# Adventure Therapy Deconstructed: A Journey Towards the Good Enough Practitioner and Professional Practice.

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**Introduction**

Adventure Therapy (AT) is a blend of talking and nature-based-therapies, wilderness experiences, adventure and experiential education (Davis-Berman and Berman, 2008, Richards, Carpenter and Harper 2011, Gass, Gillis and Russell, 2012, Harper, Rose and Segal, 2019). For the purposes of this paper AT includes any therapeutic process involving any type of adventure, which I will define as any physical undertaking involving some degree of risk and with an uncertain outcome.

There have been calls to professionalise Adventure Therapy and studies have suggested frameworks for competency to practice (Crisp, 1998; Pryor, 2009, 2012; Richards, 2015, Richards, Hardie and Anderson, 2019, TAPG). However, data to identify how AT practitioners are professionally qualified to practice across diverse disciplines, and to what extent theories of AT practice are mirrored by what practitioners deliver in the field, is limited (Natynczuk 2016). How do AT practitioners qualify themselves and what are the theoretical and practical components that practitioners would do well to assemble?

**A brief overview**

AT is a richly diverse field of expertise, therapeutic modalities and qualifications such that it has been difficult to define despite being the subject of decades of debate (Gass, Gillis and Russell, 2012). Various authors have made suggestions as to what professionalised AT might look like. Carpenter (2015) reflects on the tremendous diversity of practice in AT in terms of environment, activities and therapeutic modalities. Some practitioners are clinical psychologists, registered counsellors, others are not, and there is a tradition of amateurs working in this area (Pryor 2012). There could be as many forms of AT as there are practitioners. Crisp (1998), Ringer (1994), Gillis (1998) and Papadopoulos (2000) suggest desired skills for practitioners though much of their thinking concentrates on therapeutic skills. Venues for therapy outdoors range from urban parks to remote wilderness, the more remote and adventurous the activity; the more training, experience, expertise, and qualifications are required to be safe.

**Qualifying as a practitioner**

Establishing common ground in a diverse field has been a stumbling block to professionalising AT. This was a discussion topic at the first International AT Conference in 1997 (Bunce, 1998). Crisp (1998) suggested the ideal was to achieve cross-trained therapists and adventure leaders so that AT practitioners are "Fully competent in both safety and technical skills as well as therapeutic areas"

and this paper speaks to this ideal. Gass, Gillis and Russell (2012) preferred to consider competencies a better descriptor of ability than skills. In the UK some practitioners hold adventure sport qualifications from National Governing Bodies. These oversee training and assessment for adventure leadership such as the British Canoe Union, Mountain Training, and the British Caving Association. However, the time and effort needed to gain a number of outdoor leadership, guiding and coaching qualifications and to become accredited as a counsellor, means that there are two broad camps of practitioners: adventure biased and psychotherapy biased with seemingly few practitioners in both camps (Aldridge 2015). Natynczuk (2016) and Schwenk (2014, 2017) investigated the core competencies of AT practitioners in the UK and identified the difficulty practitioners have connecting with each other to establish and maintain a professional identity.

**Being professional**

What does it take to be 'professional' and how does being professional differ from having an occupation? Bayles (1998) describes three criteria for an occupation to claim the status of a profession: it requires extensive training, it is based on an intellectual skill, and its services are important. Howard (1998) offers three tests for the status of professional: clarity about a body of knowledge and skill, clarity about the results of professional intervention, and achieving a better result than an amateur. It follows that commissioners, employers and clients should also know what to expect when buying AT provision in terms of clear expectations around the quality of provision, accountable best practice, support from peers in a professional network, and clear marketing messages. At the time of writing there is no sole governing body for adventure therapy that holds individual practitioners accountable for their collective competencies in therapy and adventure leadership. AT practitioners in the UK should be accredited with a counselling governing body to professionally provide talking therapies and hold at least one appropriate adventure leadership award if they are venturing into remote locations, for which they would also need to be covered by an adventure activities licence if they are paid to work with people aged less than 18 years. It could be that there are insufficient numbers of cross discipline practitioners to form a professional body, perhaps because the barriers to entry are so high given the time, effort, cost, and dedication it takes to qualify both as a counsellor and as an adventure leader. AT practitioners that I have surveyed have shown, that left to their own devices, they can generally work ethically and fulfil most of the demands that being 'professional' requires. Curiously the field seems self-regulating, though in an *ad hoc* way (Natynczuk, 2016).

**Twelve components of competency**

Beyond general considerations of professional practice I would like to briefly consider twelve components of thought and practice, which I consider contribute most to the expertise of a good enough AT practitioner. These are not ranked in any priority.

**1. Pedagogy**

This concerns the principles, practice, and profession of teaching, including teaching styles adopted by outdoor educators, methods of feedback and assessment and teaching theory. Beames and Brown (2016) consider pedagogy in Adventuous Learning as a synthesis of uncertainty, mastery, agency, and authenticity. In addition I have found utilising students' natural curiosity a rewarding and helpful introduction to experiential learning as a co-discoverer (Natynczuk, 1991). Managing pedagogy influences the therapeutic alliance so it is important to consider how practitioners go about facilitating meaningful experiences. Probably the most influential schools of thought have been Behaviourism (Abramson, 2013), Constructivism and Social Constructivism (Jones and Brader-Araje, 2002), and Liberationism (Freire and Freire, 2004). Briefly these pedagogic approaches can be described thus:

Behaviourism: learning is teacher centred with the use of direct instruction and lectures. One could expect to see a mixture of lecturing, modelling and demonstration, rote learning, and choral repetition. All of these activities are 'visible' and structured, and are teacher led. However, during the lesson students might become the centre of activity as they demonstrate their own learning.

Constructivism: students are put at the centre of learning via experiences and reflection from inquiry based learning. Students are thought to come ready to learn, and the teacher builds activities to facilitate learning. Younger children work things out physically perhaps through play, whereas older children might tackle symbolic and abstract ideas. A lesson might include individualisation, a slower pace, hidden outcomes, and less teacher talk, perhaps with an emphasis on being outdoors, and engaging with nature.

Social Constructivism: a collaborative process between student and teacher with learning in its social context. The teacher might limit the choice in topics, use teacher modelling, questioning, and a mixture of individual, pair, and whole class exercises.

Liberationism: Freire and Freire (2004) focussed on removing two barriers to learning: poverty and hunger. The student voice is central, with democracy encouraged into the classroom. The teacher and students make discoveries together. This approach speaks strongly of Maslow's Heirachy of Needs, a model well known to students of counselling and adventure leadership, though perhaps apocryphal (Mathes, 1981).

**2. Philosophy**

Philosophy can be summarised as the rational investigation of being, knowledge, and right conduct, a system or school of thought, the critical study of the basic principles and concepts of a discipline. It could be any system of beliefs, values or tenets, or a personal outlook or viewpoint. Russell (1946) gives a comprehensive overview. For AT we should also include the essential component of landscape and nature for its influence on thinking and being. Most importantly philosophy has to include tests of thinking through good, robust, scientific enquiry.

**3. Ethics**

Ethics are important to professional organisations (Howard 1998) and to business in general (Caplan, 2013). Having an ethical code in place demands a disciplinary policy for transgressions, which could lead to expulsion from a professional association (Gray 2010). Khele, S., Symons, C., and Wheeler, S. (2008) investigated complaints to a UK governing body for counselling and psychotherapy and showed that the disciplinary system of such a professional association has to have 'teeth' to maintain a good level of credibility for the organisation, and to demonstrate that it takes its own ethical framework seriously.

**4. Insurance**

Should something go wrong practitioners would not want to think about their insurance needs retrospectively. Aspects to consider include professional indemnity, accident and emergency, medical, evacuation, repatriations (dead and alive), legal fees, compensation for loss of reputation, property and equipment, lost baggage, delayed travel, and more. It is very important to carefully link your insurance needs to your risk assessments.

**5. Counselling Skills**

Listening and not giving advice is a good place to start, then develop skills in active listening and applying Rogerian core conditions of congruence, unconditional positive regard, and empathy. Egan's (2002) Skilled Helper model, which is broadly integrative and pragmatic rather than theoretically dogmatic or diagnostic, seems a useful initial approach for non-professional counsellors. Qualifying as an accredited counsellor takes years, requiring further education, training, and many hundreds of hours of clinically supervised practice. An important consideration is to decide to which therapeutic modality you are the most philosophically aligned, as you will have to practice with conviction and authenticity. There are three classic 'schools' to consider; person-centred, psychodynamic, and cognitive-behavioural, within which there are possibly hundreds of approaches. However, in some instances it seems being a professional counsellor gives little advantage. Karlsruher (1974) and Durlak (1979) found non-professional counsellors tended to be more effective than professional counsellors. Hattie (1984) found para-professionals more effective than trained therapists in long term counselling (>12 weeks). Berman and Norton (1985), found no overall differences. Strupp and Hadley (1979) found non-professionals just as helpful as professionals. It seems that personal qualities are most helpful for getting useful outcomes. Non-professional counsellors tended to be more authentic, less likely to apply labels to clients, to stay safe, and clients attributed success to themselves rather than to the expertise of the 'therapist'. Difficult cases tended to be referred on and there were limited case-loads. Amateurs tended to be highly motivated to help, more likely to be culturally compatible and to give more time to clients. It seems that some training with supervised practice can be a useful first step towards integrated AT practice.

**6. Therapeutic Alliance**

Therapeutic alliance extends across everything a practitioner does to influence the quality of the working relationship between therapist and client. It seems that therapeutic modality has a smaller effect on outcomes than the quality of the therapeutic alliance (Horvath, 2001) though how this comes about in a wilderness setting is complex (Harper, 2009). Dobud and Harper (2018) discussed a redundancy of modalities in AT when compared to the effectiveness of the therapeutic alliance. A useful tool for improving and sustaining a therapeutic alliance, and to be informed whether or not a client is getting what they need, is feed back informed treatment. Dobud (2017) has applied this approach to working therapeutically during trekking expeditions.

**7. Technical Competence**

Many technical skills are transferable between adventure disciplines. Expectations around training and leadership qualifications seem to vary considerably from country to country. However, there is no excuse for having insufficient mastery for the adventure activities a practitioner specialises in. Competency (in the UK) is usually demonstrated through appropriate National Governing Body Awards where experience, knowledge, skills, group management, and fluency of practice are assessed by accredited senior award holders. Technical competency to be acquired includes, safety, first aid, self-rescue, rescuing others, navigation, rope rigging, belaying and working at height, camp craft, paddle skills, climbing skills, mountain craft, avalanche awareness, weather forecasting and more. Knowledge of natural and human history for the venues you work at can also prove very useful. It is essential to get on top of best practice in one's preferred adventure discipline and to maintain mastery both through personal adventures and on-going training beyond the level your clients experience.

**8. Adventure Leadership**

An AT practitioner will have to blend the roles of instructor, coach, safety advisor, guide, leader, and technical expert with their therapeutic modality. Care has to be taken to preserve the therapeutic alliance or much good therapeutic work can be undone, for example by being overly didactic or authoritative or somehow damaging the trust and mutual respect demanded by co-adventuring therapeutically with clients. Within this practitioners have an enhanced duty of care towards clients' physical and emotional safety. Leadership styles and awareness are on a spectrum from authoritative 'leader as hero' to something loosely democratic. I have become an advocate of the Host Leadership model (Natynczuk 2019) as it aligns closely with my preferred therapeutic modality.

**9. Continuing Professional Development**

Refreshing, enhancing and broadening one's knowledge, skills and experience can be achieved by attending conferences and training courses, through peer-to-peer mentoring, good clinical supervision, reading and research, writing, reflective practice and paying attention to feedback informed treatment. Keeping current with best practice is essential.

**10. Supervision**

A good clinical supervisor promotes reflective practice, develops new approaches and learning and ensures high ethical standards, shares expertise, and works with a therapist to assess how best to meet clients' needs (Gray 2010). Abiddin (2008) gives a comprehensive review of supervision models though Davys and Beddoe (2010) say there is little agreement on what constitutes good

supervision. Schwenk and Natynczuk (2015) wrote about supervision specifically with AT practitioners in mind. Ask your supervisor about their preferred supervision model and how this could be helpful to you.

**11. Business administration**

Knowledge and skills around business administration are important for self-employed and employed practitioners, especially when it comes to strategic thinking about your provision. Marketing strategy is a very broad subject and there are many business models to choose from, finance models to take seriously, understanding who the clients are, who funds them, where to target marketing and how to measure success. In short, how to ensure your work is sustainable. Answering "How do I make a living wage from Adventure Therapy?" is perhaps something to take advice on.

**12. Self-care and avoiding burnout**

Burnout is insidious. The main factors include working against overwhelming demands with a lack of managerial support, few resources, little autonomy, challenging interpersonal behaviour, and no confidence in an employer's core activity (Ravalier, McVicar, and Munn-Giddings, 2014). Unchecked the result is a lack of enthusiasm with increasing cynicism, exhaustion, lost self-confidence and capacity to perform, and ultimately depression. Altogether burnout represents a tremendous waste of practitioners' potential. Self-care is therefore essential: for AT practitioners it means investing in oneself through personal adventures, ongoing training, professional support through networking, good supervision, personal counselling when necessary, being efficient and effective in business, investing in good quality personal relationships, and not being afraid to ask for help when it is needed.

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