

What is Adventure Therapy?

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The field of Adventure Therapy is experiencing substantial growth and is becoming more well-known. This increased popularity is leading more readers to the literature in search of information. Many of these readers have had little or no prior exposure to the field of Adventure Therapy. This paper is intended to provide an overview for those readers to help them better understand the principles and theories upon which Adventure Therapy is based. This will serve as a foundation for the chapters that follow in this text. At the same time, the authors believe that there is a need to understand Adventure Therapy in the context of broader mental health treatment. Toward that goal, this paper highlights the theoretical constructs that Adventure Therapy shares in common with other treatment approaches, as well as those that are unique to the field.



Although the intentional application of adventure education principles to therapeutic populations has been occurring for nearly forty years, many are unfamiliar with the field of Adventure Therapy (AT). It is not uncommon to encounter individuals who experienced great relief upon discovering the field of AT, having thought that they were going to have to create an entirely new discipline. This common experience speaks to both the natural fit between nature and therapy, as well as to the relative obscurity of the field. The numbers of readers of AT literature are growing as more students, traditional mental health practitioners and consumers of AT are attracted to the field. However, while there is an increase in attention focused on AT, it can be difficult for interested individuals to find an overview of the basic essential foundations of this field. In recognition of the fact that many of our readers have had little prior exposure to AT literature, we are providing this overview as a means to introduce the chapters which follow.

Another goal of this chapter is to highlight the commonalities of AT with more traditional mental health treatments. Much of AT may not be particularly unique and it is important to recognize this in developing a thorough understanding of the discipline. Moreover, as AT struggles to gain credibility in the mental health community, establishing commonalities with widely accepted mental health treatments helps to support the growth of AT as a viable mental health approach. It also may allow AT to borrow from the extensive research literature of more widely recognized mental health treatments as a means to provide support for its practices. Naturally, despite commonalities to other approaches, AT has its unique aspects. These will be highlighted as well.

Theoretical Background

Experiential Education

AT is rooted in the tradition of “experiential education” philosophies (Kraft & Sakofs, 1985), defined as “learning by doing, with reflection” (Gass, 1993). Early roots of experiential education can be traced to the educational writings of Dewey (Kraft & Sakofs, 1985). This experiential learning tradition is based on the belief that learning is a result of direct experience, and includes the premise that persons learn best when they have multiple senses actively involved in learning. By increasing the intensity of the mental and physical demands of learning, the participant “engages all sensory systems in a learning and change process” (Crisp, 1998). Psychological research on information processing provides some support of this premise, indicating that multi-sensory processing accounts for a higher level of cognitive activity and increased memory. Applied specifically to the context of AT, the multi-sensory level of the therapeutic experience inherent in adventure activities may account for the high level of change reported by practitioners (Crisp, 1998). This suggests that “integration of experience may be more deeply anchored for the client because of this broad [sensory] base” (Crisp, 1998, p. 67).

Experiential education theory also postulates that active learning is often more valuable for the learner because the participant is directly responsible for and involved in the process. In addition, experiential learning theory is based on the belief that learning is enhanced when individuals are placed outside of their comfort zones and into a state of dissonance. Learning is then assumed to occur through the necessary changes required to achieve personal equilibrium [(i.e., modern dissonance theory), Festinger, 1957]. Kraft and Sakofs (1985) outline several elements inherent to this experiential education process:

1. The learner is a participant rather than a spectator in learning.
2. The learning activities require personal motivation in the form of

energy, involvement, and responsibility.

3. The learning activity is real and meaningful in terms of natural consequences for the learner.
4. Reflection is a critical element in the learning process.
5. Learning must have present as well as future relevance for the learner and the society in which he/she is a member.

In experiential classrooms, individuals are placed in “real life” situations in which it is necessary to employ problem-solving or otherwise creative methods of working with the environment or context at hand. Therefore, effective experiential activities involve the participant in situations in which they must take some form of action to successfully cope with their surroundings. Such activities may take the form of outdoor pursuits such as hiking, rock climbing, or kayaking, but also include team-based initiative activities. Outward Bound is widely recognized as one of the innovators in incorporating the philosophies of experiential learning into adventure activity approaches (Bacon, 1983; Gillis & Ringer, 1999).

The Link to Therapy

In the late 1960's Outward Bound expanded the application of their adventure education model to therapeutic populations (Kelly & Baer, 1968). Gass (1993) has reworked the above experiential education principles and discusses how these principles can be applied to therapy.

1. The *client* becomes a participant rather than a spectator *in therapy*.
2. *Therapeutic* activities require *client* motivation in the form of energy, involvement, and responsibility.
3. *Therapeutic activities* are real and meaningful in terms of natural consequences for the *client*.
4. Reflection is a critical element of the *therapeutic* process.
5. *Functional change* must have present as well as future relevance for *clients* and their society (p. 5).

It is interesting that when examining the ideas stated above by Gass (1993), it is evident to the critical reader that most of these principles are not unique to AT. In actuality, one can see even from these basic statements that the theory of AT builds on the foundations and well-established premises of accepted psychological theory, including cognitive and cognitive-behavioral theory, humanistic theory, and elements of the interpersonal aspects of object relations theory. Therefore, it appears from this definition that what AT may offer is a potentially unique medium for the implementation of therapeutic processes assumed to be present in many therapeutic orientations. Although this may be considered controversial, the remainder

of the chapter will offer evidence to support this position.

Definition of Adventure-Based Therapy

Also referred to as “wilderness therapy,” “therapeutic adventure,” “adventure therapy,” “wilderness-adventure therapy,” “adventure-based therapy,” and “adventure-based counseling,” AT is a therapeutic modality combining therapeutic benefits of the adventure experiences and activities with those of more traditional modes of therapy. AT utilizes a therapeutic focus and integrates group level processing and individual psychotherapy sessions as part of an overall therapeutic milieu. While specific types of facilitation occur directly related to the activities, this processing is not associated exclusively with the activities alone. Rather, the activities can also be conceptualized as a catalyst for the processing which occurs before, during, and after activities; a catalyst which provides concrete examples of the immediate consequences associated with individual and group actions that can be referred to by both the client and the therapist. Therefore, therapists may begin with processing exigencies around the activities themselves and branch into other areas related to the issues of the clients. This approach tends to make such discussions more relevant for clients and therefore, arguably, more engaging.

As such, AT lends itself well to multimodal treatment and can be utilized as an intervention independent from other treatments or as an adjunct to other well-established treatments. Importantly, therapists are able to use any type of therapeutic orientation they adhere to in the processing that occurs around the activities. This view contrasts with a commonly held assumption that the postulated change which may occur in AT is singularly related to the activity participation.

Ringer (1994) defines AT as a generic term referring to a class of change-oriented, group-based experiential learning processes that occur in the context of a contractual, empowering, and empathic professional relationship. Notably, elements of this definition are not unique to AT and can be assumed generally in many therapeutic traditions. However, the emphasis on “group-based experiential learning processes” in a typically outdoor and active setting is clearly a combination differentiating AT from other forms of therapy.

Interestingly, Ringer’s definition does not mention “adventure.” This purposeful omission challenges one common misconception about AT: namely, that in order to accomplish their goals, clients must necessarily subject themselves to adrenaline-fueled feats of daring and technical skill. The fact that “adventure” is not seen as an end unto itself distinguishes AT from other types of outdoor programming devoid of therapeutic focus. In line with this definition, adventure or outdoor experiences alone are not assumed to be sufficient to facilitate deep-level therapeutic growth and

change. Instead, it is the processing of the actual experience with the client that promotes the therapeutic process. Therefore, the use of the word “adventure” may in fact be misleading and terms such as “activity-based psychotherapy” may be more appropriate (Gillis, 1992). However, this term has not become one of common usage in the literature and adventure therapy, with all of its connotations, is the name that has become standard.

In examining this discussion, it can be seen that there are problems with delineating distinct and defining parameters of AT. To address this problem, professionals within the field have been involved in an ongoing debate as to how to best articulate a clear definition of what is unique to AT as a treatment modality. Such a definition must necessarily incorporate widely accepted therapeutic principles while also differentiating AT from other therapies and from other types of outdoor adventure programs. In an attempt to focus such definitions, Simon Crisp (personal communication, August 24, 2004) offers the following:

1. Wilderness and/or adventure methods are utilized in the service of therapeutic practice. Therapeutic practice involves:
 - a. the identification of a problem the client presents with,
 - b. application of a theoretical framework based on a theory of personality, behavioral and psychological problems and process of change that explains the origin and nature of the problem;
 - c. selection of strategies of client management and method(s) of intervention which logically and parsimoniously relate to b);
 - d. strategies and methods are routinely reviewed and modified according to client need.
2. Professional relationship exists between therapist and client with the following characteristics:
 - a. therapist brings to the relationship training and experience necessary and appropriate to meet all foreseeable needs of the client, including a capacity to assess and manage (a) life-threatening and other crises, (b) psychological boundaries, and (c) any potentially competing needs of the therapist,
 - b. a contract is formed between therapist and client about the aims, limitations, methods, expected outcomes and risks of therapy,
 - c. therapist works towards the best interests of the client and holds this at all times the overriding principle in determining the actions of the therapist, and the therapist acts to protect the client from harm—both physical and psychological.

Once again, the singularly unique aspect of this definition is the emphasis on activities as a means of accomplishing the other common ther-

apeutic goals. This appears to hold true as well for the definition put forth by Alvarez and Stauffer (2001): "Adventure therapy is any intentional, facilitated use of adventure tools and techniques to guide personal change toward desired therapeutic goals" (p. 87). Again, it is also this focus on the use of activities to accomplish said goals which seems to differentiate AT from most other therapeutic orientations. Based on this, perhaps AT can be best seen as an activity-based approach to treatment that attempts to meet similar goals as do other treatments. Therefore, what must be parceled out as theoretically unique to AT is the mechanism by which AT can accomplish these goals in ways that are more efficacious than other treatments for particular clients. This is a question that remains as yet unanswered. Simply put, it is essential that the field of AT begin holding itself accountable for answering the questions posed to all other treatments: Is this treatment effective? For whom, and under what circumstances?

Thought of in this way, AT can begin to be seen as more similar to other types of treatments than different. The logical assumption should follow then that AT is assumed to operate under the same scientific and clinical umbrella as other mental health treatments, and therefore, practitioners of AT should be held accountable to the same standards as other practicing mental health professionals. However, in reality this is not always the case. AT is often presented by its proponents as though it is a unique and separate entity, an entity somehow not responsible for upholding such standards. This presents a clear contradiction between established standards of mental health practice and AT.

This dilemma is reflected in the ongoing debate within the AT field about the necessary qualifications for an adventure therapist. Let us return to the definitions offered above in an effort to gain some clarity. While Ringer's reference to a "professional relationship" would not suggest that the facilitator necessarily be credentialed, Gillis' inclusion of the word "psychotherapy" clearly indicates the involvement of an academically trained therapist. Crisp attempts to elucidate the issue by defining "professional relationship" but avoids delineating the training, so that uncredentialed professionals might meet the criteria (note that the title of "therapist" is not restricted in many jurisdictions). One can see that clarity is not easily achieved.

The debate surrounding this topic is extensive and heated. It has serious implications since the outcome would prescribe who is qualified to conduct AT programs. Some in the field advocate for a required level of competency as reflected by a specified level of training and accompanying credential, while others advocate "training through experience." This discussion may reflect a presently existing division one finds between those AT practitioners who have followed the more established route of academic and clinical training and those who have learned their clinical skills through direct experience. A related controversy involves the use of the

term adventure therapy with some advocating that adventure therapy programs must involve clinically trained therapists, while those programs working with clinical populations without clinically credentialed staff should be referred to as therapeutic adventure. Further discussion of this topic is beyond the scope of this paper. For more information the reader is referred to chapters by Crisp and Williams in this edition.

From the standpoint of mental health practice, the eventual outcome to this debate must involve holding AT to the same standards of care as are other mental health treatments. This would necessarily include a thoughtful examination of ethical practice in AT as well (Newes, 2000). However, in order for this change to occur, there must be further efforts made to establish a foundational knowledge that indicates that AT shares more similarities with other mental health treatments than is commonly believed within the field. It is only with the establishment of such a belief, as well as a clear semantic and theoretical link, that AT will in actuality operate under the aforementioned umbrella of scientific and clinical practice.

Goals of Adventure-Based Therapy

AT proponents have articulated a variety of goals that are recognized as being associated with the modality. While recognizably unsupported by solid empirical data, the following section will broadly summarize these interconnected goals. First, clients are thought to generally increase in self-awareness, leading to an increased recognition of behavioral consequences and available choices; second, clients have a higher level of accountability both to self and others; third, clients are thought to learn healthier coping strategies leading to increased environmental control; fourth, through AT, clients are thought to be provided tangible evidence of success, thereby correcting negative self-conceptions and leading to a more positive self-concept; fifth, clients are thought to learn creative problem-solving, communication, and cooperation skills; and sixth, AT is thought to facilitate realistic appraisal of individual strengths, weaknesses, and self-imposed limitations. Ultimately, this increased awareness is thought to lead to better decision-making abilities.

Overall, AT programs have the overriding goal of an increasing self-awareness in a variety of domains. In line with this, it is thought by AT theorists that connections between behavior and the results of such behavior become more apparent. Therefore, clients can be provided with concrete examples of dysfunctional behavior and shown that alternative behavioral and interpersonal choices can lead to success. Relatedly, Bandoroff (1989) argues that adventure activities, with the feedback and consequences available through such experiences, provide learning that enables participants to begin regulating their own behavior. Amesberger (1998) expands on this goal, noting that AT involves:

...the reflection on internalized norms and values with the aim to support a person to find new and more suitable structures for his or her life. Destructive and dysfunctional behaviors or emotions should be recognized in their effects, as well as helpful and effective ones (p. 29).

Along with this increased insight and capacity for controlling their behaviors comes a higher level of accountability. This goes well beyond the elementary goal delineated in most programs of accepting responsibility for behavior. What we are alluding to here speaks more to integrity. Clients develop an understanding that they have a higher calling than what their prior conduct would reflect. The AT treatment is designed to help them get in touch with that potential and begin to live in alignment with the higher standards dictated by this greater sense of self. Such a life implies an accountability to self that entails, but is more than, accountability to others.

Of note is the fact that the above noted tenets are clearly embedded in the therapeutic process itself, as opposed to embedded within the activities. Taylor (1989) postulates that the exposure to uncertainty or ambiguity accompanied by increases in levels of confidence and skill that can be achieved through the AT process will facilitate a healthier coping response. It is believed that as clients learn and use new modes of coping, they gain greater control of their environment (Nadler & Luckner, 1992). It is hoped that by coping with the treatment environment in new ways, clients can learn to achieve increased personal and environmental control outside of the treatment. This is an experience which may be novel for many clients.

According to Herbert (1996), through AT “persons challenge themselves, and in doing so, (re)learn something about themselves” (p. 5). To accomplish this, mastery tasks, or initial successes, associated with the activities counteract and disprove internally focused negative self-evaluations, learned helplessness, and dependency (Kimball & Bacon, 1993) at a time when such processes may be intensely activated. This heightened activation combined with concrete evidence of success may facilitate further learning. Ultimately, feelings of success and control also associated with the mastery tasks can then serve as additional reinforcers to support changed behaviors. Thus, it is a circular process of interpersonal and intrapersonal activation, success, and reinforcement.

Priest and Baillie (1987) discuss additional possibilities for client change, stating that “The aim of adventure education is to create astute adventurers: people who are correct in their perceptions of individual competence and situational risk” (p. 18). Relatedly, through AT, clients can learn skills related to problem-solving, cooperation, communication, and facing challenge (Herbert, 1996). It is thought that through this process, clients learn to more realistically appraise their own personal strengths and weaknesses, both on a personal and an interpersonal level.

Through this process, clients begin to recognize their own self-imposed limitations and increase in their awareness of available choices, thus becoming better able to accept responsibility for their level of success or failure. As clients increase in this self-knowledge and self-awareness, it is believed that they are ultimately able to make more realistic and healthy decisions. These are important skills many clients lack. Moreover, Taylor (1989) notes that the increased levels of confidence, skill, and self-awareness that participants may gain through AT encourages clients to see uncertainty as a challenge and not a threat, a change with potentially far-reaching positive consequences for clients.

Ultimately, these proposed changes can perhaps be summarized in this inherent underlying assumption embedded within the adventure-based therapy literature: the assumption that by becoming aware of available choices, and by experimenting with different behaviors in a novel environment where one is receiving immediate and realistic feedback, clients can learn to actively influence their probability of success. Furthermore, through AT clients learn to demonstrate personal competencies, build upon skills, accept personal responsibility, more accurately assess themselves, and maintain a higher degree of control over their environment. It is also believed that having an increased capacity to regulate one's own behavior will facilitate further increases in levels of self-awareness, competence and a more internal sense of control of one's own world.

Again, it is important to be aware that these assumptions and goals are common to many other treatment approaches. In fact, statements such as those above with their emphasis on self-awareness and the interpretations of challenge vs. threat carry clear elements of humanistic theory, and the focus on self-knowledge and the increased awareness of available choices directly parallels the humanistic tradition (Csikszentmihaly, 1990; Raskin, & Rogers, 1989; Maslow, 1971). In addition, one can see elements of cognitive, behavioral, and object relations theory embedded in this discussion of the goals of AT.

Characteristics of Adventure Therapy

Having discussed the theoretical background, definition, and the goals of AT, a discussion of the specific characteristics of AT is warranted. Fourteen characteristics, including those delineated by Kimball and Bacon (1993), will be discussed in turn: (1) multiple treatment formats, (2) group focus, (3) processing, (4) applicability to multimodal treatment, (5) sequencing of activities, (6) perceived risk, (7) unfamiliar environment, (8) challenge by choice, (9) provision of concrete consequences, (10) goal-setting, (11) trust-building, (12) enjoyment, (13) peak experience, and (14) therapeutic relationship.

Multiple Treatment Formats

First, adventure programs range in scope from those which incorporate adventure-based techniques with more traditional modes of therapy to those that utilize full-scale extended expeditioning as their therapeutic medium. These types of programs are differentiated based on *where* the therapy is taking place, for what length of time the clients involved, and what types of *programming* are being utilized (Gillis, 1995). As Gass (1993) suggests, three main areas exist within the adventure-based therapy field: (a) activity-based psychotherapy, (b) wilderness therapy, and (c) long-term residential camping.

Given the diversity of programs, it is important to be clear as to what type of program is being referred to under this broad rubric of “adventure therapy” when considering AT from a scientific perspective. Unfortunately, this distinction is not always clearly noted and can be difficult to determine when examining the literature.

Activity-based psychotherapy.

Activity-based psychotherapy (Gillis, 1992) utilizes adventure activities as one type of intervention in the client’s overall treatment plan. This type of therapy can occur at the therapeutic facility of the client, at another nearby facility designed for such interventions (e.g., ropes course), or simply in a park or open space using mobile elements. The AT intervention may range from a regularly scheduled one hour group to a full day in duration, which is typical for a ropes course experience.

This type of format is often used in inpatient or residential settings, but can also be used in combination with outpatient psychotherapy. The experiences tend to be contrived (i.e. the facility and initiatives are developed specifically for such an intervention), and focus on teambuilding, trust and problem-solving (Banaka & Young, 1985; Witman, 1987; Witman & Preskanis, 1996). As the group builds upon previous skills and successes to overcome each successive challenge, they increase group cohesion and confidence.

Crisp (1997) more fully defines this type of adventure-based therapy by its “emphasis on the contrived nature of the task, the artificiality of the environment and the structure and parameters of the activity being determined by the therapist” (p. 58). In addition, he notes that the goals of the particular activities are often a specific outcome. These outcomes are typically planned for, and influence the selection of the activities by the therapist.

As previously discussed, it is the activities that make AT unique. However, it is equally important to recognize that the conscious use of therapeutic technique designed to work toward a specific outcome is something that AT has in common with all mental health treatments. In addition, it can be noted that potentially all therapeutic situations can be thought of as contrived, although AT clearly takes this to another level.

Wilderness therapy.

The second format discussed by Gass (1993) is wilderness therapy. This type of program is what most associate with the general term “adventure therapy.” Such programs are frequently utilized as an independent treatment and are commonly explored in the efficacy literature for AT. Wilderness therapy interventions have been employed with a wide variety of clients, ranging from military veterans to survivors of domestic violence. However, the vast majority of programs serve adolescents, with diagnoses covering the gamut from developmental disorders to mood disorders.

In wilderness therapy, programs utilize an expedition-oriented format in remote settings and treatment lasts anywhere from 7 to 60 days, although programs may be longer. Some programs employ a basecamp model where clients may spend up to a month in a permanent camp developing skills and participating in clinical assessment before embarking on an expedition. The wilderness therapy intervention is known for its intensive treatment and its capacity to generate dramatic change in a short period of time. These programs typically follow either an Outward Bound or primitive living skills model, and the teaching and practicing of wilderness skills is an important aspect of the intervention. Not only is the learning of these skills necessary for the client’s survival and comfort, but it is also believed that this learning provides an opportunity for clients to increase their skill base and thus, their own individual level of perceived competence [(i.e., self-efficacy theory) Bandura, 1977].

The wilderness model allows the development of individual strength within a cooperative framework. Operating as a small, self-sufficient team in a wilderness environment requires mutual decision making which demands trust, cooperation, effective communication and good problem-solving. The members of the group are dependent upon each other for their success as well as their survival. This promotes empathy, sharing, support, and patience and fosters a strong sense of community. This interdependence makes it likely that individual strengths will be maximized and weaknesses minimized. However, the stressful nature of the experience ensures conflict, and the interdependence of the group demands that participants learn conflict resolution (Bandoroff, 1992).

A new term, “outdoor behavioral healthcare,” has been coined to describe wilderness treatment programs that are dedicated to upholding standards common to mental health practice (Russell, 2003). This consortium of programs in the U.S. (Outdoor Behavioral Healthcare Industry Council) incorporates a clinical model which includes client assessment, development of an individual treatment plan, the use of established psychotherapeutic practice, and the development of aftercare plans. OBHIC is committed to research as well and launched the most impressive outcome study to date which included 1600 participants from eight programs

(Russell, 2003). These benchmark findings provided support for outdoor behavioral healthcare as an effective treatment intervention for youth. A review of this research along with the results of a two year follow-up study can be found in the chapter by Russell in this edition.

One problem with wilderness therapy programs is that follow-up tends to be limited. Since clients typically come from a wide geographic area, programs generally pass the responsibility for aftercare onto local resources. Thus, aftercare services are provided by professionals who are likely unfamiliar with the client's experience and therefore, less able to build on the treatment gains experienced by the client. From both a research and a clinical standpoint, this lack of follow-up provides significant problems when evaluating long-term treatment gains associated with this type of program (Newes, 2000; Wichman, 1991).

Long-term residential camping.

The third type of therapeutic adventure program is long-term residential camping, also known as therapeutic camping. This format has tended to be used primarily with youth-at-risk and adjudicated adolescents. Program length varies, ranging from several months to as long as two years. Such programs are characterized by Buie (1996) as utilizing considerable acreage, having a permanent base camp, and temporary campsites built by campers (typically tent-covered wood platforms). Clients are responsible for providing for their own survival needs and, according to Gass (1993) "the client change is seen to be associated with the development of a positive peer culture, confronting the problems associated with day-to day living, and dealing with existing natural consequences" (p. 10). The focus on group living as a major component of treatment is similar to other types of treatment programs, as is the reliance on structure. Education in traditional school subjects is also provided during such programs.

These long-term camping programs are less intensive than the short-term wilderness therapy programs described above. They are often more similar to other types of residential programs, such as boarding schools, than wilderness therapy programs. The primary difference between a long-term residential camping program and a therapeutic boarding school is the use of a natural setting and the emphasis on self-sufficiency. Therapeutic camping programs generally utilize wilderness expeditions as well, although they are typically less intense than a wilderness therapy expedition. Moreover, the basecamp phase employed by some wilderness therapy programs resembles the therapeutic camping model. This overlap of programming blurs the distinction between treatment models and makes research comparing these modalities challenging.

Group Focus

The second characteristic of AT is group focus. While some AT pro-

grams utilize individual psychotherapy as well, overall AT is considered to be primarily a group process. As in many therapeutic settings, groups typically range from 6 to 14 people (Kimball & Bacon, 1993) and the clients tend to be somewhat heterogeneous in terms of therapeutic issue or diagnostic category. Although the target group could be a family or a multi-family group, this is not the average AT client group. Since the most typical AT client is adolescents, the group focus is especially valuable due to its developmental appropriateness for this population.

As with any group psychotherapy, this group component is a vital part of the overall therapeutic aspect of the intervention. Similar to any therapy group, the group in AT provides support, feedback, and a potent interpersonal context. Uniquely, however, in AT, specific activities are presented to the group as challenges to be overcome, and success depends on each individual member participating in completion (e.g., by standing on a platform, scaling a rock face, or negotiating unmarked terrain to a specified destination). In order to master any of the challenges, the group must cooperate, apply skills, creatively problem-solve, and rely upon each other.

Herbert (1996) discusses more completely the issue of creative problem-solving as it relates to AT. What is expressly different about AT and other problem-solving formats is that in order for the tasks to be completed, all participants must play a role in order for the group to succeed (i.e., utilization of superordinate goals). Therefore, activities require the group to discuss and decide on different strategies, implement such strategies, modify those that are unsuccessful, or implement new strategies: all potentially important skills for clients to practice. Not only does this process involve the successful completion of the task, but group dynamics involved in the decision-making process are closely monitored, and the interpersonal aspects of the activity are then processed by the therapist in a similar fashion as any other type of group therapy.

Drawing from the theory of interpersonal group psychotherapy (Yalom, 1995), it is further thought that group focus leads to the intensive activation of a client's interpersonal patterns, which, in conjunction with appropriate therapeutic processing, facilitates therapeutic change. This assumption also echoes Yalom's "social microcosm" theory of group functioning in which it is assumed that "patients will, over time, automatically and inevitably begin to display their maladaptive behavior in the therapy group" (Yalom, 1995, p. 28). Therefore, this group context provides an environment for the enactment of individual pathology, and the problem-solving associated with the group process may lead to further concrete representations of this, as well as provide an opportunity for the practice of new behaviors.

Also similar to interpersonal group psychotherapy, it is not just what happens during this problem-solving process but how it happens in the

group that is of interest. For example, how did the group decide on which strategy to use? Who was the leader? Did some clients participate in the decision-making process more fully than others? Is this a common response for them or a new behavior? What was it like to work through this problem? How did it feel? Each of these components, along with others that can lead into deeper level therapeutic processing, provides a rich opportunity to observe and process a client's relational processes.

It is also thought that the more active and concrete nature of the "task" in AT may lead to greater involvement for all clients than does traditional group psychotherapy. Importantly, such higher levels of involvement have been shown to be a significant predictor of psychotherapy outcome (Gomes-Schwartz, 1978). In a traditional therapy group, certain members can achieve "success" regardless of the level of participation of others. While it can recognizably be argued that a skilled group therapist in any therapy setting can involve the entire group, or in fact involve the entire group around any individual's client's lack of participation, it may be that this type of "non-participation," with its impact on the group, is less likely to occur in an AT setting. Simply put, it is thought to be more difficult for a client to remain unengaged, as the activities themselves necessitate participation by all members in order for the group to achieve success. In addition, one can speculate that clients who process experience in a less verbally oriented manner may participate more fully in this type of intervention. If this were the case, it would perhaps allow for greater growth among those clients for whom traditional psychotherapy feels too threatening or invasive. In fact, it could be argued that traditional "talk therapy" is ill-suited for adolescents in general, and an action-oriented approach is more developmentally appropriate.

Finally, the power of modeling (Bandura, 1986) is an important aspect of the group experience. Naturally, the opportunity to observe and imitate other clients is available in any form of group treatment. In AT the involvement in the activities could provide a tremendous opportunity for modeling of appropriate communication, cooperation, feedback, and help-seeking, again, in what is speculated to be a less threatening format to defensive clients. Thus, such clients may be better able to attend to and utilize such modeling.

Processing

Another descriptor of AT programs is that a great deal of time is spent processing the experience with clients and facilitating the transfer of learning into a client's daily life. It must be noted again that this processing is not necessarily associated exclusively with the activities alone. The activities can be conceptualized as a catalyst for the processing which occurs before, during, and after activities: a catalyst which also provides concrete

examples of the consequences associated with individual and group actions. Despite the fact that some of the activities being processed are contrived, the interactions that they create are real and in present time. The opportunity to deal with issues in the here and now provides relevance that is often difficult to obtain in conventional therapy.

To engage in this processing, tools such as individual psychotherapy, group psychotherapy, journal writing, individual time for reflection, modeling, self-disclosure, and metaphoric processing (Gass, 1993) may be utilized throughout the course of an AT program. While the techniques listed above may be familiar to clinicians, the extensive use of metaphoric processing is an aspect of AT which may be fairly unique in its application and thus, warrants further discussion

“The use of metaphors in adventure programming often serves as the key factor in producing lasting functional change to clients” (Gass, 1995, p. 235). Metaphors are vital for linking the learning and growth achieved through the adventure-based experience to situations found in the client’s “real life,” thereby providing the generalization so necessary for maintaining these gains. It is important to recognize that this perceived lack of relevance to realistic situations that the client may encounter is one of the most commonly voiced criticisms of AT. Clearly, the AT intervention is not about climbing over walls or surviving in the wilderness but about accessing the resources that will allow clients to surmount the walls in their lives and survive the challenges that they face at home.

While the setting and activities utilized by AT programs, whether it be the wilderness or a ropes course, are replete with powerful metaphors, the most effective metaphors are believed to be client-generated. When using metaphor in AT, the therapist takes on the role of conduit, actively helping the client to build such metaphors. Adventure-based practitioners postulate that the use of metaphor helps the client to continue utilizing the learning and growth provided through the adventure experience in ongoing and productive ways. Although the use of nature makes AT a natural fit for metaphoric work, the development of the use of metaphors in adventure programming is associated with the work of Milton Erickson (Bacon, 1983; Itin, 1998). Popularized by Ericksonian psychotherapy, the use of metaphor is common to many therapeutic disciplines.

Applicability to Multimodal Treatment

Another characteristic of AT is its applicability to multimodal treatment. As aforementioned, AT can be used either as an independent intervention or as an adjunct treatment. A wilderness therapy program is the most typical example of AT as an independent treatment, whereas an activity-based group session at an inpatient treatment facility would be considered adjunctive. Importantly, the focus on group level processing in com-

ination with the individual psychotherapy which takes place around the activities provides a therapist with the opportunity to utilize standard and accepted treatment orientations and practices.

Sequencing of Activities

Fourth, in order to allow for the group to develop the skills and the level of cohesion necessary to achieve success in the activities, such activities are incrementally sequenced in difficulty. This sequencing also provides initial successes, or “mastery tasks,” fostering feelings of capability while counteracting internal negative self-evaluations, learned helplessness, and dependency (Kimball & Bacon, 1993). This provision of a mastery task (success) concurrent with the activation of negative self-evaluations in the face of challenge is an important component for the therapeutic change thought to be associated with AT. The mastery task provides an opportunity to confront and tangibly disprove such evaluations. It is the therapist’s role to facilitate such a transfer as such connections are not presumed to be an automatic reaction to the activities.

Conversely, activities presented with inappropriate sequencing can be counterproductive and reinforce negative self-conceptions for individual participants. The activation of such negative internal processes for a client without the opportunity to counteract such feelings with success can further reinforce existing beliefs in personal ineffectiveness. In addition, such negative conceptions can also permeate the development of a group identity. Therefore, it is vital that the therapist avoid creating a situation in which the group repeatedly experiences failure as it can be recognized that this dynamic can carry the highest potential for emotional harm and would be likely to limit therapeutic potential. By the same token, exclusive success is not desirable either, as failure is useful for the group process and helps to teach frustration tolerance. As with other types of therapy groups, it is recognized that effectiveness is often dependent upon the facilitator remaining aware of where the group is in its development (Yalom, 1995) and taking this into consideration when planning.

Perceived Risk

On the surface, challenges are often structured so as to appear to be impossible or dangerous to the group. In reality, the challenges are in fact low in actual risk but high in perceived risk, with the term “risk” referring to not only physical risk, but also intra- and interpersonal risk as well. A classic example is rappelling, where a participant must descend down the face of a rock wall. As anyone who has ever rappelled can attest, the perceived risk to life and limb is extreme as one steps back off of the cliff edge. However, risk management considerations dictate that all AT activities remain low in actual physical risk. On the other hand, high levels of emo-

tional risk are encouraged. Since emotional risk is more subjective and more difficult to control, it is critical that therapists constantly monitor the emotional risk for each client, as well as for the group, throughout the intervention. This is precisely one of the central arguments for having clinically trained staff involved. The complex interaction between physical and emotional risk is illustrated in the following example. Standing on a platform and falling backwards into the arms of group members (i.e., trust fall) requires more trust than utilizing another person's support to cross a log. However, at earlier points in a group's development, this need to be supported (i.e., depend or rely on someone else) while crossing a log, could be perceived as carrying as high a level of interpersonal risk, along with the associated intrapersonal risk, as any physical activity for some clients.

Conceptually, perceived risk is thought to create tension and disequilibrium within the individual, ultimately leading the client to a position of choice [(i.e., dissonance theory), Festinger, 1957]. With regard to this conviction, Herbert (1996) notes that "In order for a person to achieve equilibrium, persons are challenged to make necessary adaptations" (1996, p. 5). He goes on to state: "Adventure-based work recognizes that it is the effort to overcome obstacles and, in effect, overcoming one's own fears that is critical." (p. 5). Through this combined process of relieving dissonance and overcoming fears, it is commonly believed in AT that clients are shown that old patterns are destructive and new choices can lead to more successful behaviors.

This perception of risk is so central to AT that Amesberger (1998) notes: "The most striking difference between adventure-based therapy and traditional psychotherapy is the client's strong involvement in a reality that is neither harmless nor perfectly safe" (p. 29). Although emotional risk clearly permeates traditional psychotherapy as well, it is the perceived physical risk that is a cornerstone of AT and distinguishes it from other forms of therapy.

Unfamiliar Environment

Another core characteristic of AT is that it is usually conducted in an environment unfamiliar to the client. This use of an unfamiliar and novel environment is thought to unbalance (Minuchin & Fishman, 1981) the client, further activating their underlying inter- and intrapersonal processes. It is hypothesized that the client has no familiar template from which to draw their reactions to the new situation, and thus it is the conviction of AT practitioners that the client must eventually rely on potentially new and ideally, healthier ways of behaving in order to achieve success (Gass, 1993) and equilibrium. In a sense, this can perhaps be conceptualized as providing an opportunity for clients to be free of past determinism. Gass (1990) postulates that this allows clients to explore problems rather than

being overwhelmed by them.

The assumption underlying the unfamiliar environment in AT theory is that by taking a person out of their normal context, the client is exposed to new situations where old patterns of coping probably will not work. As social microcosm theory (Yalom, 1995) maintains, it is typical for clients to revert to earlier learned and more dysfunctional ways of behaving in such stressful situations. However, through the AT activities, the client may be provided with more tangible evidence of the consequences of dysfunctional behavior than is typically provided in group psychotherapy. These concrete consequences of dysfunctional behavior in combination with a novel environment, an environment that invites and may even necessitate new ways of behaving, could provide an impetus for change. In addition, the group can also provide reinforcement for new behaviors.

This environmental unfamiliarity in AT is also thought to allow for the client to experience the therapy without drawing from their typical expectations and defenses. Therefore, it is thought that this unfamiliarity may allow for a client to approach the therapeutic experience with less of a defensive posture. The engaging nature of the activities (i.e., fun or challenging), and the surreal environment (i.e., ropes course or wilderness) also help to make AT less threatening. Golins (1978) contrasts AT to traditional therapy methods on this issue of defensive posturing, noting that “traditional individual or group therapy methods may be particularly threatening for persons who have difficulty expressing themselves and/or establishing new relationships” (p. 27). To compare this with traditional psychotherapy research, Orlinsky and Howard (1986) have found “the dimension of the patients openness vs. defensiveness to be related to outcome” (p. 219). If in fact AT does work to lower defenses, this finding suggests that lowered defensiveness may contribute to a more positive outcome for clients.

As with dysfunctional behaviors, it is thought in AT theory that when a client’s defenses do inevitably become activated, the therapist and the client may be provided with tangible examples through the activities and the interpersonal interactions during the activities, of the ways in which defenses operate in a client’s life. In addition, the unfamiliar and novel AT setting may then provide a situation that is less threatening for some clients to experiment with new and less defensive behavioral and relational patterns. Again, the gamelike or surreal environment may also make it more inviting for clients to “try on” new behaviors (Golins, 1980).

Relationship Between Perceived Risk and Environmental Unfamiliarity

Herbert (1996) discusses how the unfamiliarity of the environment and the high level of perceived risk interact and how this combination is presumed to affect the client. He refers to this interaction as “challenge/stress,” and reviews how it is believed by AT proponents that

the dissonance created by the unfamiliar environment, in combination with a high level of perceived risk, results in an increased intensity of the activation of interpersonal and intrapersonal processes. Herbert goes on to discuss this interaction and subsequent activation as a potential change mechanism, noting: "Stressful experiences that are likely to occur throughout an adventure-based program serve as impetus for individual change" (p. 5). Gass (1993) also discusses this phenomena in terms of positive stress, or eustress.

It is this belief in client dissonance and the associated intensive activation of intra- and interpersonal processes, the unbalancing based on the lack of familiar "templates," the opportunity for new behavioral choices, the reinforcement provided by the activities, and the associated processing that moves AT most completely away from outdoor adventure programs and into the realm of therapy. While intensity (Minuchin, 1974) is employed in many treatment approaches, it is uniquely inherent in AT.

The AT literature purports that clients who make new behavioral choices in order to complete a novel challenge perceived as high in risk, particularly one they had previously thought themselves incapable of, consequently see themselves in a new light. The ultimate goal of such a transaction is for clients to recognize their own self-imposed limitations. This awareness is believed to increase clients' self-esteem, and such gains have been linked in the psychotherapy literature to decreases in anxiety and depression (Gilbert, 1992). Again, as noted above the AT intervention offers clients the opportunity to confront negative self conceptions and tangibly disprove them. Moreover, Priest (1993) has suggested that participants will be able to influence their probability of success in an adventure experience if they have realistic perceptions of risk involved in the choices they make, as well as a realistic sense of their own competence.

Challenge by Choice

Related to the discussion of perceived risk is the recognition that clients are given the option of "challenge by choice" (Schoel, Prouty, & Radcliffe, 1988). This allows for a client to choose to not participate in an activity for whatever reason. It is important to recognize that the choice to not participate in an activity is not necessarily negative and may have as many therapeutic implications as participation (i.e., choosing to not participate is still a choice). Such an instance may potentially reflect positive steps toward clients asserting their personal boundaries by recognizing and acting on personal discomfort, a potentially important issue for many clients. In such a situation, the therapist makes every effort to include the client in some way, such as "spotting" or observing. According to Royce (1987), "The key to growth in any situation is that the participants should choose to confront their fear rather than being forced to engage in fearful

activities. This allows for the individual to take control of one's life instead of being other-directed." (p. 28). It should be noted that while the client ultimately always has the choice to not participate, that option is often not presented as a viable one in wilderness therapy and therapeutic camping programs, where compliance is a primary goal.

Challenge by choice is thought to be based not only on the recognition of risk involved in activities and related boundary issues, but also to an extent on the construct of learned helplessness (Seligman, 1975). Groff and Dattilo (1998) discuss learned helplessness theory as it relates to AT, noting that past experiences leading to attributions which result in feelings of helplessness can generalize to other areas of a person's life, potentially resulting in a decreased motivation to engage in activities where one is unsure of the outcome. It is believed that challenge by choice can help lead to the recognition of the power of individual choice that can perhaps begin mitigating learned helplessness (Groff & Dattilo, 1998), thus contributing to the development of a greater sense of control for the client and more realistic cognitive attributions for events. As learned helplessness has also been espoused as a causal element in depression, this may be an important link to explore regarding AT's potential for therapeutic change (Gilbert, 1992).

Schoel et al. (1988) share this example to illustrate the power of challenge by choice:

A short-term patient [from the Institute of Pennsylvania Hospital], a lawyer, was very depressed, denying his problems, not involved in anything, complaining of a bad back, etc., reluctant to do anything. He eventually tried some of the activities, and on the last day got up on a high element [ropes course] and completed it. According to the therapist, "he felt he never would have attempted the Incline Log at all if we had pushed him. The important thing is that we gave him the decision-making power." (p. 132).

Provision of Concrete Consequences

An additional descriptor of the AT approach is that the activities provide an opportunity for concrete consequences, positive and negative, of a client's behavior to be readily apparent. Beyond those aspects mentioned previously, another important element of this characteristic is that individual actions have consequences for both the group as a whole and the individual in relation to the group. A client who is unable to, or chooses not to, work successfully with the group is impacting the entire group's functioning. Therefore, the client may find his or her place within the group altered, may miss out on the group accomplishment, or even more concretely, may

have a wet sleeping bag due to not setting up a tent correctly. Conversely, clients also experience the impact of positive behavior as well within the group. Such consequences at the group level may provide an opportunity for important developmental learning for individual clients. While these consequences are common to all group treatment modalities, the abundance of natural consequences in AT is a hallmark of the intervention. Natural consequences are particularly effective because they do not rely on an authority figure for enforcement, and in AT they tend to be particularly impactful, as the following example illustrates.

As a hypothetical example, at the start of a week-long wilderness expedition, the group leader tells participants to pack rain gear on the top of the pack. The group leader is aware that there is potential for a rainstorm during the course of the day and hopes to help the participants learn to be prepared. Jeff refuses to listen and acts in defiance of the leader, packing all of his rain gear on the bottom of the pack. Later in the pouring rain, Jeff is forced to remove all of the other items from his pack in order to reach his rain gear. The other gear, and Jeff himself, becomes soaked in the process. This gear included some of the dry food that was planned for the group's meal that evening. Justifiably, group members become angry with Jeff and he becomes temporarily ostracized, leading to conflict in the group and consequences for Jeff as a group member. The rainstorm also provided a natural individual consequence to Jeff for not heeding the advice of the group leader. Of course, had the weather not been warm, the leader would have intervened for safety reasons to prevent Jeff from becoming soaking wet.

Goal Setting

Goal setting in AT involves identifying for each client the objectives of program participation, with the ultimate goal being to tie the intervention to specific treatment outcomes for clients. Such goals are not related to the activities, rather, as with any psychotherapeutic treatment, goals are focused on specific problem areas for individual clients. As with any therapeutic intervention, these goals are developed after consultation with the client and/or the referral source and must be held in the therapist's awareness throughout the scope of the intervention. In addition, group goals are also established and often a "full value contract" is agreed upon, specifying the parameters of acceptable behavior within the group. This type of contracting maintains that all participants work together as a group to achieve both individual and group goals, adhere to necessary safety guidelines, and give and receive feedback when appropriate (Schoel et al., 1988). These guidelines are also established to promote physical and psychological safety for all participants.

Trust-Building

As in any therapeutic process, trust-building is a crucial characteristic of AT. Clients must learn not only to trust their therapist, but also to trust and depend on other members of the group, allowing for the closer examination of interpersonal processes related to trust as an ongoing therapeutic issue. This again is not unique to AT but rather mirrors the theory of interpersonally oriented group psychotherapy, and most specifically relates to the stages of therapeutic group development (Yalom, 1995).

The process of building trust is accomplished through the aforementioned sequencing of activities involving an increasing level of cooperation and group interaction. Most adventure-based therapy begins this gradual trust-building process by learning basic level information about each participant, allowing for the trust building process to begin in a way that may feel more natural for clients than does traditional group psychotherapy. As the activities progress, a higher level of self-disclosure is required and participants share deeper level experiences and emotions. As previously mentioned in the discussion of defenses, the activity focus of the group may allow an alternate medium for individuals to gradually share parts of themselves without the fear of being ridiculed or laughed at (Rohnke, 1995). Thereby it is speculated that the activities could provide a vehicle for emotional sharing and closeness for those to whom the more direct approach found in traditional psychotherapy may be overly threatening.

Physical trust is also incorporated and is conceptualized as a gateway to interpersonal trust (Schoel et al., 1988), with the assumption being that as clients increasingly entrust other group members with their physical safety, they will gradually begin to entrust the group with their emotional safety as well. As overall trust increases, the group becomes more autonomous and self-reliant, as well as more willing to openly communicate. As with a traditional therapy group, it is felt that when the group reaches this level of autonomy, that it is the most powerful vehicle for lasting change (Yalom, 1995). Compared to more traditional forms of therapy, AT would be considered unique in its use of physical trust.

Enjoyment

Enjoyment is also a component thought to be inherent in AT, and this is another aspect of AT that may be considered unique. Therapy is not often characterized as fun. Simply put, it is felt by supporters of AT that people are more invested in their treatment when it has positive reinforcement, and allowing for elements of therapy simply to be fun may be one way to provide an opportunity for such reinforcement. An increased level of enjoyment may also help in increasing attention levels and is believed, to take some of the seriousness out of threatening topics. This does not suggest treating such topics lightly, but rather, taking a less direct approach

might reduce a client's reluctance to discuss such areas and ultimately lead to more open discussion of frequently avoided issues. This can be seen in some ways as similar to systematic desensitization, where aversive stimuli are paired with relaxation in order to decrease anxiety levels. It seems plausible that in AT this type of enjoyable interaction may function similarly to relaxation in facilitating therapeutic change.

To create such an atmosphere, many activities in the early phases of an adventure-based intervention are designed to increase group cohesion through sharing laughter. These activities "break the ice" and are thought to move the group more quickly and efficiently into the "working phases" of a group's development.

Peak Experience

The final characteristic of adventure-based therapy is peak experience. Herbert (1996) states: "the purpose of the peak experience is to provide an opportunity to practice all of the learning that has occurred and apply it to this one intensive challenge" (p. 6). These experiences can consist of an actual peak ascent or similar climactic wilderness experience, or can take the form of a group activity requiring a high degree of cooperation and trust. In both types of situations, clients perceive the challenge as more intense and complex than prior activities, and these types of experiences are often employed to provide the culmination of the group experience. Of all the characteristics described above, this is the one which may vary the most based upon which type of programming format is utilized.

While the actual therapy setting where the peak experience occurs is certainly unique to AT, this search for a peak experience is clearly something that is shared with other therapies. The emphasis on peak experience as a part of self-actualization is a crucial underlying assumption of humanistic theory (Csikszentmihaly, 1990; Maslow, 1971). Maslow discusses the power for growth embedded in such peak experiences at length, noting that "in a fair number of peak experiences, there ensues what I have called the "cognition of being" (p. 173), noting that this refers to "a technology of happiness" and the avenue to "pure joy" (p. 174).

Therapeutic Relationship

A description of the characteristics that define AT, as well as the change mechanisms that may be operating in AT, would not be complete without a discussion of the therapeutic relationship. Given that the strongest predictor of outcome in psychotherapy research has been shown to be the therapeutic relationship (Orlinsky, Grawe, & Parks, 1994), it is worthwhile to consider the implications of the extended and intensive relationship that is found uniquely in the AT experience. This is particularly true in wilderness therapy programs that last for at least one week and beyond, where the therapists

sometimes live together with the clients in the wilderness. Specifically, it is interesting to consider the potential effects for the client of continuous involvement with the therapist, as well as the group, that lasts for an extended period of time on an around-the clock basis.

It can be speculated that for some clients this may be immensely threatening. For such clients this may result in their being unable to form positive relationships as their defensive reactions may become intensely activated and further entrenched, essentially making it impossible for them to engage in therapy. However, it may be that just the opposite is true—that such intensive relationships developed on an ongoing basis with no opportunity for withdrawal may in fact facilitate the creation of more positive internal representations based on this all-encompassing level of relationship. Advocates for AT offer much anecdotal evidence to support the latter argument.

Consider the fact that if client and therapist are together for twenty-one days on a twenty-four hour basis, this translates into 504 hours of therapeutic contact, an approximate time equivalent of ten years of weekly psychotherapy. Excluding the hours spent sleeping, that still is roughly 330 hours of contact, an equivalent of approximately six and one-half years of weekly psychotherapy. Obviously a 21-day experience with no follow-up is not the equivalent of 6 or 10 years of weekly psychotherapy. Such a comparison of the numbers is provided merely to illustrate the potential potency of this amount of time between therapist and client spent continuously.

The opportunity for the development of therapeutic relationships in the different, more time intensive, and more multidimensional way provided by the AT experience may facilitate growth in clients based in this relational bond. It also possible that there may be an effect based on this twenty-four hour contact that is simply not available in traditional forms of psychotherapy. Clearly, the access alone is an important factor. Therapists in the field are available to capitalize on teachable moments. The level of support that the therapist can offer with continual presence and during such an intensive experience is another valuable consideration.

From an object relations (psychodynamic) framework, the development of such a potentially unique relationship in AT may provide greater opportunity for corrective emotional experience to occur. That is, the experience helps to heal a prior traumatic event. For example, a caring and supportive relationship experienced with the therapist may help the client to work through abandonment by a parent. If so, such occurrences may become more firmly anchored for the client based on the fact that the relationship becomes a part of their daily existence for a period of time and thus, is grounded in “real experience.”

Related to this is the potential power of modeling (Bandura, 1986) that could occur in such a situation. The therapist is living in the same conditions and is required to perform the same tasks as the client.

Opportunities for modeling abound as the therapist faces many of the same daily stressors and must cope with the same hardships as the client. Moreover, the therapist's willingness to expose him or herself voluntarily to these difficult conditions inspires a degree of intimacy, trust, and mutual respect that goes beyond that found in traditional therapeutic settings (Greenwood, Lipson, Abrahamse, Zimring, 1983). Such high regard for the therapist is likely to help the client to be more open to imitating the therapist's behaviors.

It is important to acknowledge that not all wilderness therapy programs maintain a therapist in the field throughout the expedition. In fact, it may be more common for the therapists to visit the field for one or two days per week. Nevertheless, the therapist's willingness to meet the clients in those conditions is very meaningful to many clients and may break down barriers that exist when a client visits a therapist's office. Perhaps more importantly, the AT therapist understands the process that the client is going through and that may be enough to forge a strong relationship when a client is in the midst of such an intensive experience. Of course, with or without the ongoing presence of a therapist, all programs have field staff who are available on a continual basis. For many of the same reasons described above, these staff members are able to develop close relationships with clients and are responsible for much of the therapeutic change that occurs in wilderness therapy programs.

The unconventional therapeutic relationship described above also extends to activity-based psychotherapy and therapeutic camping. Although these formats may not offer the intensity of an expedition-based relationship, therapists are still working outside of an office setting. This alone makes them more accessible for many clients who feel distrusting or defensive in a traditional psychotherapy setting. Moreover, the relationship is activity-based and as mentioned, this is less threatening for many clients.

Illustrative Example

To illustrate, Jane is a hypothetical 32-year-old woman who typically blames others for her problems and often uses threats to get her way. Jane has come to therapy because she "has trouble in relationships" and her ultimate goal in therapy is to both understand and change this problem. Imagine Jane, 30-feet up in the air on a high ropes course element. Her heart is pumping, her fears and anxieties are increasing, and she is beginning to become frustrated because she believes that she cannot proceed. It is likely that if Jane approaches the situation in her "standard way," by yelling at others and blaming them for her inability to complete the task, she will remain where she is and only become more entrenched in her spiraling negativity. This behavior will inevitably alienate members of the group, making it unlikely that they will come to her aid and support her in succeeding.

The level of risk which Jane perceives in the situation has led to an experience of disequilibrium, or feeling unbalanced, leading to Jane's reenactment of previously dysfunctional interpersonal patterns. In this instance, with no further therapeutic intervention, Jane remains stuck on the ropes course and there is tangible evidence of the consequences for her continued maintenance of old ways of behaving. Should she manage to simply get down off the course, she may have learned something, but it is unlikely that the learning will provide lasting characterological change. In fact, an equally likely scenario is that the intervention may be harmful for Jane by reinforcing her negative self-conceptions.

However, if the therapist processes this experience with Jane and the group in a way that helps her to recognize her dysfunctional ways of behaving, as well as assisting her to achieve some level of control and an increased willingness to work with others, she is much more likely to complete the activity successfully. This processing may take place later in individual sessions as well. On the group level, other members also provide Jane feedback as to the consequences of her actions, both while such actions are occurring and afterwards in a group session.

Should Jane succeed, such a success will ideally reinforce for Jane the new and more positive ways of behaving, as well as illustrate for her the negative aspects of behaving in her old patterns. If the therapist were to expand this processing to an exploration of where these dysfunctional patterns originated (using a psychodynamic orientation), Jane could potentially gain insight into these origins and perhaps begin establishing more functional ways of relating to both herself and to others on a level beyond that provided by the activity alone. Should the therapist continue his or her relationship with Jane upon her completion of the AT intervention, such concrete examples provided by the activities could perhaps be referred to as points of reference by both Jane and the therapist. In such an instance, the process of change that began for Jane during the course of her AT treatment component, could potentially be continued and deepened through this ongoing relationship.

What can be seen here is a direct parallel to traditional psychotherapy, with the activity itself simply providing both the catalyst and a concrete external representation of pre-existing issues for Jane. Jane's behavior can be explored, as well as her cognitions, affect, and interpersonal functioning. Repetitions of the activity or participation in new activities can give Jane an opportunity to practice different ways of behaving, thinking, feeling and relating, again, with tangible and easily seen results. Over time, the illustrations provided by the activity can be referenced by both Jane and her therapist. Ideally, a skilled therapist builds upon this learning process, allowing for the activities themselves and the processing associated with them to become an inextricably linked and circular process. This type of

model can be used in any of the aforementioned settings when the activities are processed in a therapeutic manner.

Conclusion

As AT becomes more widely recognized as a credible treatment approach, it is important that the literature be able to clearly represent what exactly adventure therapy is. It is also vital that those within the field have a thorough understanding of the theoretical principles that underlie this approach. It has been the experience of the authors that many practitioners, caught up in their enthusiasm for their work, believe that AT is a totally unique treatment approach. This misconception is not helpful in advocating for AT's acceptance in the mental health field. On the contrary, AT shares many commonalities with well-established treatment approaches. In fact, as this paper has attempted to demonstrate, AT is more similar to other types of treatments than different. This is not a liability but rather, an asset that can assist AT in gaining wider recognition among the mental health treatment community and help AT to demonstrate its viability as a treatment approach.

At the same time, there are aspects of AT which are unique and help to make it an effective intervention. Most notably, the activity base which serves as a foundation for AT clearly distinguishes it from other forms of treatment. There is substantial theoretical evidence to suggest that the activities inherent to AT, and more specifically the theoretical process that surrounds the activities, contribute largely to its effectiveness. The research evidence, however, is not as convincing. More process evaluations are needed to substantiate this claim, and future research must address this shortcoming. The field of AT must begin to hold itself accountable for answering the questions posed to all other treatments: Is this treatment effective? For whom, and under what circumstances? To its proponents, AT has long been seen as a powerful treatment intervention; as we "come of age," it is time to garner the evidence to convince the broader mental health establishment.

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