A Census of Outdoor Therapies: Portraying the Canadian scene

ABSTRACT

This study identified seven forms of therapy conducted in the outdoors. Each form was defined, distinguished by its unique elements, and clearly differentiated from recreational, educational, and developmental programming in the outdoors. Using these dividing criteria, a census was conducted to identify the best practices of outdoor therapeutic programming in Canada and paint a picture of the Canadian profession in 2021. As a result of qualitative interview data and quantitative survey data, a continuum of outdoor therapy programming was created that delineated these seven unique forms between the two dimensions of risky challenges in small groups and individual eco/nature immersion.

KEYWORDS

Outdoor therapy; nature-based therapy; wilderness therapy; adventure therapy; land-based healing.

INTRODUCTION

Canada is the world's second largest country after Russia, but ahead of the USA and China (World Atlas, 2021). Canada has the longest coastline on the globe: 202,080 kilometres spanning three oceans: the Pacific, Arctic, and Atlantic (World Factbook, 2021). It has some of the planet's most extensive wilderness (undisturbed by humans) and most diverse natural ecosystems including arctic tundra, subarctic taiga or deciduous Boreal Shield woodlands, Rocky Mountains or Montane Cordillera, mixed woods, coniferous rainforest, plains/grassland prairies, wetlands, lakes, and marine ecozones (Ecological Land Classification, 2017). Its defacto wilderness hosts 25% of the Earths' wetlands and holds 20% of its freshwater in more lakes (60%) than all the other global nations (40%) combined (Messager, et al, 2016).

Canadians live mostly in cities along their southern border with the USA and are heavily influenced in the long term by neighbouring American zeitgeist and media (Government of Canada, 2021; Surlin & Berlin, 1991). Nevertheless, Canada is a pluralistic society with a national policy of multiculturalism (Minister of Justice, 1985). The international Organization for Economic Co-operation and Development (OECD, 2021) recently named Canada as the best country in the world for acceptance of minorities.

Canadians are known as a peace loving people with an international reputation for their politeness, so much so, that at least one province passed key legislation preventing parties from using an apology as a statement of fault or liability in court (BC Ombudsperson, 2006). Canada often receives top billing as the single best place to live with the highest quality of life (US News & World Report, 2021).

However, Canada has fallen down in its treatment of indigenous people, especially with regard to their health and colonization history (McCallum, 2017). Like many nations, Canada apologized and struck a Truth and Reconciliation Commission to address the past, but failed to account for previous wrongs by not openly allowing indigenous self-determination and access to their lands (Corntassel & Holder, 2008).

Canada is proud to be the second most educated country in the world after South Korea, with 63% of Canadians earning a higher education/tertiary degree (OECD, 2021). They also enjoy relatively free

healthcare as a fundamental human right, paid for by taxes and administered on a provincial basis (Canadian Senate, 2002). Almost all essential care is enveloped through this system, but it does not cover everything. For example, mental health services, prescription medications, dental care, and home care for the elderly are only reimbursed to a necessary minimum or not at all (Health Canada, 2021).

The personal risk taking of Canadians is high in sports (Legacies Now, 2010), tourism (Aventure Ecotourisme Quebec, 2021), play (Coe, 2016), and outdoor activities (Harper & Robinson, 2005). Canadians are considered risk takers at leisure, but not at work, however, the business world is changing as Canadian companies are becoming less risk averse (Carmichael, 2019). Canada was ranked highest in North America and Europe for entrepreneurial activity, ambition, and new start-up businesses, as well as being in the strongest position to economically recover from the recent pandemic (Global Entrepreneurship Monitor, 2021; OECD, 2021; Desai, 2016). The nation's culture of innovation has been attributed to a strong ethnic diversity of immigrants willing to take risks (Rideau Hall Foundation, 2019).

Despite this highly urbanized population of risk takers, supported by excellent healthcare, with ample access to a vast natural wilderness, outdoor therapy has failed to gain great traction as a treatment modality in Canada (Harper, 2017). So, these therapies in Canada sits idly at "the confluence of two different professions: adventure guide (outdoor leader) and (clinical) therapist" (Harper, 2011, p. 17).

In this study, **outdoor therapy** (OT) was a treatment that developed coping strategies, resolved trauma, transformed behavior, and reduced resistance to change by combining experiential sensory methods and therapeutic interventions with engagement in natural, wild, and remote environments. Elements contributing to its mechanism of change included: countering situational risk with personal competence, working together in small groups, immersing in nature, engaging with therapy, facilitating discussion, continuing support, and connecting by metaphor. Clients directly benefited by improving their health: physical, emotional, mental, cognitive, behavioral, social, and spiritual well being.

OT also went by a number of other therapy labels such as adventure, wilderness, nature or nature-based, environmental, and land-based healing. Collectively these were referred to as forms of OT in this study. However, not all outdoor programs necessarily held therapeutic/therapy intent. These outdoor programs could have had recreation, education, or development objectives as distinguished by Table 1.

+ = plus everything to the left of this cell (to change behavior, feelings and thinking should also change)

EMPHASES	Recreation	Education	Development	Therapy
Primary Purpose	To change FEELING	To change THINKING +	To change BEHAVING +	To change RESISTING +
Experiential Learning Cycle	ACTION & activities	+ REFLECTION & discussion	+ INTEGRATION & metaphors	+ CONTINUATION & support
Facilitation Techniques	None / not necessary	Fundamentals & Funneling	+ Frontloading & freezing	+ Fortifying & solution-focusing
Staffing Present	Competent leader	+ Skilled facilitator	+ Psych. training	+ Licensed Clinician*
Design and Delivery Focus	Enjoyment, play, fun, skills, tourism	New/old concepts, awareness of need	Coping strategies (grow function)	Trauma resolution (ease dysfunction)

** Culturally appropriate counselors/elders are substituted for licensed clinicians in land-based healing*

Table 1: Distinguishing features of four fields of outdoor programming (adapted from Priest, 1996).

As one moves from the left side to the right side of this table, programming becomes increasingly sophisticated and complex. The types of programs emphasize different primary purposes, parts of the experiential learning cycle, and facilitation techniques. While the emphasis is obvious, the impact is additive, as those on the right may also use content from categories on their left. No type of program is better than any other. They simply differ and are uniquely applied to various clientele and their needs.

Recreational programs change the way people feel by focusing on fun and enjoyment. Since the outdoor activities are powerful enough to change feelings on their own, no facilitation is necessary from a competent outdoor leader. As a result, recreation programs spend all their time doing activities and no time talking about the learning, growth or change that may come from those activities. Examples of recreation programs include play, sports, tourism, guiding, outfitting, and learning new skills.

Educational programs change the way people think by focusing on learning concepts and becoming aware of needs to change. In order to change client thinking, some discussion or debriefing questions after the activities are necessary from a skilled facilitator. As a result, education programs spend a maximum time doing activities and a minimum time talking about the learning that arises. Examples of educational programs include school based outdoor or environmental studies and instructing skills.

Developmental programs change the way people behave by focusing on coping strategies that grow functional actions. Behavioral transformation often requires frontloading questions before and freezing questions during the activity so as to provide a comparative experience from a psychology trained facilitator. As a result, development programs spend a balance of time doing activities that is equal to the talking about the growth that can result for clients. Outward Bound is a well-known example.

Therapy programs change the way people resist being changed by focusing on trauma resolution, distress reduction, and easing any associated dysfunctional behaviors. Resolving trauma and reducing resistance requires advanced psychotherapeutic techniques such as talk therapy, fortifying, or solution-focusing from a licensed clinician or similarly qualified individual. As a result, therapy programs spend a minority of time doing activities and the majority of time talking about change and client outcomes.

How are the therapies similar? All outdoor therapy or therapeutic programs involve building skills. Not only do programs teach outdoor skills, such as hiking or other living skills, but they also inculcate coping skills. The therapeutic programs develop strategies to manage stress and social interactions, while also regulating emotions and behaviors. Therapy, conducted by a licensed mental health clinician, resolves trauma and reduces resistance to change, above and beyond the skills building of therapeutic programs.

Since these therapies take place outdoors, nature plays a critical part in the holism of humans. Most outdoor therapists see humans as a part of nature, rather than apart from it. Since we are a form of nature, reconnecting with the outdoors is necessary from time to time, especially when our health is in need of healing. This kinship or affinity for nature is missing from many clients' lives (Kellert, 2003).

Some of these outdoor therapies deliberately involve risk taking challenges in order to build resilience, confidence, and self-esteem. Risk is the potential to lose something of physical, mental, emotional, social, financial, or spiritual value. Encountering real and/or perceived risks create intense responses to arising distress or eustress. These responses stretch clients outside their comfort zones and force them to adapt to the dissonance with new feelings, thoughts, and behaviors. Through repeated risking, their changes are reinforced to be transformative via reflection or facilitated discussion (Priest & Gass, 2018).

After risk and nature relationships, the success of most therapies rests on the strength of the dynamic client-therapist alliance. This key association is strengthened outdoors, because the experiences are shared. While the therapist is deliberate and accountable for the approach to treatment, the client is actively involved and responsible for the creation of their own therapeutic environment (Harper, 2009). Aside from taking place outdoors, and being immersed in nature with a therapist, outdoor therapies are prescriptive (as per mental health professionals) and employ kinesthetic activities that are experientially engaging on cognitive, affective, behavioral, and spiritual levels (Gass, Gillis & Russell, 2020).

How are the therapies different? Seven forms of outdoor therapy were identified from a review of the literature, including a recent edited volume (Harper & Dobud, 2021). These are summarized in Table 2.

Form of Therapy	Common Location	Required Element	Specific Clientele	Modalities
Wilderness	Wild & remote (not human disturbed)	Risk taking in wild & remote places	Open to all	Facilitation
Adventure	Outdoor (or inside)	Risk taking	Open to all	Facilitation
Land-based	Ancestral territory	Cultural activity	Indigenous heritage	Elder discussion
Eudemonic	Residential facility or summer camp	Normalizing, fun, playful activities	Living with disease, disability or disorder	Counselor or group dialogue
Nature-based	Natural setting, forest or field	Nature immersion with therapist	Open to all	Talk and other therapies
Animal-assisted (horse, dog, cat)	Ranch, stable, park, zoo or backyard	Animal interaction with therapist	Open to all	Varied
Horticultural	Garden, farm or indoors	Plant cultivation with therapist	Open to all	Varied

Table 2: Seven forms of outdoor therapy with differentiating components (identified by shaded cells).

While all therapies take place primarily outdoors, **adventure** therapy has a definitive risk taking element associated with it. **Wilderness** therapy has the same risk taking element, but adds the component of being conducted in wild and remote places, thus making it a specialized subset of adventure therapy. Real and/or perceived risk provides for physical, psychological, and spiritual stress. This moves clients beyond their safe haven and causes them to acclimatize with new feelings, thinking, and/or behaviors.

These changes in feeling, thinking, and behavior are then subjected to therapeutic dialogue to reinforce transformations. During the outdoor portions of programs, both these forms employ similar facilitation techniques from outdoor leaders with therapists in support roles. Away from the outdoors, a therapist has the main discussion role, while outdoor leaders support the therapy. Therapist supervision is a key difference between therapy as a process and therapeutic as a product (Becker, 2010; Javorski, 2021).

Land-based healing is the term given to a specific form that restores well-being by returning to nature and is operated by First Nations, Inuit, and Metis (Redvers, 2020). It takes place on ancestral territory (land, water and air that may be blessed and prepared for healing), involves cultural activities (fishing, hunting, trapping, gathering, and daily chores), serves people with an indigenous heritage (mostly restricted to members of each traditional society), and catalyzes change through Elder discussion (cultural story telling with morals and metaphors). Land-based healing programs commonly address presenting issues of suicide, addiction, depression and underlying medical diseases associated with the colonial dispossession from food sources and other natural resources. They do so through cultural

reconnection and a sacred synergy with nature that can only be described as a spiritual relationship with returning to the land. These indigenous programs tend to be located in remote northern communities.

Nature-based therapy is commonly found in large urban cities, where access to areas of nature is not so commonplace. In the mindful presence of sensory immersion in a natural environment, therapists and counselors apply many modalities including: Cognitive or Dialectical Behavioral Therapies, Narrative Therapy, Somatic Transformation, Eye Movement Desensitization and Reprocessing, or Acceptance and Commitment Therapy. In most cases, these programs address mental health issues such as: trauma, anxiety, depression, compulsion, obsession, and stress disorders, like Post Traumatic Stress Disorder.

Eudemonic programs are often summer camps or year-round residential facilities for clients living with a chronic or terminal disease, physical or mental disability, and/or a condition or disorder. Eudemonia suggests feelings of contentment, happiness, comfort, satisfaction, and well-being. These emotions, along with playful activities, can normalize and heal the feelings of participating clients. Although these camp-based programs were clearly recreational in purpose, they had some additional therapeutic value.

Horticultural and **animal-assisted** forms of therapy involve plant cultivation and/or animal interaction under the watchful eye of a trained therapist. By caring for the flora or fauna, clients are engaged in meditative and compassionate activities, and then discuss these with the therapist. These forms can happen indoors and are not as dependent on the outdoor setting or role of nature as the forms above.

How are the therapies separated? These forms of therapy are by no means isolated or disconnected. They can be blended together for greater effect. For example, eudemonic camps for kids with medical concerns can include gardening and equine therapy for the benefits of children. Land healing programs often include adventurous risk taking and take remote expeditions into de facto wilderness areas.

In this study, eudemonic, horticultural, and animal-assisted therapies were excluded. Adventure, wilderness, land-based and nature-based therapies were included. This division was made, because the latter four forms were dependent on the outdoors and aspects of nature, while the former three were independent from nature and the outdoors as evidenced by their capabilities to operate solely indoors.

PURPOSE

The purpose of this study was to identify Canadian outdoor therapy programs and survey their defining characteristics to create a comprehensive census. Further examination of these identified programs led to a consensus on the composition, constitution, and continuum of outdoor therapy in Canada. This was important because outdoor therapies had become popular promotional terms for many programs and yet without a clear picture of exactly what represented their delivery of these kinds of outdoor therapy.

In 2006, only a half dozen well known adventure therapy programs were described to exist in Canada (Harper, et al, 2009). By 2014, attendance at a series of regional adventure therapy symposia, a literature scan, and a systematic review identified 56 adventure programs using the term therapy, but without a confirmed understanding of the term or other programming descriptors (Ritchie, et al, 2016).

METHODOLOGY

Programs were identified and questioned in French and English, the two national languages of Canada. Figure 1 diagrams the flow of program numbers and percents obtained at each step of the methodology.

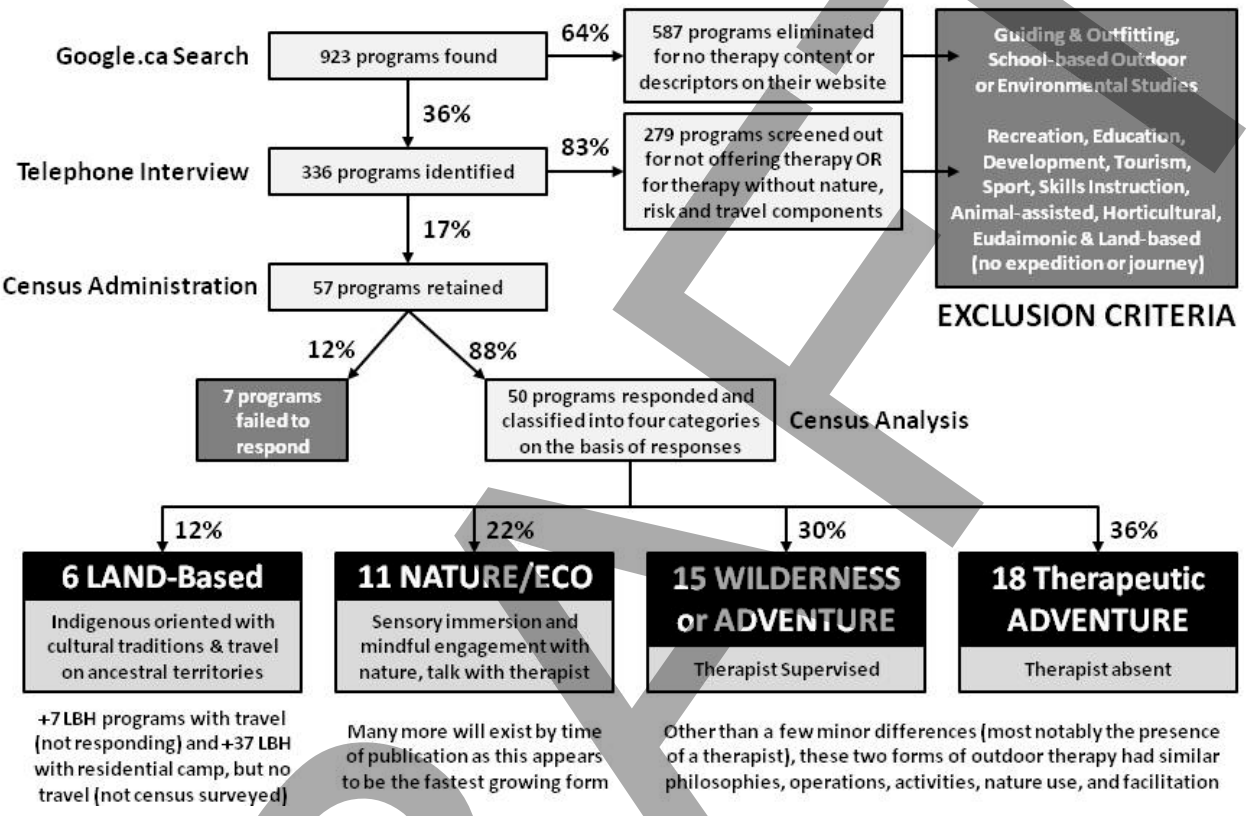

Figure 1: Flow of Program Numbers and Percentages throughout the Methodology.

SEARCH: Three google.ca searches (web, image, and map) were conducted using the Boolean terms: "Canada" AND "outdoor therapy" OR "adventure therapy" OR "wilderness therapy" OR "ecotherapy" OR "nature-based therapy" OR "land-based therapy" OR "land-based healing" OR "environmental therapy" (collectively known as outdoor therapies). Each search was followed to its final entry and 923 programs were found. The websites and related advertizing of these programs were examined for the presence of outdoor therapy content and descriptors. This eliminated 587 programs (64%) for lack of content or descriptors. The eliminated programs were mostly guides, outfitters, school outdoor field trips, and environmental study courses. Apparently, google.ca does not distinguish therapy from recreation or education. The resultant 336 programs (36%) were identified as potentially therapeutic in intent.

INTERVIEW: Of the 336 identified programs, those with a vague therapy connection were contacted by telephone to confirm their therapeutic intent. Seven questions were asked of program coordinators or directors. These were not asked in those cases where the information was clearly present on websites.

1. Do you offer outdoor (adventure, wilderness, land/nature-based) therapy?
2. How much of the program takes place outdoors and how much is indoors?
3. How much time involves travelling (journeying/expeditioning) with clients?

4. How much time is spent indoors or at a residential (camp/base) facility?
5. What kinds of risk taking/challenge activities do clients participate in?
6. What role does nature play in outdoor therapy within the program?
7. What is the balance of therapy conducted in groups or one-on-one with individuals?

The majority of 279 programs (83%) were screened out for not offering outdoor therapies. A common reply (153) indicated that they offered skill instruction, sport, or tourism as part of their program, but were not associated with any therapy or therapeutic intent. A few (16) mentioned that they used the term therapy to attract clients, but had no actual therapists on staff. Some (28) were residential treatment centres that had tried some form of outdoor therapy in the past, but abandoned these efforts because their counseling staff considered the practices to add little value beyond recreational exercise.

In this step, 45 eudemonic, animal-assisted, and horticultural therapy programs were reached. Although these therapy forms were not initially included in this study, their answers to interview questions were enlightening. One horticultural program discussed risk taking in terms of client feelings of guilt and anguish when their cared for plant died. A couple of animal assisted programs echoed this sentiment around lack of responsibility and self-blame when an animal wasn't properly looked after. Both forms of therapy noted much circumspection and mindfulness for clients while caring for the plant or animal. All, but two or three, were individually focused with a licensed clinician or therapist conducting the therapy.

The eudemonic programs (17 summer camps) depicted programming that balanced important elements of therapeutic benefits. For example, these described: equal amounts of time indoors and outdoors, some challenging travel with some cabin/tent camping, and half the activities done in small groups with the other half as individuals. Three programs noted that, when anything highly emotional came up for clients, a special counselor was available to discuss their feelings during the day and was on-call at night. Also in this step, land-based healing programs without risk or travel components were separated from those with. Those programs without challenge or journeying tended to be held in residential settings and did not see themselves as offering outdoor programs. These 37 were not included in the census.

CENSUS: The retained 57 programs (17%) were surveyed by an email inviting their completion of an online questionnaire. This was conducted over a one month period (from mid-May to mid-June, 2021) and inquired about their: location, philosophy, use of nature, purpose, clientele, affiliations, activities, staff, and facilitation methods. Follow up email messages and phone calls ensured a high return rate.

The census was conducted during the start of the recent Canadian COVID-19 recovery. Many programs, especially those in the north and centre of the country, were still closed with respondents not checking email or voice messages. In the midst of the census, a mass grave of over 200 children was discovered at the Kamloops Indian Residential School on May 28 (New York Times, 2021). With the expectation that new investigations with ground-penetrating radar, of other historically Catholic residential schools, would bring many more such shameful discoveries, the researchers were met with understandable anger and suspicion from indigenous land-based healing programs during the follow-up phone calls. A few (3) of the non-responding land-based healing programs (7, 12%) confirmed over the phone that they were not prepared to contribute due to recent events. The answers of the responding 50 programs (88% response rate) were examined and confirmed for therapeutic or therapy intent. These confirmed outdoor therapy programs (N=50) were classified into one of four types with these defining elements.

1. **WILDERNESS or ADVENTURE therapy**: therapist present, risk & travel in remote location (n=15)
2. **Therapeutic ADVENTURE**: therapist absent, travel, risk & challenge outdoors or indoors (n=18)

3. **LAND-based healing**: TRAVEL, ancestral territory, cultural activities, indigenous heritage (n=6)
4. **NATURE-based ECOTHERAPY**: immersion in nature with traditional talk or other therapy (n=11)

RESULTS

CHARACTERISTIC	15 Wilderness or Adventure Therapy	18 Therapeutic Adventure	6 Land-based Healing (travel)	11 Nature-based Eco-therapy
Program Purpose				
Change Feeling	29%	31%	29%	35%
Change Thinking	24%	34%	27%	25%
Change Behaving	32%	23%	35%	25%
Change Resisting	15%	12%	9%	15%
Health Focus				
Spiritual	8%	16%	24%	21%
Physical	23%	24%	25%	25%
Emotional	30%	30%	26%	27%
Mental	39%	30%	25%	27%
Client Gender				
Male	59%	48%	36%	38%
Female	37%	47%	61%	51%
Non-binary	4%	5%	3%	10%
Other	0%	0%	0%	1%
Client Age				
Average	18 yrs	22 yrs	17 yrs	27 yrs
Youngest	12 yrs	20 yrs	12 yrs	14 yrs
Oldest	38 yrs	35 yrs	22 yrs	68 yrs
Staff				
Program Leaders	11	15	35	5
Administrators	2	7	5	1
Indigenous Elders	2	0	2	1
Therapist/Clinician	5	0	2	3
Support/Clerical	6	3	13	4
Activities				
Games/Icebreakers	10%	11%	6%	6%
Team PS Initiatives	15%	12%	16%	15%
Ropes/Challenge	2%	6%	1%	1%
Daily Outdoor	13%	23%	27%	34%
Expeditions	21%	29%	22%	3%
Solo/Isolation	8%	11%	6%	20%
Community Service	3%	5%	9%	3%
Group Therapy	15%	3%	11%	17%
Time Division				
Doing	63%	75%	63%	50%
Discussing	37%	25%	37%	50%

Table 3: Summary of descriptive characteristics with numerical answers.

Data were analyzed seeking to distinguish among these four forms of outdoor therapy (OT): wilderness or adventure therapy (WAT), therapeutic adventure (TA), land-based healing with travel (LBHT), and nature-based or ecotherapy (NBET). Some descriptive characteristics are summarized in Table 3.

Location: WAT were mostly found in the eastern provinces with a strong concentration in Quebec. TA was most common to Ontario and British Columbia. LBHT was equally distributed around the nation, including northern territories. NBET were concentrated in British Columbia and the Atlantic provinces.

Program Purpose: On average, WAT aimed to change behavior more than feeling, thinking or resisting. On average, TA was deliberately focused on changing thinking, before feeling or behaving. LBHT was also centred on behavioral change, before thinking and feeling. NBET was oriented toward changing feelings before thinking or behavior. Changing resistance was the lowest priority for all four OT forms.

Mission: All Canadian OT programs were oriented toward improving the well-being of clients. WAT in Canada appeared to focus on psychotherapy (with a therapist) utilizing nature and risk as the unfamiliar and stimulating catalysts for lasting client change. TA in Canada (without a therapist), also engaged with risk and nature, but with more emphasis on experiential activities and less on expeditions. LBHT, unique to Canada, emphasized travel on ancestral territory, indigenous knowledge, traditional practices, cultural activities, and Elder story telling. NBET, the fastest growing of the OT forms, was clearly directed toward improving mental health, happiness, and well-being by spiritually reconnecting clients to nature and themselves, participating in relative safety and without risks.

Clientele: Although a few programs were open to all genders and ages, the majority of WAT programs were aimed at youth (12-19) serving more males than females. The TA programs served mostly adult populations, but with more programs uniquely designed for two specific sub-populations: service members (2 programs) and women only (2 programs). The LBHT programs were exclusively for indigenous youth, youth identifying with indigenous lineage, and youth, who might not identify as indigenous, but were from indigenous areas. NBET programs served all ages, with a focus on adults before youth and children, but several were also particularly welcoming to LGBTQ2S+ clients.

Presenting Issues: Youth in the WAT programs were referred for: anxiety, depression, complex trauma, substance use (alcohol or drugs), addiction (gambling or internet), malbehaviours, family dysfunction, oppositional disorder, impulse control, and victim or perpetrator of violence. Adults and youth in the TA programs tended to present with social isolation, lack of self-esteem or confidence, digital dependency, reluctance to exercise, absence of direction or purpose in life, helplessness, anger, anxiety, and depression. Youth in LBHT programs arrived with low self-esteem or confidence, family issues, mental health concerns, behavioural troubles, substance abuse, suicide ideation, loss of culture or knowledge, colonization impacts, and intergenerational trauma. Adults in the NBET programs presented with distressful lives (family or work), relationship difficulties, complex trauma, burnout, anxiety, depression, grief, obesity, emotional disregulation (anger or impulse), and the need for lifestyle support (LGBTQ2S+).

Health Focus: WAT placed a heavy emphasis on mental health, likely due to the mental illnesses of their youth clients. TA highlighted dual concern for emotional and mental well-being, likely due to similarly presented issues by their adults. LBHT balanced spiritual, physical, emotional, and mental well-being of the whole person, as is customary in the indigenous view of wellness. NBET also expressed duality on emotional with mental health and they were the next most balanced of the OT forms regarding health.

Client Gender: WAT programs served more males than females. TA served genders equally. LBHT and NBET served more women than men. Non-binary clients were best represented by the NBET programs.

Client Age: WAT served mostly youth with an average age of 18 years (from 12 to 38 years old). TA served mostly adults with an average age of 22 years (from 20 to 35 years old). LBHT served mostly youth with an average age of 17 years (from 12 to 22 years old). NBET served mostly adults with an average age of 27 years (from 14 to 68 years old). Despite the vast majority of programs being available to all ages, some forms of OT were clearly serving particular age sectors in Canada.

Staff: All OT forms were expectedly heavy on program leadership and light on administration. WAT programs had high numbers of therapists, while TA programs had none. LBHT relied on Elders for story telling and WAT and NBET also included Elders in their programming staff. LBHT programs held their second strongest staff numbers in support and clerical functions, along with WAT and NBET programs.

Ethics & Professionalism: All but one or two programs in each form of OT adhered to a code of ethical conduct, offered "Challenge by Choice" (Rohnke, 1989) and followed the principles of a "Full Value Contract" (Schoel & Maizell, 2002). Programs reported professional memberships in provincial, federal, and international organizations, such as: the (USA) Association for Experiential Education (13), their respective provincial camping associations (10), Paddle Canada (9), Association of Canadian Mountain Guides (7), and Aventure Écotourisme Québec (6). While no professional representation existed for OT in Canada, only a pair of respondents listed their registration with provincial therapy associations.

Activities: WAT made best use of expeditions, group therapy, and team problem-solving initiatives. TA echoed this model with the exception of very little group therapy, replaced by daily outdoor pursuits like climbing, paddling, and hiking. LBHT applied daily outdoor activities such as hunting and gathering, along with expeditions and team problem-solving initiatives. NBET echoed this arrangement with the exception of very few expeditions, replaced by solo/isolation and group therapy following daily outdoor activities which immersed clients with their senses in the surrounding nature. Games and icebreakers were notable parts of all OT programs, while ropes or challenge courses were surprisingly not well used. Service was lightly used by all forms except LBHT, where clients gave back to their home communities.

Role of Nature: WAT programs saw nature as the true creator of adventure: "risky adventure is a state of mind that is experienced by coming into contact with nature…nature can be both the context and the modality of intervention… risky adventure is a catalyst for social, emotional, and relationship development" (translated from French speaking respondent). Respondents emphasized the important consequences and stressors that arise from nature, as well as mentioning its soothing or rejuvenating value, a remote "digital disconnection" provided from social media, and the automatic "spiritual reconnection" offered to understanding one's place and self.

TA programs also noted the hardship and consequences that come from nature along with rejuvenation and renewal. "All activities are based around the ocean…it can be both soothing or stress-relieving, while simultaneously intimidating or scary" (responding administrator). "Nature is also an impartial judge…good decisions and poor decisions all have consequences" (responding trip leader). "Nature provides a setting in which to become more mindful…it allows participants to be cut-off from society and technology, making it a better setting for connecting with themselves and others" (another administrator). "Nature creates hardship and yet provides the vehicle for healing…unpredictable problems from nature without a defined solution are collaboratively overcome by participants…they

also experience a solo, where the peace and connection with the natural world is the main healing tool (another trip leader). TA programs appeared to place hardship and consequences ahead of restoration.

LBHT programs operated integrally with nature: "connection to the land is inseparable from culture [and] nature is a way of further connecting with culture and as that spiritual connection deepens so does the resilience from those reasons for attending the program" (indigenous program respondent). "Young people are very connected to their environment and their behavior changes immediately upon contact with it…time is allotted just to be in nature and to practice traditional activities" (another indigenous program respondent). These included fishing, hunting, trapping, medicine harvesting, spirit baths, sweat lodges, nature walks, and canoe journeys with camping along the way. Youth learn life skills, traditional teachings, spiritual connection, and a sense of purpose for and belonging to nature.

NBET programs spotlighted the restorative properties of nature and commonly viewed nature as the co-therapist. "Nature exists 'beyond the human' and so when we're in nature there's something 'more than us' that is reflected back…if our mind and attention is given the chance to tune into this, our nervous system relaxes" (responding ecotherapist). "I often look to nature to lead the direction of the therapeutic journey through metaphor, reflection, movement or other ways of engagement" (another responding ecotherapist). Methods that engage clients and get them to tune in more deeply than a simple walk through nature include: sensory immersion exercises, feathering kindling for a fire, listening to bird alarm sounds, making objects of personal value borrowed from nature, and contemplation in place. In addition to the mental well-being, several respondents noted the nature encountered physical health benefits: reduced blood pressure, heart rate, muscle tension, and stress hormone production.

Time Division: WAT divided program time into an average of about two thirds doing activities and one third discussing these. TA averaged about three quarters doing and a quarter discussing. LBHT had an average that was the same as WAT. NBET struck an averaged balanced of half doing and half discussing.

Therapy/Facilitation: Program time spent discussing was guided by therapy modalities and facilitation techniques. Field staff in WAT programs employed a range of techniques from none (let the recreation experience speak for itself), through structured questioning (what? so what? now what?) afterward, to frontloading and framing beforehand. Therapists applied Cognitive Behavioral Therapy, Impact Therapy, and Solution Focused Brief Therapy to assist clients in making sense of their adventures. They also reinforced the stages of change and consciously used metaphor to enhance transfer of learning. Clients were encouraged to self-facilitate with staff supervising client performance, coaching, and reflecting.

TA leaders used the same range of varied facilitation techniques, but no therapy per se. They also commented about the use of metaphor and other valuable debriefing techniques, such as dyad and triad dialogue before small group discussion, modeling behaviours, solo meditation, client selection of a personal power animal, meditation techniques, and a new contemplative question each day.

Several programs noted the multiple generations of facilitation (Priest & Gass, 1993). Now outdated, this approach has been replaced by a hierarchy of facilitation techniques (Priest & Gass, 2018) ranging from fundamentals and funneling (basic education skills for thinking), through freezing and frontloading (intermediate development skills for behavior), to fortifying and focusing (advanced therapy skills to counter resistance). Upgrading of techniques may enhance adventure program delivery and impact.

LBHT programs appear to use traditional sharing circles, storytelling with metaphoric messages from elders, and motivational interviewing of one another (a technique from occupational therapy). NBET

therapists identified several modalities that they relied upon to process trauma: Cognitive Behavioural, Dialectic Behavioural, Narrative, Immediacy and Attunement, Acceptance and Commitment, and Intensive Short-Term Psychodynamic Therapies. Additional methods beyond traditional talk therapies included: guided mediation, story sharing, feeling validations, somatic awareness, and metaphor. Metaphoric transfer appears to be common to all forms of OT studied.

DISCUSSION

Wilderness or Adventure Therapy: Conducted under therapist supervision, small groups of WAT clients engaged in adventurous risk taking, where nature provided consequences and respite. The presence of a therapist and mostly youth presenting with behavioral before mental concerns, meant that WAT was most focused on changing behaviors and mental health. Therapists relied on Cognitive Behavioral Therapy, Impact Therapy, and Solution Focused Brief Therapy as modalities to treat their clients.

Therapeutic Adventure: Led by a trip leader, AT employed risk taking in small groups and nature for recovery, to work mostly with adults, but some youth. Activities were less expedition oriented than WAT, but more about experiential activities. TA was most focused on changing thinking and improving mental and emotional health, since clients arrived with mostly personal issues of social isolation, low self-esteem, poor confidence, and lost in purpose and direction. This is where a few specialized programs for service members and women only were located.

Therapeutic Adventure AND **Adventure or Wilderness Therapy**: Beyond their major difference of a therapist being present (former without, latter with) and a few minor differences (behavioral versus thoughts), these two forms of OT were substantially similar. For example, both had almost identical activity blends. WAT utilized expeditions, group therapy, and team problem-solving initiatives, while AT swapped more outdoor pursuits for less group therapy. Both WAT and AT saw nature as the provider of risk and consequences, before acknowledging its restorative properties. Field staff for both forms of OT also used the same facilitation techniques. All forms of OT utilized metaphors to boost learning transfer.

Land-based Healing (with travel): Analysis of these programs was incomplete, due to half (7 out of 13) LBHT programs choosing not to respond due to recent residential school tragedies. Therefore, no declarations beyond description can be drawn from these data. Further research into these programs by an indigenous scholar is warranted to determine state-of-the-art practices in Canada. A comparison should be made between those programs that include a travel component and those that are stationary at a residential camp to determine the unique contributions of expeditionary learning (Cousins, 1998).

LBHT is uniquely Canadian and involves travelling through and camping on ancestral territories, while using traditional knowledge, cultural practices, and Elder storytelling to heal indigenous youth. These youth present with low self-esteem or confidence, family issues, mental health concerns, behavioural troubles, substance abuse, and suicide ideation. These are known to emanate from colonization and the intergenerational trauma of being forcibly dispossessed from their land and consequently losing culture and knowledge. LBHT concentrates on behavioral change, by returning youth to the land, so they can reconnect with nature, participate in fishing, hunting, trapping, medicine harvesting, spirit baths, sweat lodges, or nature walks, and balance their holistic spiritual, physical, emotional, and mental well-being.

Nature-based or Ecotherapy: Accomplished mostly one-on-one with a therapist, clients immerse themselves in the restorative properties of nature in order to primarily change feelings and improve emotional health, while participating in relative safety and without risks. The fastest growing form of

OT, it served all ages of clients presenting with distressful lives (family or work), relationship difficulties, complex trauma, burnout, grief, obesity, emotional disregulation (anger or impulse), or the need for lifestyle support, and was especially friendly toward exceptional or marginalized populations. The primary method of NBET treatment involved deep concentration in nature with sensory activation and mindfulness. This was followed by talk therapies (Cognitive Behavioural, Dialectic Behavioural, Narrative, Immediacy and Attunement, or Acceptance and Commitment) continued in a natural setting.

On the basis of some qualitative data gathered during the interviews and quantitative analysis from the census, a generalized continuum evolved as shown in Figure 2. All forms involved nature, experiential methods, and therapeutic intent. A therapist or elder was present during varying times in each form.

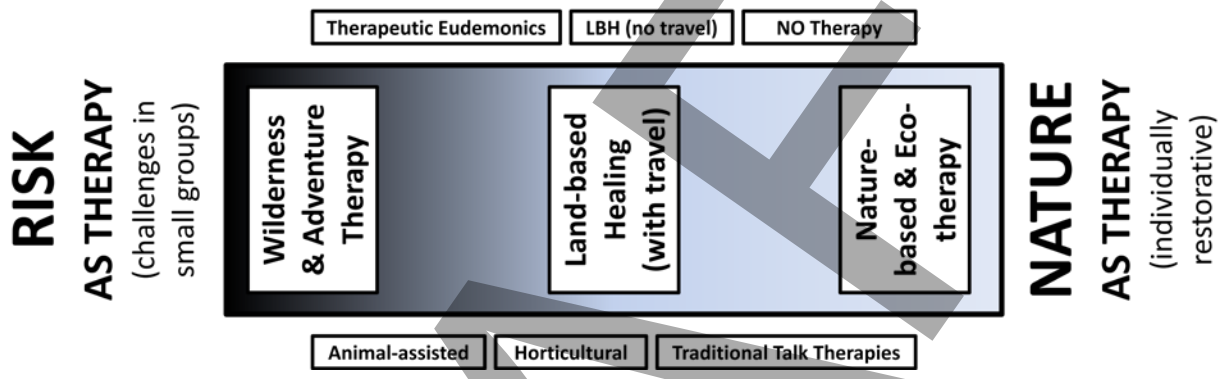

Figure 2: A generalized continuum showing relationships among several forms of outdoor therapy.

Those forms of outdoor therapy on the left (wilderness or adventure) involved risk taking or challenge and took place primarily outdoors, often with a journeying component. Therapy was conducted mostly in group process with a facilitator, counselor, or other leader, but with the supervision of a therapist or licensed clinician. Nature provided a means to test oneself, whilst gaining an affinity for wild places.

Those forms on the right (nature-based or eco-therapy) involved contemplation or meditation and took place during immersion in the eco-restorative properties of nature. Therapy was conducted in individual process with a therapist or licensed clinician. Nature played a more critical role in this form than others.

The form in the middle (land-based healing with travel) balanced risk taking or challenge on expedition with contemplation or meditation in nature. They utilized both small group and individual processes. Immersion in nature was for making a spiritual connection and benefitting from its rejuvenating assets.

Therapeutic eudaimonics, land-based healing (no travel), no therapy, animal assisted, horticultural, and traditional talk therapies were placed outside the continuum. A large part of their programming either subjectively did not involve a therapist or objectively could easily take place indoors with a therapist.

CONCLUSION

Outdoor therapies in Canada range from risk taking as therapy in small client groups (adventure and wilderness therapies) to individual nature immersion (eco-therapies). Land-based healing (with a travel component) balances the risk taking and nature immersion in a uniquely Canadian and indigenous way.

Land-based healing in a residential setting (without travel) appears to lack the adventurous risk taking and yet engages in a deeply spiritual manner with nature. Therapeutic eudaimonics, animal assisted therapy, and horticultural therapy do not appear to depend on risk, nature, or the outdoors to the great extent that the other forms of outdoor therapy do: for natural learning consequences and restoration.

While this study appears to have painted an accurate portrait of outdoor therapies in Canada on average, it may be limited by not having found every single program. Some therapists may have a full practice without need for an Internet presence and therefore were not discovered during the Google.ca search. A few phone interviewees may have desired to be excluded from the study for privacy or proprietary reasons and therefore stated that they were not engaged in any form of outdoor therapy. Other census non-respondents may have opted out by not completing and fully submitting their answers due to a personal preference not to be compared with other or more well-known programs.

The definitions of therapies related to the outdoors are challenged in Canada; some operators are reluctant to define these in case they can't meet the definition. These are further confused by diverse follow-up procedures. Aftercare can range from non-existent to ongoing residential treatment with or without family involvement. Mainstream therapy can see these forms as extreme or mysterious. They can lack professional representation, while best practices are unlikely to be shared among programs.

A "nature counselor" title has replaced is the "life coach" label for non-therapists seeking new work. As a result and unless the outdoor therapy profession gets its collective act together, its reputation will be become further diluted by unscrupulous imposters pretending to deliver therapy, but only providing recreational programming, thus failing to bring change and giving the entire industry a bad reputation.

If not self-regulating, outdoor therapy programs will become less authentic and more controlled due to liability restraints and government legislation aimed at attempting to over manage the real dangers. No risk means no chance of challenge or uncertainty. So, reducing the therapeutic use of perceived risk, will require adventures to be faked or "disneyfied" and not genuinely expressed in all forms of therapy.

This has been the unavoidable pattern in the USA and other nations. Canada is poised to follow suit.

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