treatment Applications section for more information.

8. Work intentionally to develop client engagement and participation in a mutually agreed upon treatment contract. This is another tenet of "challenge by choice" (CITE).

9. Choose activities and interventions based on an assessment of the needs of the client and the conditions present in the group environment. See Assessment section for more information.

10. Focus on empowerment of the target population through use of the following techniques:

- Allow clients to experience the consequences of their choices, within safe parameters. This tenet embraces the basic concept of experiential education that people learn more by struggling to work through problems as opposed to being given the solution.
- Work intentionally to give clients control over their learning, which comes from a sense of perceived freedom and ability to make their own choices and therefore assume the consequences associated with their choice. This relates to Choice Theory (CITE). Use natural and logical consequences to support client change (Newes, 2000; Newes & Bandoroff, 2004).
- Establish a protocol within the group for members to choose their level of involvement in activities. This is commonly referred to as "challenge by choice," although other variations are widely used depending on context (CITE).
- Help clients to establish healthy boundaries that protect them physically and emotionally.

11. Use opportunities created by the shared nature of the activity within the group to model desired behaviors. Opportunities are available for modeling by practitioners and other participants. These may include:

- Effective methods of dealing with and solving problems that are within the client’s sphere of influence.
- Effective coping mechanisms for managing problems, both those problems that clients can change and those they cannot.
- Effective communication skills.
- Positive relationship skills, including accepting and giving feedback, addressing problems, negotiating boundaries and intimacy, and increasing authenticity.

12. Facilitate the development of awareness and integration of the experience of participating in a functional community where mutual aid is the norm. Through this experience, clients are more aware of how to manage failure, frustration, errors as well as successes, achievements, intimacy, and social relationships within the group context.

13. Facilitate opportunities for group members to work toward and experiment with skill development and/or mastery in desired treatment outcomes.

14. Work intentionally to provide a wide range of opportunities for clients to reflect on what they experienced in the group and connect and generalize this learning to other life situations. Reflection may come in times of solitude, times of discussion, opportunities to write or draw or construct something that represents their experience, times filled with music, and times of additional physical activity aimed at integrating the experience.

## Family Adventure Therapy

Family adventure therapy has many parallels to group adventure therapy, as a family is a specialized type of group. Adventure therapy with families can be challenging due to the need to accommodate a wide diversity in age ranges and developmental levels, as well as personal needs of various members of a family. However, family adventure therapy has the potential to assist families with a variety of treatment goals. Most notably, it can be a powerful tool in helping struggling families to develop a working family structure. In addition, this type of treatment can allow families to develop improved communication or problem solving skills, mend damaged relationships, build trust, or develop appropriate boundaries and roles, among other things (Berman & Davis-Berman, 1994; Gass, 1994; Bandoroff & Parrish, 1998; Bandoroff & Scherer, 1994; Becvar & Becvar, 1988; Clapp & Rudolph, 1990; Gerstein, 1996; Gillis & Gass, 1993; Jacobsen, 1992; Mulholland & Williams; 1998).

**Practitioner Guidelines**

1. A thorough understanding of family structure, dynamics, and theories of healthy family functioning is required (Gass, 1994; Becvar & Becvar, 1988; Newes, 2000).

2. Practitioners maintain a respect for non-traditional family systems and cultural competence skills for dealing with diverse family systems (Gass, 1994; Schoel & Maizell, 2002).

3. Practitioners maintain an awareness of the internal and external risk and protective factors impacting the family system (Lung, Stauffer & Alvarez, 2008; Berg, 1994).

4. Consider the family roles, age ranges, and levels of human development represented by family members, as well as the relationship of the family members to the treatment goals in developing a strategy for the use of adventure activities as the catalyst for change (Lung, Stauffer & Alvarez, 2008; Newes, 2000).

5. Adventure therapy with families starts with a thorough assessment of family functioning, which guides the establishment of treatment goals, as well as choice of activities for the treatment process (Gass, 1994; Lung, Stauffer & Alvarez, 2008; Gerstein, 1996).

6. Attend to both emotional and physical safety issues vigilantly during family adventure therapy sessions. The active nature of the activities results in families revealing their natural way of responding that can include highly charged safety issues for family members

(Becvar & Becvar, 1988; Bandoroff & Scherer, 1988; Bandoroff & Parrish, 1998; Gass, 1994; Devault & Strong, 1986; Newes, 2000).

7. Facilitate the family's engagement in an active, experiential process as the catalyst for change:

- Use adventure activities to alter and enhance the family dynamics, structure, and patterns of interaction.
- Introduce novel situations, which may offer the unique opportunity to teach families how to play and have fun together as a legitimate treatment goal.
- Highlight new patterns of interaction within the family session that have the potential to improve family functioning.
- Work to develop more appropriate relationships and boundaries within the family structure. Facilitate family member's experience of positive feedback and support within the family session.
- Attend to family members' responses to positive changes in family functioning and facilitate their experience of healthier family functioning with an eye toward acceptance and celebration of their growth.
- Facilitate the family's response to participating in a functional family experience in which the family processes both successes and failures.

- Facilitate family members' experimentation with alternative modes of coping, making decisions, and communicating with one another that emerge during the activity or are required to complete the activity.
- Help the family to integrate the shifts experienced during the intervention in establishing a new family identity that highlights their connection and competencies.

8. Make observation of family functioning that are demonstrated in the here and now of the therapy session. These issues are often revealed in a concrete manner and are potentially less defended and more available for therapeutic inquiry. The increased awareness of ineffective family behaviors can allow for clarification of family goals. The increased awareness of family strengths can allow for clarification of intervention strategies and identification of resources available to support change.

9. Attend to bonding issues within the family treatment context. Adventure family therapy has a strong potential to heal strained relationships between family members in the following ways:

- Integrating family members back into their family system
- Learning to relate to one another in a positive manner
- Building positive alliance in the relationships
- Experiencing one's family function in a positive, supportive manner

## Individual Adventure Therapy

Individual adventure therapy is useful in a diverse variety of settings, including community mental health offices, schools, and the wilderness trail. The use of activities in individual counseling often enhances the development of a positive therapeutic alliance.

**Practitioner Guidelines**

1. The basic tenets of clinical individual counseling practice as derived from social work, psychology, and counseling literature also apply to adventure-based individual therapy. For example, the adventure practitioner is expected to utilize effective interviewing technique, accepted standards of ethical practice, and general understanding of clinical issues in his or her practice of individual adventure therapy.

2. Consider the impact of diversity issues on client functioning including age, class, race, religion, gender identity, sexual orientation, and ability.

3. Use activity, or a specialized environment such as wilderness, as one of the main processes of treatment. It is not simply a transitional tool to lead into discussion-oriented therapy. The issues that arise out of the context of the activity or environment are the focus of the therapeutic effort.

4. Assessment data regarding the individual client and the environment in which he or she lives and operates is important to therapeutic relevance and success.

5. Adventure therapists need to vigilantly attend to and manage their personal responses within this context of treatment. The fact that the therapist and client have a shared experience, that in some cases involves physical touch and closeness, enhances the need to self-monitor and evaluate for boundary infractions, counter-transference, or ethical issues.

6. Be prepared to use other experiential activities in this context of treatment. The intimacy of only involving one person in the treatment session, along with the lack of intra-group dynamic or the benefits of a communal experience, both lend themselves to the use of art, crafts, and other experiential tools.

## Assessment in Adventure Therapy

The treatment application section will deal with assessment of individuals and the treatment environment that is necessary for the effective and intentional use of adventure tools and techniques. In some clinical contexts, more formal psychological assessment occurs as well. While access to that type of information could potentially provide relevant and useful information, this section is focused on the type of assessment that occurs during an intervention, as well as immediately before and after.

Practitioners vary in the degree of emphasis they put on an in-depth initial assessment, although many consider having information about a clients' previous history to be an important aspect of providing effective treatment.

During the course of an activity, assessment is an on-going process that occurs during an intervention, as well as before and after activities might include checking-in during every session with individual clients to assess their mental status and reported emotional state, monitoring their readiness for the intervention, or observing interpersonal interactions and making note of observable behavioral change based during the course of an experience. A thorough assessment informs treatment decisions such as what activity to choose, how to frame that activity, and what facilitation decisions one makes during the course of the session (Lung, Stauffer & Alvarez, 2008; Gass, 1995, 1993a, 1993b; Hoyer, 2004; Kimball, 1993, Kimball & Bacon, 1993; Russell, 2004; Newes, 2000). The needs of individual clients should be taken into consideration, as well as the overall needs of the group. AT goes beyond focusing on the achievement of group goals by taking the individual clinical needs of clients into consideration, as well as the clinical value of the group interaction.

Within an experiential context, every activity clients engage in can be used to gather assessment information. From the very initial introduction, the way in which clients engage with the process provides valuable information. The way clients engage in the invitation to participate, how they engage with peers and the practitioner, whether they plan or jump ahead impulsively, how they discuss and think about the challenge presented, what expectations they have for interaction with others, and the non-verbal communications that occur are just a few examples of the range of assessment information available throughout the course of one activity. Experience-based therapeutic assessment depends greatly on the skill level of the facilitator to ascribe meaning to what he or she observes during any activity, to continually assess the needs of individual clients, and to choose ongoing activities based on that information. Applying the information gained from on-going assessment to the application of adventure interventions, requires a high level of in-session flexibility to meet the demonstrated needs (Hoyer, 2004; Gass, 1995; Russell, 2004; Newes, 2000).

The skill of the practitioner lies in the ability to use the assessment data to inform choices such as when it may be appropriate to strengthen or lessen the intensity of the ongoing interaction, when to stop and process, when to focus more on a group or more

on the individuals, and a myriad of other ongoing factors. These factors are also what tend to differentiate the experienced from the less experienced practitioner, and those new to the field are encouraged to seek mentorship in these aspects. The primary assumption held is that outward behavior is often the function of underlying causes, and that the activities provide an opportunity to activate and observe this relationship.

It is also important that practitioners engage in on-going self-assessment. Due to the shared nature of adventure interventions, the practitioner must be aware of personal responses that have the potential to either enhance or interfere with the treatment process. It is essential that the practitioner be able to differentiate his or her own personal reactions to the activity or the clients from reactions specific to the context at hand. This allows the practitioner to effectively use that interaction as an assessment tool, as opposed to inadvertantly remaining in a primarily reactive mode. This is quite similar to the clinical concept of transference and the skilled practitioner learns to utilize their reactions as an additional assessment tool.

Assessment topics that will not be discussed in this session include the following:

1. Intake or initial assessment: See Operational Guidelines for Clinical Practice

2. Assessment for environmental context of treatment: See Operational Guidelines for Clinical Practice

3. Assessment for interpersonal context: See Operational Guidelines for Clinical Practice

4. Assessment of what activity to use: See Matching

5. Assessment of outcomes: See Research

**Practitioner Guidelines for Assessment**

1. Continuously assess client functioning and needs in the treatment context and use the information to inform and impact the course of treatment (Gass & Gillis, 1995; Kimball, 1993; Russell, 2004; Newes, 2000; Schoel & Maizell, 2002; Nadler, 1993):

- Determine the mood, level of readiness to participate, and general attitude of participants going into the intervention.
- Assess physical capabilities of the client.
- Assess the client's readiness, interest, and involvement in any assumed process of change.
- Assess client's internal state and external behaviors relative to emotional and physical safety.
- Assess client's progress toward stated treatment goals.
- Attend to disequilibrium and discomfort as it is experienced during the activities and attend to the needs of clients.
- Attend to the client's interpersonal functioning and be aware of interpersonal factors that may relate to behavior change or trigger behavioral issues.
- Attend to issues that could lead to escalated or crisis situations and take action to de-escalate whenever possible.

2. Attend to both positive and negative behaviors in assessing clients, groups and families as well as different behaviors based on contextual factors.

3. If working with groups, assess group roles, stage of group development, and group dynamics (Newes, 2000; Kimball & Bacon, 1993).

4. If working with families, assess family structure, dynamics, and needs of various family members in the treatment process (Newes, 2000; Russell, 2004).

5. Be proficient in behavioral observation. Use the activities as a platform to continually add to your information base about the client's current status, worldview, behavior patterns, internal belief structures, and needs (Gass, 1993c). Looking for congruence across contexts can be useful as an observation of differences in client behavior based on context. By using activities as the platform for ongoing assessment, practitioners can observe activated communication patterns, coping abilities, problem-solving skills, cognitive structures, and degrees of congruence in behavior (Newes, 2000; Gass, 1993b).

6. Use activities to assess environmental conditions experienced by clients and to re-create desired conditions for the treatment context. (Gass & Gillis, 1995; Kimball, 1993; Russell, 2004; Newes, 2000; Schoel & Maizell, 2002).

7. Ongoing assessment of safety issues in the physical environment is an important aspect of effective application of adventure interventions. This includes environmental factors such as weather, gear, and risk. Psychological and emotional factors should be considered and the possible negative impacts of activities should be continually evaluated.

8. Continually assess the interpersonal process and attend to associated behaviors, such as client anxiety, conflicts between group members, giggling and other behaviors that may signal avoidance of deepening interactions, non compliance, or any other unusual or notable behaviors for this client group.

## Intervention in Adventure Therapy: Treatment Outcomes

Treatment interventions in adventure therapy typically combine facilitation and activity components. This section describes a number of intended treatment outcomes.

The use of adventure activities as an intervention allows for great flexibility in how each activity is utilized in treatment. The combination of the activity with varying facilitation choices can allow one activity to be employed for several different intended treatment outcomes. For example, rock climbing can be used to address trust, creating options, moving beyond self-imposed limits, or exploring relationships.

There are a variety of reasons a practitioner may decide to use certain adventure activities or facilitation approaches within a therapeutic intervention. These reasons are as diverse as the populations served in treatment, and will vary in response to the practitioner's assessment. It is important to remember that the intervention includes both the activity and the appropriate facilitation of that activity with the client. For information about research on treatment outcomes, refer to the Research section.

Well-constructed adventure therapy interventions are designed to assist clients in progressing in their change process in order to reach desired goals (Newes, 2000; Russell & Hendee, 2000; Lung, Stauffer & Alvarez, 2008; Alvarez & Stauffer, 2001; Bacon,

1983, 1988, 1989; Itin, 1994, 1998, 2003; Gass, 1985). The following text describes treatment outcomes that are often sought in adventure therapy, regardless of the type of activity selected. The identified outcomes are not intended to be an exhaustive list, but to highlight those most common to adventure therapy. Most of these potential treatment outcomes exist in all environmental and social contexts of treatment to some degree. Some outcomes may not apply to some contexts; for example, if a practitioner is operating in an individual therapy context, then group cohesion is not likely to be an intended outcome of the intervention.

**Responsibility**

Adventure activities create situations that encourage clients to be responsible to other people. Interventions are structured to allow clients to experience the natural consequences of their choices, which provides a feedback loop that informs clients about the positive and negative aspects of these choices. Clients are able to develop a sense of contributing to something larger than themselves and have the opportunity to be motivated and encouraged by others. (Copland Arnold, 1994; Eisenbeis, 2003; Levine, 1994; Mitten, 1994; Newes, 2000)

**Cooperation and Relationship Building**

Adventure interventions can be used to support clients in developing willingness to work together and an ability to do so effectively. Many times, adventure activities encourage clients to build positive, healthy interactions with others. Clients can achieve a sense of balance between cooperating with group or societal expectations and attending to individual needs and boundaries. Clients have the opportunity to learn and practice managing social, emotional and physical risk. Clients can develop trustworthy behaviors and the ability to trust others. Adventure interventions allow opportunities to model healthy relationships, begin building trust in the group, and explore positive risk-taking in social settings. Interventions can be designed to create group or family cohesion and to develop belonging, which can be critical to the developmental stage of clients (Corsini & Wedding, 2004; Newes, 2000; Lung, Stauffer & Alvarez, 2008; Nadler, 1993).

**Intrapsychic Outcomes**

Clients are able to increase their self-awareness regarding their level of functioning through practitioner and peer feedback. Adventure activities challenge client's pre-conceived notions about themselves, others and practitioners in a way that allows clients to change prior negative cognitions. Clients can develop self-efficacy and self-confidence through gaining experience working through obstacles successfully. (Gillen, 2003; Hart & Silka, 1994; Levine, 1994; Mitten, 1994; Newes, 2000)

### Social Skill Acquisition

There are a variety of opportunities with adventure activities for social skill acquisition. Clients are also given an opportunity to learn and to practice appropriate social skills, and to utilize skills they already possess, such as communication, following directions or conflict resolution. This can improve the client's ability to interact effectively with others. Clients can experience effective social interactions and practice the skills needed to maintain them (Russell, 2000).

### Resiliency

Developing a client's ability to cope with challenges and be resilient is frequently a sought after outcome of adventure therapy. Practitioners often work with clients on skills related to problem solving, emotional management, coping skills, and the development of some self-confidence and reasonable persistence. Practitioners often work to increase client's feelings of self-efficacy or belief in their ability to manage issues. Clients are able to identify their strengths and learn to enhance their ability to use their strengths to achieve positive outcomes (Newes, 2000; Russell & Hendee, 2000).

## Intervention in Adventure Therapy: Facilitation Skills

The broad topic of intervention is divided into two sections in this document. This section describes facilitation skills used to enhance the effectiveness of treatment. It explores how the practitioner works throughout the therapeutic process and asserts that the intentional use of these skills critically impacts adventure therapy programming. The Adventure Activities section describes various activities used in adventure therapy, reasons for using them, and practitioner guidelines for using them.

The specific interventions selected and the method of facilitating the process for any particular treatment population is based on the assessment of client needs and existing conditions in the treatment setting. This section articulates how intentional practitioner choices regarding the following components impact the therapeutic process:

- Therapeutic Alliance
- Matching Interventions to Enhance the Therapeutic Intent
- Therapeutic Environment
- Treatment Skills
- Processing

Decisions on topics ranging from the choice of activity, the choice of intervention strategy, creating the ideal treatment environment, treatment skills of the facilitator, and methods to process experiences are discussed. The intentional choice of the activity involves both decisions about *what* activity to employ and *how* that activity will be presented and facilitated.

## Facilitation: Therapeutic Alliance

Developing an effective therapeutic relationship between the practitioner and the client, often referred to as therapeutic alliance, is a critical component to effective facilitation and successful treatment. Adventure therapy (AT) has the potential to enhance the development of a positive therapeutic relationship. These interventions support not only the alliance with the practitioner, but also development of alliance among other participants in the treatment process (Newes, 2000; Gass, 1993; Gerstein, 1992; Itin, 1994; Ringer, 1994).

There are multiple beliefs among practitioners as to why this is the case. Some ideas include:

- Shared experience in the treatment process. This highlights the collaboration between practitioner and client in developing treatment

objectives and solutions(Alvarez & Stauffer, 2001;Gilbert, Gilsdorf & Ringer, 2004; Newes, 2000; Lung, Stauffer & Alvarez, 2008)

- Potential for dynamic modeling on the part of the practitioner in areas such as responding to challenges, giving and receiving feedback, coping with failure, and having fun (Lung, Stauffer & Alvarez, 2008;Newes, 2000; Luckner & Nadler, 1992; Nadler, 1993).
- Focus on the here and now engagement of the treatment process. Intervention can occur at the point of performance, providing immediate feedback and support related to emergent treatment issues (Gass, 1993, 1999; Itin, 1998; Priest & Gass, 1999).
- Opportunity to connect behavior to clients' inner process, emotional response, behavioral response, current coping strategies, and cognitive response. This reflects a particular theoretical perspective that says it is valuable to link behavior and inner process (Gass, 1999; Itin, 1998; Newes, 2000; Trace, 2004).
- Opportunity for clients to experience behavioral success and to attribute this to the therapeutic relationship.
- Opportunities for clients to exert their power by making choices and experiencing natural consequences. This changes the role of the practitioner, as practitioners are removed from a place of doling out consequences (Gass, 1999; Newes, 2000; Priest & Gass, 1999).

**Establishing Therapeutic Alliance**

Practitioners can use several approaches to build therapeutic alliance with clients. Standard relationship building skills are employed throughout the process, but utilizing aspects of AT to enhance this development is useful. The following suggestions are provided:

- Engage in activities with the client, when appropriate (Lung, Stauffer & Alvarez, 2008).
- Build rapport through listening, responding appropriately, assuming a non-judgmental approach, and meeting clients where they are in terms of

the treatment process (Alvarez & Stauffer, 2001; Lung, Stauffer & Alvarez, 2008; Schoel & Maizell, 2002).

- Respect client choice and use client choices intentionally to support client's progress in treatment (Cole, Erdman & Rothblum, 1994; Davis-Berman & Berman, 1994; Mitten, 1994).
- Attempt to connect with client from the moment they arrive. Give client an appropriate welcome and thanks for attendance.
- Allow client to manage their own level of self-disclosure. Encourage reflection and introspection but don't demand it. As the relationship develops, it is appropriate to challenge and encourage more in this area if the practitioner is trained (Gilbert, Gilsdorf & Ringer, 2004; Rollnick & Miller, 1995).
- Make observations that demonstrate our understanding of something about the client (Mitten, 1995).
- Choose activities that foster reliance and trust in the practitioner.
- Model and encourage healthy strategies during the conflict (Lung, Stauffer & Alvarez, 2008;Newes, 2000; Luckner & Nadler, 1992; Nadler, 1993).
- Allow practitioner to be human and express genuine emotion intentionally and appropriately. For example, if a practitioner makes a mistake and demonstrates accountability, a client is likely to respect that practitioner more and perhaps be willing to do so as well (Gilbert, Gilsdorf & Ringer, 2004; Newes, 2000).
- Maintain appropriate level of self-disclosure. Respect client boundaries (Davis-Berman & Berman, 1994; Newes, 2000).

# Facilitation: Matching to Enhance Therapeutic Intent

There are several essential elements in the best practice of enhancing the therapeutic intent of the use of adventure.

1. Thorough intake and admissions process provides the foundation for the development of a treatment plan (Newes, 2000; Schoel & Maizell, 2002).
2. Assessment (both initial and continuous) is completed and includes conditions in the therapeutic environment(Schoel & Maizell, 2002).

3. Clear therapeutic goals and objectives are documented on the treatment plan(Gray & Yerkes, 1995; Lung, Stuaffer & Avarez, 2008).
4. Facilitation strategies are intentionally chosen and linked to treatment goals. See Facilitation Strategy.
5. Specific activities are intentionally chosen and linked to treatment goals. See Activity Selection.

These five areas (intake/admissions process, assessment process, treatment planning, facilitation strategies, intervention strategies) link together to enhance the participants' conscious and unconscious reflection on their experience and progress toward their treatment goals (Alvarez & Stauffer, 2003; Bacon, 1983, 1988, 1989; Itin, 1994, 1998, 2003; Gass, 1985, 1991, 1996). This section addresses the process of selecting the appropriate facilitation strategy and activity.

While activity is in many ways at the heart of adventure-based practice, it would not be best practice to start with an activity and attempt to use the same activity in the same way with every client. Alvarez & Stauffer (2003), Bacon (1983, 1987, 1988), Gass (1985, 1991, 1995), Itin (1994, 1998, 2003) and others have stressed the importance of not just gathering assessment data but actively using it to select both the facilitation approach and the activity. This assessment data may alter the choice of activity, the guidelines used in the activity, and even the name of the activity when tailoring the activity to a specific client or client group. The activity selection and facilitation reflects the therapeutic goals for the client or client group. If the goal is to increase trust, this might suggest a different activity than if the goal was to increase communication. Even within a treatment goal there will be nuances of selection. For example, if the goal is trusting oneself (as compared to trusting others) this further defines the selection of the activity, the development of the activity, and finally the facilitation of the activity. These guidelines assist the practitioner in adapting activities for environmental, developmental, cultural, and clinical considerations which result in a more informed, intentional decision making process during facilitation.

## Matching Facilitation Strategy to Client Needs

Matching the facilitation style to the client's needs should take into account the stage of change for the individual, family, or group. It also takes into account the behavior or

action words that the client generates in the session. If there are not specific actions to engage with, we often initiate an activity to begin the process. Not only does this connection develop a solid therapeutic relationship, it also assists with creating meaningful themes or metaphors for the therapeutic process.

The process should also take into account language. An attempt to use the same language and verbal intent that is being expressed by clients in the presentation of the activity. In the literature, this is referred to as tailoring derived from the Ericksonian perspective.

Matching an intervention to mirror your client's ecological position is extremely powerful. For example, the choice of an activity that is difficult to master and often results in a client feeling "stuck" would be a very dynamic choice for an adolescent struggling with school and verbalizing that he or she feels "stuck" in the situation.

The goal is to use all of the above information to frame the seven generations of facilitation. These generations are described in the literature, which identifies when they were introduced to the field, not that one approach is superior to another (Bacon, 1987; Gass, 1985, 1991; Priest & Gass, 1993, 1995; Itin, 1995, 1998).

**The Seven Facilitation Strategies**

In best practices, it is understood that there are multiple approaches to facilitating client learning and that one approach is not a best practice. Best practice in enhancing of learning is understanding the multiple facilitation strategies and applying these appropriately to the given clients, context, and therapeutic goal. It is imperative that a practitioner has a full understanding of the various approaches and an understanding of why one approach would be used or applied over another. These approaches must be viewed as tools and just as any craftsman or artist must have multiple tools to avoid the perennial "I have a hammer so it must be a nail" phenomenon; so must the adventure therapist. The following are brief descriptions of the seven generations.

*1st Generation: Letting the Experience Speak for Itself*

Involves simply doing the activity or experience with minimal introduction except for the logistics or safety information. The emphasis in the use of this generation is doing and self-reflection.

*2nd Generation: Speaking for the Experience*

The activity is introduced in a similar manner to the first generation, but it is debriefed differently. The practitioner tells the participants what they have or should have learned from the activity. Essentially, the facilitator is providing feedback to the client. It is about directed attention to a specific issue.

*3rd Generation: Debriefing the Experience*

Generally, the activity is introduced in much the same way as the first two generations, but the activity is consciously processed afterward. The attention is on conscious or guided reflection upon the activity.

*4th Generation: Frontloading the Experience (Direct)*

In this generation, the practitioner may tell or guide participants before the experience on how what they want the client to focus on in the activity. It is about guided attention before the activity.

*5th Generation: Framing the Experience (Metaphor)*

The activity is introduced isomorphically (mirroring) the client's previous experience with opportunities for the client to make changes toward achievement of the treatment goals. The more isomorphic the experience, the less debriefing will be necessary. Practitioners seek metaphors that match the client's experience. This generation is about guided unconscious attention before the activity. The use of metaphor is ultimately about exploring unconscious resources to help clients find alternative paths to make changes in previously established patterns.

*6th Generation: Frontloading the Experience (Indirect/Paradoxical)*

The experience is introduced in such a way that the actual intent of the practitioner is unclear. Common techniques in this approach include predicting client behavior that may not be consistent with their goal. For example, stating to the client "I suspect that when things get hard, you will sit down and give up." Another common technique is the prescription of a symptom, such as when someone has a tendency to be negative, the practitioner may request that the person be negative for a certain period of time. These approaches often create a therapeutic double bind, in that if the client sits down, they

have done what the practitioner predicted and if they don't, they have likely worked toward their goal. This generation is ultimately about indirectly guiding the unconscious process.

*7th Generation: Flagging the Experience*

In this generation, the facilitator uses elements of hypnotic language to help participants mark a path for the unconscious mind to provide resources for the resolution of an issue or address a goal. Participants are naturally absorbed in activities; hypnotic language helps clients use this natural absorption to access the untapped resources of the unconscious mind. It takes advantage of the natural trance state that often develops when dealing with height can be useful in helping clients find the internal resources to continue to move in a rock climb or high element.

## Matching the Activity to Client Needs

Selecting an activity that meets the needs of clients is an important skill of the Adventure Therapy (AT) practitioner. The practitioner must be flexible enough to choose and adapt activities as needed to assist clients in reaching their goals through participation in the activity and reflection on the significance of their participation.

*Clinical Goals*

Every decision you make is related to the clinical goals of your client. In fact, starting the decision process by considering these goals will guide your work toward intentional choices in activities. The goal or purpose of the activity is the core of the decision regarding when to use it. While a client may, and often does, take the activity in a totally unexpected direction, the practitioner attempts to enter the intervention with an activity that usually leads clients to address particular issues that are german to their goal achievement

*Client Interests, Strengths, and Limitations*

A practitioner can greatly influence client engagement, level of involvement, and transferability of an activity by applying the practitioner's understanding of a client's

interests and strengths to the activities used and how the practitioner decides to facilitate them. Practitioners select activities that are achievable for clients.

*Client Development*

Consider the stage of the client in the change process, the developmental stage of the client, or the stage in family or group development. Also assess client's level of emotional, behavioral, cognitive and physical development.

*Sequencing*

Activities are selected in a sequence that supports clients progress toward goals. Previous experience with activities or skills reinforces learning, assists in evaluating the progress of the client, and guides the next steps. Practitioners should make an intentional choice to connect or link activities to client needs.

*Activity Structure*

Consider what is required of a client to successfully complete an activity. It is often helpful to create a parallel process so what is required to complete the activity successfully is the same things that will be required to achieve the treatment goals. There are times when it is helpful to match the actions, movements, or energy level of the client with the actions in the activity. Yet other times, a practitioner may choose the exact opposite of these actions, movements, or energy levels in order to create a paradox or a paradigm shift. Use a client's words, actions, and typical way of responding to life experiences to adapt interventions that match his or her experiential functioning at that moment in the session.

*Activity Presentation and Props*

Assess and attend carefully to the expected implications of the props presented and use them intentionally to enhance the experience. Rules, guidelines, safety considerations, space, and time are all issues that you can adapt to meet the needs of your clients. Assess what the activity will require of your client related to their body and the client's readiness and comfort level to participate in the activity. Structure and present the activity to fit the specific needs of the client. Consider your choice of language when presenting activity or props.

*Level of Risk*

Adapt activities to compensate for what you are seeing in clients related to physical safety and emotional risk. Safety may include considering the physical skills and coordination of the client, responses during previous experiences, and the amount of buy-in or engagement from the client.

# Facilitation: Treatment Skills

Treatment skills gained through appropriate training and preparation to work with client populations are critical to the success of the treatment process. Facilitation using these treatment skills in an informed manner supports client progress toward treatment goals.

**Establishing Engagement with Treatment Process and Goals**

During the first meeting with the client, the practitioner is already establishing client engagement in the treatment process and clarifying client's treatment goals. Primary efforts include establishment of therapeutic alliance with the client and attending to diagnosis, presenting client issues, and cultural factors that may impact the treatment process. Practitioners prepare clients for engaging in treatment by building client understanding of the process, expectations for client participation, and knowledge of the purpose of client involvement in the process. Often it is helpful to frame goals in the client's own language. After this, practitioners continue to assess client needs relative to treatment goals. Practitioners choose activities that highlight verbalization of treatment goals and facilitate opportunities for reflection that focuses on these goals and the treatment process. Client engagement can be enhanced by providing client choices related to activity, level of participation, rules for activities, and development of their own treatment contract (Kimball & Bacon, 1993; Lung, Stauffer & Alvarez, 2008; Priest & Gass, 1997; Schoell & Maizell, 2002).

**Listening to and Responding to Clients**

When listening to clients, practitioners use opportunities to reflect client observations, to explore content shared by clients and to use empathic responses to assist clients in increasing understanding of their experience, responses, strengths, and struggles.

Practitioners empower clients by affirming what they are saying, allowing clients to make their own choices, and asking useful questions to help clients determine solutions on their own. Allowing natural consequences can help to aid a clients' learning processes and it is a useful tool in responding to client actions. When responding to clients, interventions are relevant to a client's diagnosis and can be manifestations of those issues are presented in the treatment context. Knowledge of diagnoses and correlating interventions are imperative to respond appropriately in this dynamic process. The manner in which the practitioner listens and responds to clients directly affects the client's engagement in the treatment process and the likelihood that positive outcomes will be achieved (Knapp, 1993; Priest & Gass, 1997; Lung, Stauffer & Alvarez, 2008; Smith, 1993).

**Verbal Interventions**

The use of verbal interventions is an important treatment skill. The choice of language directly impacts the effectiveness of adventure-based interventions. Develop a common language with clients and consciously choose inclusive language free of personal bias. From this non-judgmental stance, practitioners use strength-based and empowering language that highlights client choice. Additionally, practitioners appropriately use confrontation to assist clients in identifying patterns and consequences related to client beliefs and choices. When considering verbal interventions, take into account how to frame activities, feedback, body language, tone of voice, and other means of communication in a manner that is most effective in meeting client needs. Assist clients in connecting what is happening in the session to intrapersonal and interpersonal dynamics, as well as stated treatment goals. Furthermore, manage the use of self in an appropriate way, considering aspects such as self-disclosure, emotional responses, participation, boundaries, ethics, transference, counter-transference, and dual relationships. This may be affected by theoretical perspective or professional codes of ethics. In adventure therapy, the active participation with the client increases opportunities for boundaries infractions and for productive self-disclosure, engagement with the client, and deepening the therapeutic alliance (Gass, 1993a; Gass, 1993b; Itin, 2003Knapp, 1999; Luckner & Nadler, 1997; Lung, Stauffer & Alvarez, 2008; Priest & Gass, 1999; Mitten, 1994; Peeters, 2003; Priest & Gass, 1997; Priest, 1999; Schoell & Maizell, 2002).

**Process Interventions**

Practitioners often intervene verbally to move the treatment process forward, but process interventions are just as important to support client change. Assess and make intentional decisions about the need for structure, boundaries, use of directives (clear or ambiguous) and maintaining appropriate levels of challenge. Consider timing when intervening to change the activity, stop the process, reframe the process, increase or decrease the level of challenge, and when discussing current client interactions or process. Adventure interventions rely on the use of the activity *as* the intervention, highlighting the importance of using activity selection in making decisions related to process. Physical interventions, including placing a hand on a shoulder, using touch to maintain safety in trust activities, or standing near a client or between two clients during an activity, play an important role in the process as well. Use physical interventions purposefully and carefully. Make decisions that balance empowering client choice with allowing clients to make mistakes. The decisions that practitioners make in regards to process interventions are not formulaic and rely upon effective assessment and intentional choices (Bowne, 1993; Itin, 2003; Lung, Stauffer & Alvarez, 2008; Priest & Gass, 1997; Priest, 1999; Rohnke, 1999).

## Facilitation: Processing

Processing is about understanding what happened in the session and how it relates to the overarching treatment goals. Everything is a process and, at each moment, we are in a cyclical exchange of contributing and receiving something to the process (Itin, 2003). Processing is about understanding this idea and using it. Processing is also the techniques that we use to keep the process going, to engage in ongoing assessment, to match our interventions to client needs, and to support clients in maintaining progress toward their desired change (Gilbert, Gilsdorf & Ringer, 2004; Luckner & Nadler, 1997; Nadler, 1993).

Processing includes actions of the practitioner aimed at enhancing client self awareness and changes in client's behavior - both in the context of treatment and outside of the treatment session. Processing encourages observation and reflection on the here and now experience and development of metaphoric connection to other life situations. Processing can be guided by practitioners and by clients. The choice of processing strategy is closely related to the facilitation strategy used in matching the

intervention (Gass, 1993a; Hammel, 1993; Knapp, 1993; Gass, 1993b; Bacon, 1993; Smith, 1993; Ringer, 2003).

Facilitators enhance processing by:

- Sharing observations of client behavior throughout the activity at the point of performance (Estes, 2008).
- Establishing and affirming metaphors that clients bring to the treatment experience as well as analogies that arise from the content of the material that is expressed (Gass, 1993; Estes, 2008; Priest & Gass, 1993).
- Connecting the client's typical way of responding to life experiences to functioning in the session (Gass, 1997).
- Identifying thoughts, behaviors, and emotional responses that enhance or interfere with the client's strengths and movement toward achieving his or her treatment goals.
- Encouraging experimentation with new or healthier responses to experiential stimuli.
- Sharing information from the practitioner's personal experience of the activity that may enhance the client's learning (Lung, Stauffer & Alvarez, 2008, Itin, 2008; Estes, 2008).
- Choosing the most effective way to begin reflection, including discussion, art, journaling, or other adventure-based interventions (Knapp, 1993).
- Framing the experience in terms that are relevant to other components of the client's life to enhance the transfer of learning (Priest & Gass, 1997, Gass, 1993b).
- Encouraging the client to apply learning during the activity to other life circumstances and practice transferring awareness and skills into his or her life (Gass, 2008).
- Encouraging others in the process to provide feedback and observations for the client.
- Letting go of preconceived ideas about what the activity was intended to teach and process what the client presented during the activity.
- Celebrating successes and highlighting strengths manifested during the activity (Estes, 2008).

- Using a variety of facilitation strategies in an intentional manner to support client progress. The processing of an activity should be linked to the facilitation approach chosen (Priest & Gass, 1997; Estes, 2008).

## Intervention: Adventure Activities

This section introduces activities as the primary mode of intervention and the primary catalyst for change in adventure therapy. Each section defines a category of activity, why that activity could be selected, and practitioner guidelines. These activities are not limited to one specific application and can be used in conjunction with one another. Critical components for all adventure activities include, but are not limited to:

- Physical and emotional safety (Alvarez & Stauffer, 2001)
- Clear therapeutic intent (Priest & Gass, 1999, 1997; Luckner & Nadler, 1992; Schoel & Maizell, 2002).
- Effective facilitation (Lung, Stauffer & Alvarez, 2008; Brown, 1999).
- Client preparation for activities
- Clear behavioral expectations
- Engagement of the client (Alvarez & Stauffer, 2001).

### Practitioner Guidelines

The hallmark elements of adventure activities include a sense of the unknown, an element of real or perceived risk, and an element of mental or physical challenge. A practitioner will attend to all of these elements and consider how they intersect with the treatment outcomes desired.

Practitioner guidelines are discussed that are relevant to all activities used in the application of adventure therapy.

### Categories of Adventure Activities

The diversity of activities available to the adventure practitioner is so great that it would be difficult to capture all activities or even all types of activities. Creativity and

adaptation are at the heart of adventure work. The following pages are an attempt to give substance and definition in a way that is useful in gaining an understanding of adventure activities, reasons for their use, and practitioner guidelines for using them.

- Cooperative activities (games, ice breakers, de-inhibitors)
- Initiatives
    - No Prop and Low Prop Initiatives
    - Low Constructed Initiatives
- Trust Activities
- High Constructed Elements
- Service Learning
- Solo
- Natural Environment/High Adventure Activities
- Expeditions

**Connection to Treatment Outcomes**

The use of adventure activities as an intervention allows for great flexibility in how each activity is utilized in treatment. The combination of the activity with varying facilitation choices can allow one activity to be employed for several different intended treatment outcomes. Therefore, each activity section of this site identifies several reasons why that category of activity may be used but this in no way indicates that those reasons are the only potential uses of the activity. More information about intended treatment outcomes common to a wide variety of adventure activities is available in the Treatment Outcomes section.

# Intervention: Cooperative Activities

**(Games, Ice-Breakers, De-Inhibitors)**

Cooperative activities involve interaction between clients and practitioners that require clients to engage with others for mutual benefit toward the development of therapeutic outcomes. Cooperative activities are often designed by the practitioner with the intention of creating positive interaction and fun. It is important to draw a distinction

between games and activities. Games are playful and without expectation for change in a person. Activities, in this context, are chosen specifically for the clientele and with therapeutic intent. Even an ice breaker is selected with a clear intent in mind (Lung, Stauffer & Alvarez, 2008).

While one might consider the activities that come after these the main course, clients may be affected to a degree that we cannot predict. The practitioner must remain cognizant that the actual level of challenge or anxiety experienced by clients from the cooperative interactions may be a significant issue. Although cooperative games may appear less intense, is defined by the client's experience and planning should be supported by assessment (Lung, Stauffer & Alvarez, 2008).

Unlike many games, which often have a "winner" and "loser", cooperative activities focus on shared process. Often, the goal is for clients to work together with the hope they will discover how they work with others and whether this opportunity to work cooperatively is new or reinforcing.

**Reasons for Using Cooperative Activities**

There are a variety of reasons a practitioner may decide to use cooperative activities as a therapeutic intervention. Some intents may initially appear contradictory, and may be mutually exclusive depending on facilitation choices. For example, reducing stress and providing feedback to increase a client's awareness of their functioning may be contradictory as receiving feedback may be stressful for the client. It is important to remember that the intervention includes both the activity and the appropriate facilitation of that activity with the client.

*Creating Therapeutic Alliance*

Cooperative activities are generally designed to be fun and offer an opportunity for the practitioner to relate to the client on an "enjoyment" level rather than having a focus on problems and deficits. Developing an effective therapeutic relationship between the practitioner and the client is a critical component of successful treatment. These activities can not only support the alliance with the practitioner, but also among other participants in the treatment process. The shared nature of the experience in the adventure context can enhance the therapeutic alliance as the practitioner is involved

with the client in the actions. This fosters increased participation in the therapeutic process.

*Developing an Effective Treatment Environment*

Cooperative activities can assist the clients in developing norms that support therapeutic progress. In a treatment context, creating expectations of confidentiality, respect, safety, belonging and appropriate communication is important. Cooperative activities can enhance the engagement of the client in the treatment process. With effective facilitation, clients will be able to practice accountability and responsibility within the established norms of the group. Cooperative activities involve elements of humor, fun, silliness, and laughter that contribute to development of an effective treatment environment.

*Assessment*

Cooperative activities provide a good opportunity for assessing various aspects of treatment. Practitioners are able to immediately observe client's level of functioning, including interactions with the practitioner and other participants, willingness to engage, and comfort level taking risks. This ability to observe the group provides an assessment of the client's baseline functioning, the developmental stage of the group or individual, and a client's readiness to engage in the treatment process. Cooperative activities can be used to address a lack of knowledge about clients or to assist clients in assessing and learning about one another.

*Cooperation and Relationship Building*

Cooperative activities can be used to support clients in developing willingness to work together and an ability to do so effectively. Many times, cooperative activities are fun and encourage clients to build positive, healthy interactions with others. This intent is supported by being clear with clients about why they are present, what is going to happen to them, and exploring with them how they may react to the situation. The goal may be to move clients toward cooperative interaction one small step at a time. Cooperative activities allow opportunities to model healthy relationships, begin building trust in a group and in the group's abilities, and explore positive risk-taking in social settings.

*Social Skills Acquisition*

There are a variety of opportunities with cooperative activities for social skills acquisition. Clients are able to increase their self-awareness regarding their level of functioning through practitioner and peer feedback. Clients are also given an opportunity to learn and to practice appropriate social skills, and to utilize skills they already possess, such as communication, following directions, or sharing. Cooperative activities may challenge client's pre-conceived notions about themselves, others and practitioners in a way that allows clients to change prior negative cognitions. Cooperative activities can potentially support clients in addressing boundary issues related to space or appropriate touch in a manner that is fun and non-threatening. Addressing these boundary issues relies on effective facilitation to manage appropriately and safely.

**Practitioner Guidelines for Using Cooperative Activities**

It is important as a practitioner to consider that no matter how fun or simple an activity may seem, client reactions to what they are asked to do will be diverse and not always predictable. Due to the potential range of client reactions, using cooperative activities and facilitation is essential. The intervention relies on both to be effective. The following practitioner guidelines should be considered when providing interventions using cooperative activities:

- Remain focused on the therapeutic intent of the activity or there could be a breakdown in the therapeutic process. Activities should be selected that support client progress toward treatment goals.
- Be aware of client cultural beliefs and values about working with others, physical boundaries, and play. Be able to cope with client reactions in a culturally competent manner.
- Use cooperative activities to create less anxiety, stress and frustration than are typically encountered with more involved initiatives. This may act to ease stress experienced by clients who enter with some anxiety about what they are expected to do.
- Attend to the perceived physical and emotional risks experienced by clients, including the cognitive and emotional investments. Do not underestimate perceived risks with particular clients. For example, if practitioners

encourage too much risk too soon, they may damage the therapeutic alliance and trust developed with clients.
- Model appropriate interactions, safety, participation, and maintain a climate of positive energy.
- Monitor for safety, both physical and emotional, and support adherence to any established expectations of clients.
- Create a space in which clients can reduce stress and have fun that generates positive interactions, providing a break from the intensity of the treatment process. Use these activities to change the energy or direction of a group, to refocus, or to reduce stress.
- Consider the need to debrief the therapeutic impact of an activity. Give feedback to clients as appropriate to reach the therapeutic intent of the cooperative activity.
- Consider style and strategies of facilitation in order to enhance therapeutic intent, choice of rules, and how to frame the activity. Be careful to avoid skipping this step.

## Adventure Activities: Initiative Activities

In the context of treatment, initiative activities aim to engage participants in the initiation of emotional or behavioral action towards achieving a therapeutic goal. They require participants to take initiative at solving problems, making decisions, or communicating with one another. Often, they are related to solving problems, and typically encourage a group of people to work together toward a specified outcome. Many initiatives are structured to require physical and mental coordination among participants in order to be completed. Although successful completion is often the focus of clients, it is the process that participants engage in that is the primary focus of the treatment. Initiatives are commonly used with clients in a group context, but it is important to state that these activities are used in a variety of social contexts, including individuals and families.

Initiatives have been divided into two categories here: no and low prop initiatives and low constructed initiatives. There are many terms in the field used to describe or categorize these activities, and many activities are even commonly referred to by

different names. There is some overlap within these categories as well. For example, Wild Woozy is an activity in which participants balance with one another to move across two cables that get farther apart. It is typically thought of as a low constructed initiative. However, practitioners have developed a portable Wild Woozy using two boards joined by a hinge that works in a similar fashion as the constructed wire activity.

Each activity can be structured in different ways to meet intended treatment outcomes or to be effective for varying populations. The categories used here are intended to assist the description of adventure activities and are not intended to be comprehensive or limiting. Creativity and flexibility are helpful skills when facilitating these activities because they allow a practitioner to address client needs in a more specific and targeted manner.

### No and Low Prop Initiatives

No and low prop initiatives refer to activities that either have no extra items in order to participate or that have portable elements, such as cones, carpet squares, or hula hoops. An example of a low prop initiative is marble pass, in which clients are tasked with passing a marble from one point to another through tubes without touching the marble or allowing the marble to touch the ground. There are numerous examples of no and low prop initiatives, and each activity can be structured in different ways to better match the treatment needs of clients. These activities have great versatility not only in their adaptability, but also in the ability to facilitate them in almost any environment.

### Low Constructed Initiatives

Low constructed initiatives refer to activities that have constructed components, often platforms or cables, that physically elevate clients during the experience. These activities typically involve an element of physical risk and require spotting to maintain a high level of safety. An example of a low constructed initiative is islands, in which participants are asked to get across three platforms using two boards. Components of problem solving, trust and cooperation are necessary to completing the activity.

### Reasons for Using Initiatives

There are a variety of reasons a practitioner may decide to use initiatives as a therapeutic intervention. Initiatives, of any category of activity, have a great degree of

flexibility regarding how the activity is structured and introduced for the client. Practitioners make several choices about what intent will be the focus of the activity. Additionally, clients are encouraged to seek their own meaning and outcomes from their experience. This is addressed in more detail in the facilitation section and is a good reminder that the intervention includes both the activity and the appropriate facilitation of that activity with the client.

*Cooperation and Relationship Building*

Initiatives typically require cooperative interactions in order to be completed. This structure supports clients in developing the ability to work together effectively and engage in positive interactions. There is an opportunity with initiatives to assist clients in developing effective social skills through feedback and support. Allowing the group to work through issues together in the context of the treatment environment supports clients in acquiring the skills needed to develop healthy relationships. This includes the development of empathy, conflict resolution skills, and an understanding of effective functioning (Rohnke & Butler, 1995).

*Trust and Cohesion*

Trust and cohesion are commonly sought outcomes of initiative activities. Initiative activities create situations of clients providing support, maintaining safety, and taking care of others. In addition to developing aspects of trust, clients are asked to manage healthy risk by choosing to participate and allowing themselves to trust others. Some activities lend themselves more to these outcomes than others. When the goal is to build trust among group members, activities can be structured to require peers to be responsible for the safety of their group members. Each group member typically has the opportunity to build trust by managing this responsibility successfully. Alternately, the goal may be to build a trusting relationship between the client and practitioner, among family members, or with authority figures. When clients and practitioners successfully manage the safety and well being of others, it supports the development of trust and cohesion. Another potential treatment outcome is supporting clients in managing issues of boundaries, personal space, and appropriate or inappropriate touch. It is critical that a practitioner assesses the client accurately in terms of readiness to manage this type of activity safely (Rohnke & Butler, 1995).

*Problem Solving, Communication and Coping*

Engaging in initiatives typically requires some level of problem solving by clients. Clients are asked to manage the steps of problem solving, including generating ideas, developing plans, implementation, making errors, evaluating and revising. This process can be new to clients or frustrating, which can encourage clients to identify, develop, and use coping skills. Clients in a group setting have the opportunity to observe and learn skills from one another as they work through activities. Clients develop emotional management strategies that they can implement and evaluate. Communication is central to this process, and the effectiveness of the client's communication impacts the positive or negative results of the client's efforts. Initiatives allow clients to not only identify and address issues in these areas, but also allow clients to develop and practice new skills within the context of the treatment environment. Quality facilitation is important to this process in order to maintain a level of growth without setting up the client to experience levels of stress that are debilitating or unmanageable.

*Responsibility and Self-Awareness*

Initiatives create situations of clients being responsible for themselves and others. Clients are able to increase their self-awareness regarding their level of functioning through practitioner and peer feedback. Activities are often structured with consequences that provide feedback to the client about behaviors and appropriate facilitation will assist the client in connecting this feedback to treatment objectives. Initiatives may challenge client's pre-conceived notions about themselves, others and practitioners in a way that allows clients to change prior negative cognitions or to be more aware of their current functioning. Additionally, with this awareness and feedback, clients are asked to be accountable and responsible for their behavior and its resulting impacts on the client and others. Clients are asked to be present, engaged and focused on the process.

**Practitioner Guidelines for Using Initiative Activities**

Initiatives provide wonderful opportunities for clients to reach their identified treatment outcomes when used appropriately. The range of initiatives activities is tremendously diverse in relation to cognitive difficulty, physical engagement, risk, and investment on the part of the client. It is critical that use of these activities in a treatment context is paired with quality facilitation and aligned with the following practitioner guidelines:

- Attend to activity selection carefully to ensure treatment environment, client functioning, safety, level of risk and therapeutic intent are all taken into consideration (Rohnke, 1984, 1989; Rohnke & Butler, 1995; Priest & Gass, 1997).
- Sequence initiatives to support client in movement toward treatment goals by progressively building skills and attending to assessment information. The facilitation section addresses sequencing (Priest & Gass, 1997).
- Activities should not be intentionally structured to be traumatizing, debilitating or unmanageable for clients. Attend to the perceived physical and emotional risks experienced by clients, including the cognitive and emotional investments (Priest & Gass, 1997).
- Monitor for safety, both physical and emotional, and support adherence to any established expectations of clients (Priest & Gass, 1997).
- Be aware of client cultural beliefs and values about working with others, physical boundaries, and play. Be able to cope with client reactions in a culturally competent manner.
- Initiatives that require spotting and safety training should be facilitated by appropriately trained practitioners. Practitioners should adequately prepare and train clients who will be responsible for aspects of safety during an activity, such as spotting.
- Initiatives instructions may be ambiguous to allow the client to cope with the associated problem solving (Rohnke & Butler, 1995).
- Allow clients to make their own choices and deal with the consequences. Allow clients to fail or create novel solutions.
- Focus on the therapeutic intent of the activity but continue to assess in order to identify emerging outcomes or issues that present during the course of activities.
- Practitioners should attend to issues of counter-transference. In particular, focus on the process inherent within the activity rather than focusing on successful completion of the activity.

## Trust and Support Activities

association for experiential education

Trust and support activities involve the creation of an experience in which the client is not in total control and is required to count on other people to accomplish the task presented. It also provides opportunities for clients to be in the position where they provide physical and emotional support and have a level of control over someone's physical safety and emotional well-being. Lots of activities involve trust and support, but these activities involve a primary element of trust as an outcome (Schoel & Maizell, 2002).

Typical trust and support activities involve issues of individuals trusting other people or being personally trustworthy. Activities aimed at trusting other people usually require letting go of control in their immediate situation. Examples of these activities include falling into the arms of another person or group of people, wearing blindfolds, or otherwise moving into a situation in which one is required to count on something other than themselves for safety and personal well being. These activities generally elicit issues relative to trusting oneself to further one's own well-being, as well as to effectively support other people (Schoel, Prouty & Radcliffe, 1988; Smith, 2005a, 2005b).

These activities are generally used after an initial engagement in the treatment has been established, such as when clients are familiar with one another or have done a series of cooperative and problem solving activities together (Bisson, 1999). They include Trust Fall, Blindfold Trust Walk, Vertical Web, Electric Fence, Mousetrap Activities, Wild Woozy, and others (Schoel & Maizell, 2002).

**Reasons for Using Trust and Support Activities**

These activities are appropriately named "trust and support activities" because that is precisely what they are intended to develop. Many times, clients in treatment have issues with trusting others, being trustworthy or both.

*Assessment*

Trust activities provide a good opportunity for assessing trust and support dynamics and issues. Practitioners can observe how clients respond to activities requiring trust and how clients cope when faced with life situations in which their control is limited. Practitioners can note a client's comfort level with allowing others to provide support, willingness to trust others or take risks, ability to maintain healthy boundaries, and beliefs about supporting themselves and other people.

*Developing Therapeutic Alliance*

Trust and support activities can be used to deepen the therapeutic relationship, both with the practitioner or with other clients in a group setting. Practitioners and clients are able to demonstrate their trustworthiness through their actions in activities. This can work to increase the level of self-disclosure from clients and enhance the safety of the therapeutic environment (Newes, 2000).

*Developing Supportive Behaviors and Interactions*

Trust and support activities allow clients to explore how they use support from others or offer support to others. The practitioner can explore with clients their perceptions of different levels of trust in a variety of relationships. These relationships may include authority figures, peers, parents, family members, practitioners, or others. Clients have the opportunity to experience the positive effects of engaging in a trusting relationship or interaction with another person. Clients are also empowered to make decisions about how they will trust others. For example, does a client choose to participate in the trust fall by falling? Or does that client assert his or her own desire to catch others but not fall, setting a personal boundary? Each reaction of a client provides a useful exploration of issues related to trust and support and how those dynamics affect the client's progress in treatment. Clients can also develop some confidence in assessing safe situations and in their ability to support others in a positive way (Newes, 2000; Schoel, Prouty & Radcliffe, 1988;Webb, 1993).

**Practitioner Guidelines for Using Trust and Support Activities**

Trust and support activities require important consideration prior to using with clients in treatment. Clients can experience a wide range of reactions to these activities; not all of these reactions are positive. To assist with decision making, these guidelines are recommended when using trust and support activities.

- • Attend to physical safety prior to every activity requiring trust from participants. Monitor the physical environment for safety hazards. Teach clients adequate skills such as appropriate behavior with blindfolds and safe spotting techniques. Ensure that participants are prepared and capable of providing support needed to maintain safety during the activity

(Alvarez & Stauffer, 2001; Schoel & Maizell, 2002; Schoel, Prouty & Raddcliffe, 1988).

- • Attend to emotional safety prior to every activity requiring trust from participants. Assess the emotional preparedness of participants for the specific activity and the treatment environment to ensure that there is systemic support for desired outcomes to be achieved. Empower the client to make personal choices and take responsibility for how he or she participates. Allow client to establish personal boundaries. Reinforce emotional safety when framing activities (Newes, 2000; Vincent, 1995).
- • Sequence activities appropriately. Start with activities that build initial levels of trust and support between the client and practitioner. These activities can be presented early on in the treatment process to facilitate full engagement - physical, cognitive, and emotional. As client becomes more comfortable with self expression and conflict management in the treatment setting, the practitioner is able to present trust and support activities requiring increased risk by the client. Maintain a balance between the level of challenge and the client's ability to meet the challenge or accept the potential failure (Bisson, 1999; Newes, 2000; Schoel, Prouty & Radcliffe, 1988; Schoel & Maizell, 2002; Lung, Stauffer & Alvarez, 2008).

## Adventure Activities: High Constructed Elements

High Constructed Elements are manufactured activities involving participation at height while connected to a harness and belay system. Activities generally involve climbing, traversing or balancing on wood, cable, and other surfaces to achieve a pre-determined objective. Often, an individual participates in the activity while being supported by peers, family members or the practitioner. These activities can also be structured to require more cooperative interactions. For example, some activities involve client pairs working together to achieve the goal. High constructed elements aim to intentionally stimulate emotional, behavioral, cognitive and physiological responses that can be used therapeutically to support client movement toward treatment goals. Dynamics often encountered include positive risk, trust, coping with challenges, emotional management and problem solving. High constructed elements are likely to involve increased perceived emotional and physical risk on the part of the participant. Facilitation of high

constructed elements requires more advanced technical skills such as rope handling, safety techniques, use of harnesses, knots and rescue (Garvey & Gass, 1997; Priest & Gass, 1997). Some examples include High Ropes, Zip Line, Climbing Wall, Pamper Pole, Rappel Tower, and Dangle Duo (Rohnke, 1999; ACCT).

**Reasons for Using High Constructed Elements**

There are a variety of reasons a practitioner may decide to use these activities as a therapeutic intervention. The paragraphs below cannot encompass all possible outcomes, but instead provide a list of commonly sought outcomes.

Practitioners may not have as much flexibility with altering activities as with initiatives, but there is still a great deal of choice in the facilitation strategy used with an activity to reach treatment outcomes. For example, a practitioner, client, or family member may be able to operate a belay system with appropriate training to work on trust issues (Gass, 1991, 1993; Hovelynck, 1998; Priest & Gass, 1997; Schoel & Maizell, 2002). A climbing wall activity can be structured to ask clients to set and work toward a self-identified goal rather than framed with a goal to reach the top (Gass, 1999). This can help clients develop skills in setting realistic and achievable goals. It is important that adventure activities used in a treatment context are used with therapeutic intent and facilitated accordingly.

*Relationship Building and Cohesion*

The increased perceived physical and emotional risk involved in high constructed elements can encourage clients to express caring and provide support for one another in a tangible manner that assists in the development of group cohesion. Clients may develop empathy for one another as they have a similar and shared experience. Cooperative and supportive dynamics of the process assist in building relationships. These dynamics can also support the development of therapeutic alliance or assist in reinforcing appropriate relational roles. For example, an adolescent client who is mistrustful of adult authority figures has the opportunity to rely on an adult to maintain their safety with a positive outcome (Braverman, Brenner, Fretz & Desmond, 1993; Denti & Leiderbach-Vega, 1992; Hart & Silka, 1994; Schreiber, 2005; Stopha, 1994).

*Coping Skills and Emotional Management*

High constructed elements can trigger a diverse range of emotions in clients. Clients may experience excitement, fear, anxiety, pride, elation, euphoria, frustration or many other feelings during the course of activities. A commonly sought outcome of high constructed elements is to assist clients in developing and implementing various coping skills and emotional management strategies. The process involved in asking clients to set boundaries for themselves about what level of participation is appropriate for them and to stay emotionally connected to the activity regardless of the level of physical participation supports these outcomes. Also, facilitation can assist client in developing self-expression and communication skills that support emotional management and development of coping skills. (Gass, 1993; Hart & Silka, 1994; Levine, 1994; Schreiber, 2005; Stopha, 1994). This outcome can be enhanced by sequencing activities to allow clients to develop coping skills progressively (Bisson, 1999; Hart & Silka, 1994; Itin, 2003; Lung, Stauffer & Alvarez, 2008; Schoel & Maizell, 2002). For example, participating in a climbing wall prior to engaging in high ropes may allow clients to identify strategies and comfort with the equipment at lower heights before progressing to the higher elements. Further, client skills and engagement can allow for a safety assessment as to whether the high elements are even appropriate for them.

*Goal Setting and Problem Solving*

Often, high constructed elements involve a level of problem solving. On a climbing wall, one must decide on a route. On a high ropes course, one must figure out how to get across elements. Clients approach these activities with their own set of expectations and desired goals. Facilitation of these activities can support clients in developing a process for setting achievable goals and working through the steps to reach them. This may involve some tolerance for frustration, management of impulsivity, revision of goals, and self-evaluation. Clients are able to see their progress in a concrete manner. Paired with meaningful facilitation, clients can transfer this process to other life areas (Braverman, Brenner, Fretz & Desmond, 1993; Hart & Silka, 1994; Levine, 1994; Schreiber, 2005; Stopha, 1994).

*Self-Confidence*

As clients develop skills in setting and achieving goals, as described above, there is also an opportunity to develop more confidence in their abilities to be successful. For a client who lacks self-confidence, the progress made in participating in high constructed elements can be used to reinforce gains made in treatment and challenge their

pre-conceived negative feelings about their abilities. These empowering outcomes can relate not only to their ability to participate in an activity, but also in their ability to support others and be responsible or trustworthy. Additionally, clients may develop an improved belief in their ability to be successful. This is referred to as self-efficacy (Braverman, Brenner, Fretz & Desmoond, 1993; Brown, 1999; Rohnke, 1999; Levine, 1994; Newes & Bandoroff, 2004; Schreiber, 2005; Stopha, 1994).

*Trust and Responsibility*

High constructed elements can impact the development of trust in many ways. One aspect is simply to reinforce a client's ability to trust others. High constructed elements rely on systems of safety to prevent injury in a very concrete manner. In order to participate, clients must exercise some level of trust that they will be cared for. Developing trust can be a critical component to relationship building. Activities may be structured to reinforce trust in adults and authority figures or to reinforce trust with peer groups, either through participants being responsible for safety directly, as in belaying, or indirectly, as in providing encouragement and support.

Another aspect of developing trust is an opportunity to develop skills in behaving in a trustworthy manner and developing trust from others. Clients may be asked to be responsible for the safety and support of others, which supports a client in having positive feelings about their ability to be responsible (Denti & Leiderbach-Vega, 1992; Newes & Bandoroff, 2004; Schreiber, 2005.)

Managing personal risk responsibly is another common reason for using high constructed elements. Practitioners can assist clients in developing an ability to identify when risk taking is appropriate or to differentiate a negative from a positive risk.

**Practitioner Guidelines for Using High Constructed Elements**

High constructed elements require elements of facilitation that deserve particular mention. These activities can trigger strong emotional responses from clients. Practitioners must remain cognizant of this and plan to use these activities in a manner that reflects careful assessment of clients and preparedness to respond to client reactions effectively. The following practitioner guidelines highlight special considerations for using high constructed elements:

- Adhere to industry standards in constructing, maintaining, and using high constructed elements. Maintain appropriate industry levels of training and continuing education (ACCT).
- Be competent in all required technical and facilitation skills for high constructed elements being utilized. Be able to train clients appropriately in the technical skills required of them in order to participate (Priest & Gass,1997; Priest, 1999).
- Assess treatment environment, client functioning, safety, level of risk and therapeutic intent carefully to ensure appropriateness of using the high constructed elements (Lung, Stauffer & Alvarez, 2008; Schoel & Maizell, 2002).
- Sequence high constructed elements in a manner that allows clients to progress toward identified treatment goals.
- Do not expose clients to stress that is traumatizing, debilitating, or unmanageable. Attend to the perceived physical and emotional risks experienced by clients in high constructed elements. This includes maintaining a safe treatment environment and assessing the social implications of a client's participation.
- Allow for clients to choose from multiple ways of participating, such as providing verbal encouragement, assistance in problem solving, setting a personal boundary to not physically participate, or taking some other role in the session.
- Attend to the overall group functioning throughout the facilitation of high constructed elements with groups. Although these activities often highlight individual performance, issues of emotional and physical safety are often closely connected with the level of support, empathy, and focus being demonstrated by others who are present.

## Adventure Activities: High Adventure/Natural Environment Activities

Activities in this section are challenging to categorize for their diversity, both in terms of the activity itself as well as the length of time the activities may occur. Activities

discussed here include overnight camping, backpacking, rafting, kayaking, hiking, mountain biking, rock climbing, caving and various other outdoor pursuits. These activities can occur in a day, a weekend, or as part of an extended expedition trip. Expedition activities are discussed in a different section.

In high adventure activities, the consequences of failure to attend to safety requirements can be more severe than in lower-adventure, natural environment activities, such as hiking or fishing. High adventure activities will typically involve more skills development and mastery over some time (Priest & Gass, 1997). In these activities, practitioners must sequence appropriately and assess accurately for competence and confidence, both in regards to physical and emotional safety (Bisson, 1997; Csikszentmihalyi & Csikszentmihalyi, 1997; Neri, 2003). Examples of high adventure activities are rock climbing, paddling on moving water, mountain biking, ice climbing, caving, rappelling, mountaineering, canyoneering, or more remote and extended backpacking trips. Even in these examples, there are not clear lines differentiating high and low adventure activities. Caving could mean travelling through a cave environment that is complex and lengthy or be a more low adventure activity if the cave is simple and short.

Natural environment or low adventure activities have decreased risks and minimal requirements for skills development. The duration may be shorter and may not require advanced skills to be completed successfully. Examples include hiking, creeking, fishing, or paddling on flat water in a controlled environment. In these activities, it is still critical to remain aware that the activity may seem to be low intensity for the practitioner, but may in fact be a high intensity experience for the client.

**Reasons for Using High Adventure/Natural Environment Activities**

Whether low or high adventure, activities in adventure therapy must be intentionally utilized as a part of the change process for clients. In these natural environment or high adventure activities, the structure and requirements of the activity are intentionally used in the process of treatment. Examples of this include using rock climbing to support clients in developing trust and problem solving skills or using primitive skills to support clients in developing an increased sense of self-efficacy and tolerance for the frustration involved in gaining new skills. Commonly sought outcomes of natural environment and high adventure activities are identified below to illustrate how the structure of these activities can lend itself to supporting client change.

*Responsibility and Self-Awareness*

Natural environment and high adventure activities can be intentionally structured to support development of responsibility and self-awareness. One way this is accomplished is the use of natural consequences. In an outdoor context, the results of choices become quite tangible. If a client is expected to learn paddling skills to manage their canoe travel, and applies his or herself to the training, this will immediately affect the client's ability to move forward in a positive manner. Additionally, clients are able to become more self-aware of the results of their own choices when the outdoor environment or activity provides feedback related to these choices. It minimizes the ability of the client to blame others for self-imposed negative consequences. Clients are able to see the impacts of their behavior on themselves, others, and the environment. Clients are provided the opportunity to practice healthy functioning such as taking care of others and taking care of their own needs.

*Self-Efficacy and Coping Skills*

In an outdoor context, skills mastery takes on a stronger sense of urgency as it relates to survival and management of the challenges of the environment. Learning new skills takes on increased importance in coping with the new setting. For example, if clients are expected to belay for one another, the importance of learning the skill is heightened as clients are aware they are relying on one another for safety. As clients are able to develop a level of mastery over these skills, they can experience increased feelings of pride and belief in their ability to achieve. Additionally, clients can become more aware of their manner of coping with challenges, evaluate the effectiveness of this coping based on feedback from the activity or environment, and practice functional methods of coping with challenges. Also, high adventure activities can elicit intense emotional reactions from clients and supported by quality facilitation and sequencing, clients can develop improved skills in managing these emotions effectively.

*Relationship Building and Cooperation*

Participating in low or high adventure activities with another person creates a unique shared experience that can be given positive meaning attributions and enhance relationship development. Whoever participates typically must cooperate and trust one another in some manner as they create an interdependent group. This is an opportunity for clients and practitioners to apply and reinforce the behavioral expectations of the

treatment environment and to practice social skills. Clients are involved in a community that must make decisions together, which fosters a sense of mutual aid. Clients are often responsible to one another for their comfort and survival.

*Environmental Management*

The outdoor environment is one that cannot be controlled but can be managed effectively with training and experience. Practitioners provide a structure for operating within the environment that allow clients to learn how to respond. Practitioners do this by modeling with their own responses to challenges encountered and by empowering clients to make choices and experience the results of their choices. Practitioners provide the safety net while allowing clients to manage their environment in an effective way. Additionally, the environment does not include the distractions available in a client's daily life and can allow clients different opportunities for reflection than are found outside of the natural environment.

*Connection to the Natural World*

While we often focus on the impact of challenge and adventure on client functioning, the natural environment in which many of these adventure-based activities take place is also an important component in the therapeutic change process. A recent study showed that "being in nature" was an equally powerful therapeutic component as challenge and adventure (Norton, 2007). This study also showed that a connection to nature provided clients with time for contemplation and gave them a context in which to reflect on the challenges they faced amidst various high-adventure activities. It is clear that the two - challenge and adventure & the natural environment - work together to provide opportunities for personal growth and change (Quinn, 1997;Powch, 1994; Arnold, 1994; Angell, 1994;Levitt, 1994; Miles, 1993; Nicholls, 2004; Pryor, 2003;Beringer, 200; Louv, 2008).

**Practitioner Guidelines for Using High Adventure/Natural Environment Activities**

Natural environment and high adventure activities require elements of facilitation needing particular attention. Practitioner guidelines related to all adventure therapy activities still apply, but there are some additional considerations when the natural environment is intentionally used with therapeutic populations.

- Practitioners complete a thorough assessment and planning process prior to engaging in natural environment and high adventure activities. Assessment should inform the planning process of the activities and include assessment of risk, clients, staff, and environment (See Assessment ).
- Practitioners and support staff must be adequately trained to manage the environment, clients, and activities as safely as possible. This includes advanced training in the activities, backcountry medical training, and adequate clinical training to work effectively with therapeutic populations to manage the treatment process effectively (Priest & Gass, 1997; Priest, 1997a; Raiola & Sugerman, 1997).
- Practitioners must prepare clients to cope effectively with the challenges presented by activities. Clients should be screened for appropriateness and activities should be sequenced to allow clients to participate in a manner that supports them in progressing in their treatBrown, 1997; ment (Priest, 1997b; Klint, 1997).
- Practitioners must plan activities that are appropriate for the staff and clients who will be participating. This means activities are carefully planned to intentionally support client in reaching established treatment goals, land use rules are considered, and the practitioner or program is adequately equipped with equipment, safety management, and emergency response systems (Horwood, 1997; Priest, 1997c; Van der Smissen & Gregg, 1997).
- As activities increase in technical difficulty, the required knowledge and experience required of the client is also increased. This has an impact on decision making and outcomes for clients. Practitioners need to assess this dynamic throughout these experiences and respond accordingly to support client in progress toward treatment goals (Priest & Gass, 1997; Priest, 1997b; Klint, 1997).
- Practitioners maintain a focus on client treatment and facilitate in a manner that assists client in connecting behavioral and emotional responses to desired treatment outcomes (Lung, Stauffer & Alvarez, 2008).
- Practitioners maintain an appropriate treatment environment that incorporates a focus on physical and emotional safety. When allowing client to experience natural consequences, a practitioner continues to reinforce a therapeutic treatment environment and adheres to the tenet to "do no harm." Allow time for reflection in nature, as the environment is a key

reason for utilizing these activities (See above Connection to the Natural World).
- Practitioners must remember that the natural environment, while a comfortable setting for themselves, may be a very unfamiliar and threatening environment to the client. Cultural perceptions of "wilderness" must also be considered, and meeting basic needs must always be the central focus so that other, more higher level, therapeutic needs may be addressed (Lung, Stauffer & Alvarez, 2008; Mitten, 1994).

## Adventure Activities: Expeditions

Expeditionary activities involve outdoor experiences, both land or water based, aimed at utilizing natural environmental factors to support desired client change. These activities facilitate the initiation and integration of emotional or behavioral action toward achieving therapeutic goals. Existing in a community in the natural environment is a central component of the intervention, as well as reflection, solitude, and contemplation. Clients are removed from everyday distractions and are able to focus on basic needs, receiving feedback from the natural environment, peers and practitioners about their choices and the positive or negative consequences of those choices. Using the natural consequences and feedback from the environment are key components of using expedition activities as a therapeutic intervention.

In expedition activities, programs utilize wilderness expeditions in remote settings and treatment lasts anywhere from 7-60 days (Newes & Bandoroff, 2004). Program models vary greatly in length of program, structure and activities. Russell and Hendee (2000) identified four types of Outdoor Behavioral Health program models, including contained expedition programs, continuous flow expedition programs, base camp expedition programs and residential expedition programs. These interventions are believed to provide intensive treatment and produce dramatic change in a short period of time. They typically employ the teaching and practicing of wilderness skills as an important aspect of the intervention (Newes & Bandoroff, 2004) in addition to using the natural environment.

**Reasons for Using Expedition Activities**

It is important to be clear that this discussion is related to expedition activities utilized for the express purpose of changing dysfunctional problem behaviors in clients through clinically supervised interventions based on a quality assessment and developed treatment plan. The clinical goals addressed through expedition activities are varied, but frequently interconnected. For example, the interdependence required for survival and comfort on an expedition lends itself to encouraging develop effective problem solving and conflict resolution in order for the group to move forward in the expedition. Improved coping skills paired with increased self-efficacy provide a strong foundation for addressing treatment issues. The goals will often be similar to those of natural environment or high adventure activities, as these activities are often incorporated into expedition programming. The distinction of an expedition activity is the intensity and duration of the intervention, allowing for a different level of removal from mainstream society and resulting opportunities for contemplation and reflection.

*Responsibility*

The interdependence of the community in a wilderness setting highlights the importance of responsibility to one another. One way this is accomplished is the use of natural consequences. In an outdoor context, the results of choices become quite tangible. For example, if a client is responsible for setting up a personal shelter and chooses to do this well, then in the event that it rains, the client is rewarded for these efforts. Also, the community itself is an avenue for feedback, support and accountability as the group makes decisions together and must work through challenges together.

*Self-Awareness*

Clients are able to become more self-aware of the results of their own choices when the outdoor environment or activity provides feedback related to these choices. Clients are able to see the impacts of their behavior on themselves, others, and the environment. Clients are provided the opportunity to practice healthy functioning such as taking care of others and taking care of their own needs. Additionally, the environment does not include the distractions available in a client's daily life and can allow clients different opportunities for reflection than are found outside of the natural environment. The wilderness environment lends itself to reflection, contemplation and solitude as well as an enhanced connection to nature.

*Self-Efficacy*

In an outdoor context, skills mastery takes on a stronger sense of urgency as it relates to survival and management of the challenges of the environment. Learning new skills takes on increased importance in coping with the new setting. As clients are able to develop a level of mastery over these skills, they can experience increased feelings of pride and belief in their ability to achieve and to confront the issues that face them in their treatment process.

*Coping Skills*

Clients can become more aware of their manner of coping with challenges, evaluate the effectiveness of this coping based on feedback from the activity or environment, and practice functional methods of coping with challenges. The outdoor environment is one that cannot be controlled but can be managed effectively with training and experience. Practitioners provide a structure for operating within the environment that allow clients to learn how to respond. Practitioners do this by modeling with their own responses to challenges encountered and by empowering clients to make choices and experience the results of their choices. Practitioners provide the safety net while allowing clients to manage their environment in an effective way.

*Relationship Building and Cooperation*

Participating in expedition activities with another person creates a unique shared experience that can be given positive meaning attributions and enhance relationship development. Whoever participates typically must cooperate and trust one another in some manner as they create an interdependent group. This is an opportunity for clients and practitioners to apply and reinforce the behavioral expectations of the treatment environment and to practice social skills. Clients are involved in a community that must make decisions together, which fosters a sense of mutual aid. Sharing the challenges of the natural environment with practitioners can allow clients to engage in the therapeutic relationship in a less guarded manner.

*Connection to the Natural World*

While we often focus on the impact of challenge and adventure on client functioning, the natural environment in which many of these adventure-based activities take place is also an important component in the therapeutic change process. A recent study showed that "being in nature" was an equally powerful therapeutic component as

challenge and adventure (Norton, 2007). This study also showed that a connection to nature provided clients with time for contemplation and gave them a context in which to reflect on the challenges they faced amidst various high-adventure activities. It is clear that the two - challenge and adventure & the natural environment - work together to provide opportunities for personal growth and change (Quinn, 1997;Powch, 1994; Arnold, 1994; Angell, 1994;Levitt, 1994; Miles, 1993; Nicholls, 2004; Pryor, 2003;Beringer, 200; Louv, 2008).

**Practitioner Guidelines for Expedition Activities**

Expedition activities require a great deal of clinical and administrative support in order to be managed safely and effectively. Practitioner guidelines related to all adventure therapy activities still apply, but there are some additional considerations when expedition activities are intentionally used with therapeutic populations.

- Practitioners complete a thorough assessment and planning process prior to engaging in expedition activities. Assessment should inform the planning process of the activities and include assessment of risk, clients, staff, and environment. Treatment objectives are healing and purposeful, not punitive.
- Practitioners and support staff must be adequately trained to manage the environment, clients, and activities as safely as possible. This includes advanced training in the activities, medical training, and adequate clinical training to work effectively with therapeutic populations to manage the treatment process effectively (Priest & Gass, 1997; Priest, 1997a; Raiola & Sugerman, 1997).
- As activities become more remote, practitioners must have increased levels of intervention knowledge to manage client issues that may arise. Practitioners in the field need to have reasonable access to clinical knowledge, support and resources when needed.
- Practitioners must work within their scope of practice and should be clear about what their scope of practice is.
- Practitioners must prepare clients to cope effectively with the challenges presented by activities. Clients should be screened for appropriateness and activities should be sequenced to allow clients to participate in a manner

that supports them in progressing in their treatment(Priest, 1997b; Klint, 1997).

- Practitioners must plan activities that are appropriate for the staff and clients who will be participating. This means activities are carefully planned to intentionally support clients in reaching established treatment goals, land use rules are considered, and the practitioner or program is adequately equipped with equipment, safety management, and emergency response systems (Horwood, 1997; Priest, 1997c; Van der Smissen & Gregg, 1997).
- As activities increase in technical difficulty, the required knowledge and experience required of the client is also increased. This has an impact on decision making and outcomes for clients. Practitioners need to assess this dynamic throughout these experiences and respond accordingly to support client in progress toward treatment goals (Priest & Gass, 1997; Priest, 1997b; Klint, 1997).
- Practitioners maintain a focus on client treatment and facilitate in a manner that assists client in connecting behavioral and emotional responses to desired treatment outcomes.
- Practitioners should provide regular updates with client custodial body, if the client is a minor. For minor clients, family involvement in the treatment process is encouraged for maximum therapeutic benefit (O'Connell & Kutz, 2007).
- Practitioners maintain an appropriate treatment environment that incorporates a focus on physical and emotional safety. When allowing clients to experience natural consequences, a practitioner continues to reinforce a therapeutic treatment environment and adheres to the tenet to "do no harm." This means practitioners do not degrade, humiliate or harm clients. Clients must not be deprived of adequate food, water, or shelter required by the environment (O'Connell & Kutz, 2007).
- Allow time for reflection in nature, as the environment is a key reason for utilizing these activities (Miles, 1993; Nicholls, 2004).
- Practitioners must remember that the natural environment, while a comfortable setting for themselves, may be a very unfamiliar and threatening environment to the client. Cultural perceptions of "wilderness" must also be considered, and meeting basic needs must always be the central focus so that other, more higher level, therapeutic needs may be addressed (Lung, Stauffer & Alvarez, 2008; Mitten, 1994).

# Operational Guidelines for Clinical Practice

Organizations, programs and practitioners of adventure therapy have significant decisions to make related to the guidelines for operating clinical services. Many aspects of providing AT services are addressed throughout this best practices document, but this section deals specifically with operational processes. For more information on standards related to operating adventure therapy programs, refer to the most current AEE Accreditation Manual. The sections addressed for operational guidelines are described below.

### Client Transitions

Policies and procedures regarding the intake and discharge processes are described as they relate to adventure therapy. This section addresses operational standards that should be in place to support these processes to be as effective as possible. Clinical decisions about client intake and discharge are informed by operational procedures, which must take into account the need to accurately assess the appropriateness of a client for the services provided.

### Clinical Quality Assurances

Clinical quality assurance refers to processes within an organization or practice that are in place to ensure the highest level of client care is provided to each client. In this section, expectations are described for having structured, formalized processes for the review of clinical services. Operational guidelines of an organization or practice support the process of assuring the best possible care for each client.

### Risk Management in Adventure Therapy

The focus of this section is on operational standards for risk management as they relate to AT. Having an effective system in place for evaluating and managing risk is a central operational function for all levels of an organization. This section explores some clinical areas that may hold special significance with adventure therapy, including working with issues such as trauma, noncompliance, crisis situations, and program removal.

# Client Transitions in Adventure Therapy

Clients experience many transitions within their treatment process. This section focuses on the primary transitions of intake and discharge from services. Managing both of these transitions well provides organizations, programs, and practitioners improved opportunities to be effective in their work with clients. This section addresses operational guidelines that should be in place to support these processes. Whatever transition a client is experiencing, and due to the nature of AT, it is also important that communication channels are clear, open and being utilized. In addition, documentation of these processes is crucial.

### Intake

Admission to services is a key time in the treatment process for clients. It is when clients are informed about what to expect (and probably families or other natural supports as well), are educated about the risks and benefits of services, and explore treatment goals and their presenting problems. Establishing the treatment environment including the development of engagement and rapport begins at intake. Additionally, practitioners assess clients and determine if the services provided will meet the needs of the client. Therefore, it is important that established policies and procedures related to intake account for this and provide maximum opportunities to enhance the long-term treatment process.

It is best practice to have a diagnostic assessment completed by a licensed mental health professional for a client prior to or at intake. This may be completed by the AT organization, program or practitioner, or it may be provided by a different service provider. No matter the way, it is important to have a clear understanding of the client's issues in order to determine that services are an appropriate fit for the client's needs as well as the client requires the service and will likely benefit from it. If the assessment is completed by an outside provider, it will still be important for the AT provider to compare the diagnostic assessment to the AT provider's admissions criteria to ensure that the client is appropriate for services. The depth of the assessment may be determined based on the type of services being offered and will be impacted by things such as length and intensity of services, severity of client needs or behaviors, or environment of service locations.

In addition to the initial clinical assessment, AT providers are also expected to evaluate medical issues at intake. Once again, the depth of this evaluation is largely dependent on the types of services provided and activities utilized. This evaluation should include identification of medical history and issues, current medications, allergies, and contraindicated conditions. Keep in mind that many medications interact with the environment in unique ways. Be sure to consult with medical professionals about medication side effects that may impact a client's ability to participate in activities. Consider the need for access to trained medical personnel as well. For example, organizations, programs, or practitioners may need nurses on staff, doctors on call, or personnel trained and certified in wilderness medical care. The more intensive the program (whether by activity, remoteness, etc.) the more information practitioners are likely to need in order to plan and respond appropriately. Because of the physical nature of AT, some awareness of medical issues is expected.

It is best practice for operational guidelines for intake to AT services to include clear policies and procedures about clinical assessment, medical evaluation, client population, and informed consent. These guidelines should recognize program limits and provide options for referring clients to other services if it is not a good fit.

**Other Transitions**

Continued assessment throughout any program is integral to best practices. There are many transitions that occur for clients during services that may need to be addressed, including movement through the process of change, crisis intervention, situational family or residential placement changes, etc. Operational guidelines also include clear procedures and policies about continued clinical assessment, medical evaluation, client population, and informed consent. These guidelines should recognize program limits and provide options for referring clients to other services if it is found to no longer be a good fit.

**Discharge**

The client's transition at the end of a program is an important time. Clients should be prepared for discharge, as well as any family or natural supports who are involved in the client's care. Clients are more likely to be successful if some work has been done in their home environments prior to discharge to reinforce their change process. Additionally, the next steps in the client's care are critical ones and practitioners are

responsible for attempting to link clients to whatever services are appropriate for their next steps in treatment. Practitioners are also expected to communicate about discharge with all involved in order to support the client in having a successful transition. Operational standards for managing this transition should involve producing a clinical summary of client progress toward goals, a discharge plan, and recommendations for future services. Best practices for guidelines around discharge also include measuring outcomes, connecting clients with appropriate aftercare services, and communicating about services to appropriate people (families, other providers, client natural supports, etc.)

## Clinical Quality Assurances

Clinical quality assurances reinforce the commitment of a professional to providing the highest quality care to each client served. This is consistent with ethical practices expected of all mental health professionals. These assurances are structured to ensure there is a regular review process related to the quality of client care that helps address the difference between what is actually happening in services and what should be happening. The standard of utilizing clinical quality assurances applies to organizations, programs, and individual practitioners. Decisions related to quality client care are not made in a vacuum - the process of quality assurance is to be present throughout all aspects of service, whether in an organization or a private practice.

In order to have an effective system, the standards of quality to be monitored need to be defined in order to establish criteria for review. These standards are to be based on best practices and the professional norms of behavior. Policies and procedures must be in place that address the process to be used, the accountability involved, and who is responsible for components of the system. There are many options for review processes, including peer review, case studies, client satisfaction surveys, program evaluations and others. The processes selected by organizations, programs, and practitioners ultimately need to fit within the structure of services provided. The process for clinical quality assurance should be clearly documented and involve stakeholders including staff at all levels of an organization and clients.

Whatever system is implemented by an organization, program or practitioner, it should ensure that the following clinical quality assurances exist, are reviewed and are clearly documented:

- Assessment: Initial assessments are completed regarding client appropriateness for services (often these are diagnostic in nature). Ongoing clinical assessments occur throughout services in order to best tailor interventions for client needs.
- Treatment Planning: Appropriate and effective treatment plans are to be developed with clients that indicate the frequency and duration of interventions for clearly identified problems. Treatment plans include who is responsible for components and discharge criteria.
- Clinical Documentation: Documentation is to be completed completely, professionally and in a timely manner. Documentation will likely include assessments, treatment plans, progress notes, and incident reports. It may also include medical forms, evaluations, or paperwork from other sources.
- Informed Consent: Practitioners are expected to communicate clearly and openly with clients about the risks and benefits of treatment options so clients can make informed decisions about the type of treatment they want to use. After being informed, the client has the option to consent to the treatment. This can become challenging with minor-aged clients, whose parents or guardians are legally in charge of providing consent or with involuntary clients who are mandated by courts to participate in treatment. Clients, even minor-aged clients, cannot legally be forced to participate in treatment unless they present an immediate risk of harm to themselves or others (as assessed by a licensed mental health practitioner) so they must give some level of consent in order to participate and cannot physically be forced to do so. Best practice is to inform clients completely about the risks and benefits of services and to gain their informed consent to participation in treatment. Any informed consent process should be documented in order to formalize the agreement and make it clear to both clients and professionals what is expected.
- Confidentiality: In providing AT, it is expected for organizations, programs and practitioners to inform clients about their level of confidentiality and the limits of confidentiality. In addition, processes for storage of client files and managing documentation are to adhere to industry standards in mental health practice.
- Client's Rights and Grievance Processes: A clear listing of client's rights should be provided to client's at the beginning of any treatment process as

well as a description of the grievance process to be used if the client believes his or her rights have been violated.
- Program Evaluation: The effectiveness of services is evaluated in order to determine if the services are meeting designated goals. This process informs program development efforts aimed toward improving services to clients.

In summary, the best practice is to have a clear, structured system in place for reviewing the quality of clinical care provided. The criteria developed for review are expected to be based on best practices, including professional norms, industry standards of practice, and the best research evidence available. This process should involve all layers of service in an organization and be clearly documented. Clinical quality assurance helps us to ensure we are providing safe, effective, and ethical services to our clients.

## Risk Management in Adventure Therapy

Having policies and procedures in place for risk management is critical for any organization to operate effectively. Guidelines for risk management related to adventure activities are well documented and will not be explored here. The focus of this section is on operational standards for risk management as they relate to AT. Adventure therapy provides a risk-rich environment that can allow for emotional growth as long as the risk is well-managed. Organizations operate under differing philosophical paradigms and will have differing risk management needs as a result of this. Some organizations will have a higher level of acceptable risk than others, whether discussing activity selection or the types of clients to be served. However, when an organization takes on the role of providing adventure therapy, this narrows the field of acceptable risk because the ethical requirement for providing any therapy is to do no harm. Risk management decisions in AT are made in accordance with ethical standards of practice and organizations, programs and practitioners are expected to balance the level of acceptable risk effectively to limit the risk of doing harm to clients in their care.

Best practice is to have a culture of awareness that risk management is critical to the services provided and investment in the processes set in place to manage risk. The needs of clients, skills of staff, and the activities utilized will influence the amount of risk that is appropriate for any adventure therapy service. Everyone involved in the

provision of service - staff, practitioners, clients, management, etc is a partner in the process of managing risk. Know which populations or diagnostic issues you can serve effectively and which you cannot. Ensure that practitioners are educated in what is best practice for the clinical issues and populations you are providing service for.

Some topics related to risk management have aspects that need addressed as they relate to providing adventure therapy.

**Emotional Safety and Trauma**

Although AT is a powerful tool for intervention and positive change, the potential to traumatize or re-traumatize clients in adventure therapy can be high if the risk is not managed well. Therefore, it is of paramount importance for organizations, programs and practitioners to have established risk management plans in place that reduce the potential for causing trauma to clients. Each decision made in the course of providing AT, whether that is in admission, assessment, intervention, or discharge should weigh the possibility that a client may be harmed or traumatized, intentionally or unintentionally. If the likelihood for trauma is anything but low, decisions should be made that err on the side of caution to protect the best interests of the client. In addition to needing policies and procedures in place, staff training in the provision of trauma-informed care is critical when providing services to clients who have experienced trauma. Potential areas for trauma in AT are readily available - the use of escorts for assisted admissions, participation on a high ropes course, coping with extreme weather, waiting long periods to eat for clients who have dealt with neglect, or blindfolding participants are just a few examples. Additionally, the potential for trauma is largely dependent on the perspective of the individual affected. This means that the client assessment and their participation in treatment planning becomes even more critical in managing the risks associated with trauma in AT. Best practice for managing risk related to trauma in AT is to engage the client in the process, consider trauma carefully in clinical decisions, and train staff appropriately to assess and respond to clients.

**Involuntary Clients and Noncompliance**

Client self-determination and voluntary participation in treatment is central to ethical codes related to providing therapy, yet mental health services in the US frequently deal with mandated and involuntary clients. This situation is not unique to adventure therapy,

providing AT practitioners with professional guidelines for dealing with involuntary clients and noncompliance that are drawn from mental health fields. It is clear, for example, that it would be unethical to restrain a client for noncompliance. Physical restraints are to be used only as a last resort, when all other resources have been exhausted, to maintain safety when a client is placing him or herself or someone else in immediate danger.

Many AT activities involve a higher level of risk when a client is non-compliant with following safety instructions or maintaining physical or emotional safety for other participants. Travel in the backcountry, high elements such as high ropes, or initiatives activities such as trust fall require some level of client compliance in order for participants to engage safely. AT practitioners must assess clients and facilitate activities carefully so that risk is managed and clients are compliant at an acceptable level.

Best practice for AT is to maximize client investment in the process by working collaboratively with the client in developing the goals and direction of treatment. This is not always possible due to the range and severity of client needs, but practitioners can continue to strive to meet this standard as it is likely to lead to improved client outcomes and higher quality client care while minimizing the risks involved when engaging in more adversarial relationships with clients.

Organizations, programs and practitioners are expected to have policies and procedures in place that effectively manage the risks associated with noncompliance, involuntary clients, and the expected response to these issues so the risk of doing harm is reduced and client care can be improved.

**Clinical Crisis Management**

Clients may present with many different types of crisis situations in which their ability to cope with stressors becomes overwhelmed and they lose control of their behavior. A crisis situation presents both an opportunity for growth or an opportunity to damage clients, depending on how practitioners respond. Examples of crisis situations include client's engaging in physical aggression, running away, suicide ideation or attempts, experiencing psychosis, or destroying property.

In adventure therapy settings, particularly as services become more remote, significant consideration must be given to how crisis situations will be managed in order to do no harm. Best practice is that risk management plans are in place to deal with anticipated or unanticipated crisis situations, that clients are informed about their role in crisis management and engaged in planning for anticipated problems, and that AT practitioners are trained in crisis management techniques appropriate for the populations with whom they interact. In wilderness settings, it is particularly important to consider the ability of the organization, program or practitioners to manage clients in crisis in remote settings without doing harm to the client. It has clearly been demonstrated that this can be done with careful planning, training and implementation, but providers of these services are cautioned to maintain a focus on managing this risk effectively so that client care does not suffer.

**Client Removal or Program Extension**

Practitioners are faced with making decisions about client services related to removal from services or extending services beyond an initially agreed upon length of time. Policies and procedures related to client removal or program extension that account for available resources, staff skills, and ability to manage the issues presented by clients are an important part of managing risk in programs. Organizations, programs and practitioners need to have a clear idea of the severity of client issues that can be managed by the services provided and follow identified criteria in making these clinical decisions. If a client presents a significant risk of harm to self or others, program removal must be considered. The guidelines for making these decisions will vary considerably depending on the type and structure of services provided, resources available and training and experience of the practitioners. Best practice for managing this risk is to have clearly documented guidelines, policies and procedures that account for all of the above mentioned variables.

# Research

This section is intended to share available research with our community. The below bibliography includes research from the fields of psychology, counseling and psychiatric nursing. Soon, we will have additional information from the fields of therapeutic recreation and social work.

Helpful Tip: **How To Search for Words or Phrases in a PDF Document**

association for experiential education

When searching through the bibliography you will note that each citation is "tagged" with keywords. This tagging process should allow you to use the word find function on your computer to easily identify what research is available on a given topic.

View the current Research Bibliography.

## Adventure Therapy Best Practices Bibliography


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