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Mental Health Professionals' Use of Adventure Therapy with Couples and Families

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Mental Health Professionals' Use of Adventure Therapy with Couples and Families

by

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The clinical research project is a graduate requirement for MSW Students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted in a nine month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Adventure therapy (AT) is an emerging model of therapy that is being used for work with individuals and families. AT combines experiential education with therapy in a single program (Crisp, 1998). The purpose of this research paper is to explore how social workers integrate adventure therapy into their work with families. The research also explored the current status and implications of AT in terms of being accepted as an evidence based practice. A total of eight mental health professionals who have experience facilitating adventure or wilderness therapy were interviewed. The results of the research support the literature suggesting the field of adventure therapy does not have a standardized approach to program facilitation and training requirements in both therapy and adventure based or wilderness activities (Gillis & Bonney, 1986; Newes & Bandoroff, 2004; Tucker & Norton, 2012). The programs did integrate the core components of adventure therapy as defined in the literature review in this paper. The majority of participants suggested the field of AT is a valid form of therapy considered to be supported by research. Participants acknowledged the difficulty in conducting research using control groups in AT due to the countless variables; participants also questioned the need for quantitative rather than qualitative research to be considered empirically supported therapy. The findings contradict the literature that states a challenge for the field of AT for broader acceptance is the lack of empirical research that contains information that is both valid and reliable (Newes, 2001).

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Traditional therapy settings for couples and families may be limited in providing opportunities for growth and promoting change necessary to improve the dynamics of a family system. One limitation in traditional therapy is the use of verbal conversation as the primary mode of communication. Visual learners or a patient with attention deficit disorder (ADD) may communicate more effectively through the integration of other senses. A second limitation is the traditional therapist meets with clients for 50 minute sessions in an office environment that may not be suitable for all types of clients and client groups. Finally, traditional therapy programs may be limited due to the availability of resources. As mental health clinics are getting increasingly busier there is a growing need for additional programs to help the community with mental health support (Berman & David-Berman, 1995).

One option for a non-traditional therapy treatment option for families is adventure therapy (AT). AT combines experiential education with therapy in a single program (Crisp, 1998). According to Kelly & Baer, Outward Bound began one of the first AT programs in the late 1960's that combined experiential education with therapy (as cited in Newes & Bandoroff, 2004, p. 3). Traditionally, the majority of programs that use AT have been programs based in inpatient mental health facilities and programs supporting the mental health needs of adolescents (Newes & Bandoroff, 2004). As AT is being used by more practitioners, the target populations have evolved to include individuals, couples, families and groups (Fletcher & Hinkle, 2002).

Family systems that need therapeutic attention may greatly benefit from AT. AT for families provide the opportunity for better communication, reduction of denial, increased teamwork, building trust and recognizing family roles. Longer therapy

sessions benefit families by allowing for the opportunity for important family dynamics to present through the use adventure therapy that may not otherwise be revealed in a shorter and more traditional therapy session (Newes & Bandoroff, 2004).

The growing fields of AT faces two primary challenges in becoming accepted as evidence based. AT would benefit by being accepted as evidence based both for continued growth as a treatment and for the ability to bill insurance to offer programming to populations that need the extra support through their benefits. The first challenge for the field of AT is the lack of empirical research that contains information that is both valid and reliable (Newes, 2001). Second, the profession lacks standardization of training, certification or credential requirements for AT (Burg, 2001). Working with couples and families within adventure and wilderness therapy face the same challenges as the broader AT field in becoming recognized as being evidence based (Gillis & Gas, 1993).

Scope of Problem

Adventure therapy (AT) programs are challenged by not having a standardized protocol to use in defining the services they provide. AT lacks uniformity in establishing professional credentials required to perform AT (Newes & Bandoroff, 2004). For example, programs that use the word “therapy” or “therapeutic” in the title of their offering could be misleading in terms of the services actually delivered (Williams, 2004). The ambiguous titles of therapy and therapeutic bring up many questions for someone interested in learning more about a program. How is the program therapeutic? Does therapeutic mean the same thing as therapy? When a program includes the word therapy in the title, what are the credentials of the person providing the therapy component? How

often and in what way is therapy administered? Are the program leaders properly trained in both therapy practices as well as the adventure activity? Adventure therapy programs are stronger when the treatment plan or program structure is structured based on an assessment needs of the clients and provided by professionals trained in both therapy and adventure activities (Gillis & Bonney, 1986).

In order to obtain acceptance as being evidence based, AT needs to have research studies conducted with higher validity and reliability levels and based on a unifying theory (Newess & Bandoroff, 2004). Once AT establishes a base model that allows research to confirm the field as being evidence base, standard protocols for ethical programming may be established. Standardization would help maintain professional requirements for programs to follow in order to offer a high level of service to families and clients.

Significance of Evidence Regarding AT Programs for Families and Couples

Adventure therapy (AT) programming typically requires families to face a challenge together while applying a metaphor to the activity (Mason, 1987). As an example, a family may be collaborating on a challenge where the son leads and the dad follows. The role reversal creates tension if the father is not performing an activity in the way the son had planned. The therapist could then ask questions to both the father and the son regarding how the role reversal compares to situations in the home. The therapist may ask the father and son about trust, communication, leadership and responsibility and how it relates to their life at home. After the activity is completed facilitators will typically work with the families in therapy sessions to go over the activity and how it affected individual family members and the family system. Metaphors help family

members connect the activities to their lives at home. The result is an expansion of self-awareness and an increase in self-esteem and intimacy for family members and the family system (Mason, 1987). A trained therapist will help families complete the transfer of learning in order to integrate lessons they learned during a program to their life at home. AT applied to families has been found to increase self-esteem and has led to an increase in overall family health and wellness (Bandoroff & Scherer, 1994, p. 178).

The healing effects of nature also contribute to the benefits of AT. According to Greenway (1995), “Without intimacy with nature, humans become mad...the healing effect of nature is almost a given” (p.127).

Family members signing up for AT programs may not realize the field does not have uniform standards. A facilitator could have credentials as a therapist, but lack credentials in adventure activities. For example, social workers using AT in their practice were found in general to lack proper training in adventure activities (Tucker & Norton, 2012). Furthermore, a therapist with a master’s degree may simply supervise facilitators who may lack proper training in therapy but have training in adventure activities. If a family provides a significant presenting problem to work on through AT they may be disappointed if a facilitator lacks skills to control difficult family dynamics or blowups (Tucker & Norton, 2012).

Relevance to Social Work

A survey of social workers found out of 646 respondents, 10% use adventure therapy (AT) in their practice. The majority of social workers who use AT integrate it in their practice on a consistent basis. However, few social workers have the necessary training in both therapy and the experience to safely facilitate outdoor activities in an

outdoor or back country setting (Tucker & Norton, 2012). The most pressing ethical principles from the National Association of Social Workers (NASW) Code of Ethics when considering AT includes the importance of human relationships, competence, integrity of the profession, and evaluation and research.

Importance of human relationships. The first relevant ethical code for AT from the National Association of Social Workers (NASW) Code of Ethics states, “Social workers recognize the central importance of human relationships” (1999, n.p.). If an individual or a family needs extra support people turn to other humans to assist in support of the change that is necessary to better the health of the individual or family system (NASW, 1999, n.p.). Human relationships are of central importance in both social work and to work on creating change in adventure and wilderness therapy.

Competence. The second consideration for social workers using AT in their practice is competence. Social workers who are new to a field are called to seek proper education, research, training, consultation and supervision. Employing proper professional support is especially important in an emerging field that may lack standards (NASW, 1999). The field of wilderness therapy has experienced at least 10 deaths since 1990. Thousands of complaints of wilderness therapy programs have had a common theme citing “negligent program owners manipulating desperate parents with false advertising” (Canham, 2007, n.p.). Much of the time the problems occur with under-trained staff working with adolescent populations (Canham, 2007). Social workers are called to improve professional and ethical standards through competent practice (NASW, 1999).

Integrity of the profession. A third application of the NASW code of ethics for AT is integrity of the profession. Social workers are called to add to the professional knowledge from the field. In addition social workers have the responsibility to prevent the unauthorized and unqualified practice of social work (NASW, 1999, n.p.). Applying professional standards to the field of wilderness and AT, social workers need to ask questions if they experience dysfunctional or unethical practice in AT programs. If a program lacks qualified and well trained staff, or treats clients in a neglectful manner, social workers have a duty to address the unethical practice. Social workers involved in AT should also advocate for professional standards and practices in AT through professional conferences, research and organizations (NASW, 1999).

Evaluation and research. The last NASW Code of Ethics principle discussed in this paper relevant to social workers doing AT is evaluation and research (NASW, 1999, n.p.). Social workers involved in AT programs are encouraged to add to knowledge of the field based on the NASW code of ethics regarding evaluation and research. As new research studies are published, social workers using AT should be aware of any updates or changes to the outcome of studies relevant to the field to make sure their individual practice stays current with best practices.

Purpose of Research

The purpose of this research is to explore how social workers integrate adventure therapy (AT) and wilderness AT for couples and families within their practice. A secondary purpose of the research is to identify how social workers are contributing to the field of AT and wilderness therapy.

Literature Review

Adventure Therapy Defined

Adventure therapy (AT) programs differ from basic outdoor education programs by incorporating emotional growth as a key component making a program therapy based (Berman & Davis-Berman, 2000). AT is defined by Crisp (1998) as being:

A therapeutic intervention which uses contrived activities of an experiential, risk taking and challenging nature in the treatment of an individual or group. This is done indoors or within an urban environment, and does not typically involve living in an environment (p. 9).

When considering the definition of AT a distinction must be made between the terms therapy and therapeutic. Therapy is defined as “a treatment designed to relieve or cure an illness, disability, or other bodily, mental, or behavioral disorder” (Williams, 2004, p. 199). The term “therapy” is the process a client goes through to achieve positive change in their life (Williams, 2004). In contrast, “therapeutic” describes a resulting feeling for a client such as feeling happier or more relaxed (Williams, 2004). The distinction is important as AT programs may incorporate the names “therapy” or “therapeutic” into their programming.

The terms “wilderness therapy” and “wilderness AT” are commonly used to define or categorize the type of outdoor adventure program. Wilderness therapy incorporates isolation and the requirement of sleeping in the environment in either an established campground or through a trip where participants are expected to learn to be self-reliant. Common activities used in wilderness therapy include kayaking,

backpacking, hiking, climbing and other forms of backcountry travel (Crisp, 1998). For shorter day trips the term “wilderness-adventure therapy” is used. Wilderness-adventure therapy may be completed in “a short session or where a natural environment is used for an adventure therapy type of activity” (Crisp, 1998, p. 10). Finally, “wilderness family therapy” is defined as, “The process in which family members participate in a wilderness experience and take risks which are often in high-stress situations” (Mason, 1987, p. 91).

History of Adventure Therapy

AT has roots dating back to the 1800's when Friends Hospital in Philadelphia incorporated activities in the outdoors to treat mental health conditions. In 1901 outdoor therapy continued to be used through the use of tents for patients to sleep in at Manhattan State Hospital East as a way to separate patients with tuberculosis. Several camps were created in the mid 1900's that started using therapeutic approaches. The camps were setup up for populations with a wide range of medical and mental diagnosis (Gillis, 2005). Kurt Hahn founded Outward Bound in 1941 to create the first experiential education program combining the outdoors with education (Outward Bound, n.d.). Hahn's idea came from recognizing young British sailors serving during WWII lacked the skills to survive at sea. Hahn was quoted as saying, “There is more to us than we know. If we can be made to see it, perhaps for the rest of our lives we will be unwilling to settle for less” (Outward Bound, n.d.). Josh Miner was exposed to Outward Bound as an American professor living in Scotland. Miner was impressed with Outward Bound and set out to establish Outward Bound in the United States. The United States branch of Outward Bound made a significant impact in experiential education by providing programming that offered students experiences that lead to increased empowerment,

increased self-esteem, and a sense of responsibility for others. An example could be a climber who learns to climb, build an anchor and belay, as their partner climbs. An adventure such as climbing not only teaches important outdoor skills to stay safe, but also leadership skills of responsibility and self-reliance are also inherent benefits for participants. Outward Bound provided clients with the thrill and the skills in a way that other programs had not done before in the United States (Outward Bound, n.d.).

According to Gillis (2005), the term adventure based counseling was first used in 1979 and the field continued to expand throughout the 1980's to the present. The establishment of adventure activities such as ropes courses, as well as professional education programs with the focus on AT curriculum, contributed to furthering the profession of AT. The industry established international conferences and a professional organization called the Association of Experiential Education (AEE). AEE has helped influence and shape the direction of the emerging field of AT towards the goal of becoming an accepted method for doing therapy (Gillis, 2005).

Goals

Newes and Bandoroff (2004) have identified six goals of adventure therapy (AT). First, clients increase self-awareness and this in turn results in "increased recognition of behavioral consequences and available choices" (p. 7). This means that a client, such as a defiant adolescent, will quickly learn the consequence of being defiant during AT. If they decide to sleep outside and not in their tent and it rains, getting wet and cold is a direct repercussion from their decision. The second goal is to teach clients to increase their responsibility for both themselves and others in unforgiving environments. The third goal is for clients to learn better or increased coping strategies. The fourth goal is

identified as AT providing tangible evidence of success that allows for clients to increase self-esteem through viewing themselves in a more positive light and by reducing negativity. The fifth goal is that clients learn to work better with others through “creative problem-solving, communication, and cooperation skills” (Newes & Bandoroff, 2004, p. 7). Finally, the sixth goal is to debrief clients on their strengths, weaknesses and identify barriers that clients may create for themselves that may block success (Newes & Bandoroff, 2004, p. 7).

Populations Served

Traditionally, the majority of programs that use adventure therapy (AT) were inpatient mental health facilities and programs serving adolescent populations (Newes & Bandoroff, 2004). AT is now used as a tool to provide therapeutic programming to a broad range of populations. “Substance abusers, developmentally disabled children, rape and incest victims, sexual perpetrators, psychiatric inpatients, at-risk teens, adjudicated youth, couples and families” make up just some of the populations served by AT programs (Cason & Gillis, 1994, p. 41). Additional populations include women, college students, corporate employees, athletes, victims of trauma, and clients with mental health conditions such as anxiety, depression, dysthymia and adjustment disorder (Fletcher & Hinkle, 2002, p. 283). AT programs typically address issues pertaining to family, school, behavior, conduct disorders, self-esteem, depression and suicidal ideation (Davis-Berman, Berman & Capone, 1994).

Characteristics of Adventure Therapy and Wilderness Adventure Therapy

The therapeutic interventions used in adventure therapy (AT) include traditional group and individual therapy techniques. An adventure therapy facilitator uses an

adventure activity as a catalyst to provide specific examples of how a family or individual operates under stressful situations. The therapy process extends after the activity is completed to open up a dialogue with participants. A session may relate the activity to separate issues affecting the clients through the use of metaphors. Processing activities by a trained therapist is the therapeutic factor that is unique in outdoor adventure programs to AT. In experiential education, therapists are not used, and the programming is not debriefed by trained therapists directly relating to a client's or family's presenting problem or diagnosis (Newess & Bandoroff, 2004).

Kimball and Bacon (1993) identified AT as having 14 components that are built based off a model defined by researcher Michael A. Gass in 1992 (Gillis & Gass, 1993). The model includes: (1) multiple treatment formats, (2) group focus, (3) processing, (4) applicability to multi-model 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 (as cited by Newes & Bandoroff, 2004, p. 9).

(1) Multiple treatment formats. Multiple treatment formats refers to the difference between AT, wilderness therapy and a longer term residential camping scenario (Newes & Bandoroff, 2004, p. 9). The differences in activities are described below under sequencing of activities.

(2) Group focus. AT typically is setup for group work. In working with families there can be single or multi-family groups. Groups are a beneficial and necessary strategy to AT for members to provide and receive feedback and support from other group members. Facilitators are interested in both the completion of activities, and also

what happens between the members during the activity (Newes & Bandoroff, 2004, p. 14).

(3) Processing. Activities create circumstances that evoke reactions by participants. Therapists are able to witness dynamics of individuals and family systems as they happen naturally during the activity. The emotions are processed through therapy sessions after the activity. Metaphors act as a tool to experience the transfer of skills from the activities to the way things are done at home (Gass, 1991).

(4) Multi-model treatment. AT can be used as either the main intervention, or as a module of a program that includes additional programming besides the adventure activity (Fletcher & Hinkle, 2002). For example, adventure activities may be one component of a long term residential treatment program at a facility treating chemical dependency. Other programs may focus on the adventure therapy or wilderness therapy interventions.

(5) Sequencing of activities. Adventure therapy (AT) activities need to meet the client's needs and skills as deemed appropriate through assessment by the facilitator (Fletcher & Hinkle, 2002). Adventure therapists guide participants through the activities, setting boundaries and limits on what can and cannot be done, to complete a challenging activity. The activities are carefully planned to challenge clients and to allow for both successes and failures. The environment is often artificial, such as a ropes course or climbing wall. Participants in adventure activities are not sleeping in the environment such as may be the case in wilderness therapy (Crisp, 1998).

Wilderness adventure therapy activities may include trekking, rafting, canoeing, dog-sledding, backpacking, skiing, sailing, rock climbing or biking (Mason, 1987).

Another study found a high percent of programs reviewed using ropes course activities as the adventure portion (Davis-Berman, Berman, & Capone, 1994). Other activities included camping, outdoor games, rafting, fishing, biking and horseback riding (Davis-Berman, Berman, & Capone, 1994).

(6) Perceived risk. Clients must perceive a risk in an activity as a part of the requirement for adventure therapy. The intensity of a situation will likely bring on fears a client has, such as a fear of heights. A group facilitator will help the person talk about the fear that has come up, and be able to help the participant identify if there is more underneath the fear, such as a fear of failure (Mason, 1987).

(7) Unfamiliar environment. Exposure to an environment clients haven't been exposed to before will cause the client to cope with situations in new ways. For example, a teenager who throws a temper tantrum at home for not getting what they want would have to cope differently with an adventure activity that is proving to be challenging (Newes & Bandoroff, 2004).

(8) Challenge by choice. A participant needs to decide to face a challenge on their own. If they become too scared or uncomfortable with a situation, a client has the right to skip or reduce the challenge of the activity they are not comfortable participating in due to safety, physical or emotional reasons (Mason, 1987).

(9) Provision of concrete consequences. AT allows for immediate feedback of choices participants make. When a participant is stuck on a rock wall, they may feel fear or anxiety and have to find strength, trust and confidence to get to the next hold on the wall. If a poor choice is made, such as not tying a harness on as tight as instructed, the participant may be uncomfortable as they are being lowered down.

(10) Goal setting. A therapist establishes goals for clients only after understanding what the client is trying to achieve therapeutically from the program. The goal should be kept as a focus throughout the duration of the AT or wilderness programs. Both individual and group goals are established early in the program after consulting with the individuals and group/s (Newes & Bandoroff, 2004).

(11) Trust building. Trust is a major component to AT for families. Trust should be built up between members of a group in gradual small steps through activities and debriefing. Gradually trust through activities should develop into interpersonal trust (Newes & Bandoroff, 2004). When a member of a group or family is faced with a challenging situation the emotions that surface can surprise the participant. For example the participant of an the adventure activity may have thought they trusted family members or others in the group only to find in a moment of distress they lose confidence or have doubts in the abilities of other members they should be trusting. When this happens, the program leader needs to help the members work out what they are feeling and help them move past the fear and anxiety (Mason, 1989).

(12) Enjoyment. AT is meant to provide enjoyable activities and experiences for participants. For clients used to traditional therapy, incorporating fun that has a purpose can be a positive way to do therapy. If the activity relaxes clients or reduces stress, it is plausible the client is more willing to open up about issues previously avoided (Newes & Bandoroff, 2004).

(13) Peak experience. AT programs should challenge individual clients, and groups to build upon newfound skills to prepare for the climatic peak challenge towards the end of the program (Newes & Bandoroff, 2004). The form of the challenge can vary

greatly depending on the program and the clients. For a wilderness adventure program peak challenge may be a solo overnight trip, or a long backcountry trek. For adventure therapy, a peak challenge may be learning to build a climbing anchor and setting up a rappel using skills learned throughout the program. For a program working with disabled participants perhaps a challenge would be to complete a task as independently as possible.

(14) Therapeutic relationship. In adventure and wilderness therapy programs therapists generally spend a lot of time with each client throughout the program. Therapeutic relationships are often emphasized as an important factor in determining therapeutic growth. Furthermore, a therapist may experience the dynamics of a family during an activity and be able to intervene if there is conflict during the activity. Later the therapist has the ability to debrief the activity and ask further questions about what happened during the activity. The constant monitoring of the group dynamics is unique to adventure and wilderness therapy (Newes & Bandoroff, 2004).

Adventure Therapy: State of Research

Research for adventure therapy (AT) lacks both internal and external validity. Newes (2001) suggests reliable research that is empirically based is necessary in order to effectively connect AT as an application that affects change in participants. More empirical research is needed for acceptance of adventure based therapy and adventure based therapy for families to be accepted into an evidence based therapy treatment (Gillis & Gass, 1993; Burg, 2001; Newes, 2001; Neill, 2003).

In 1992, Gillis (1994) called for five improvements for the field of AT. First, he saw a need for a meta-analysis project to be completed that includes criteria to be

clinically accepted and significant. Meta-analysis is defined as “a method of statistically integrating outcomes from many separate studies” (Cason & Gillis, 1994, p. 41). Cason and Gillis called for using meta-analysis to assimilate the findings of many studies into data that could be interpreted through in depth analysis (1994, p. 41). Second, Gillis suggested research should be focused on establishing user manuals that would allow for data to be collected with them to better accept or deny specific applications of AT. Third, attention to the problem of AT staff members not having credentials necessary in both therapy and adventure programming is necessary to maintain safety and professional standards for activities and therapy components. Fourth, Gillis calls for AT researchers to share writing in a collaborative manner. Finally, Gillis suggests a need for the publication of AT research findings in psychotherapy journals (1992).

Neill (2003) suggests a need for setting industry standards for evaluating the outcomes of adventure based programs. This is done by creating statistical benchmarks and comparing outcomes of studies against the benchmark. Neill suggests this will create a standard for the industry to better identify what is working and what is not working in adventure therapy programming. Neill suggested adventure programs in general should commit to the most up to date formats for analyzing outcomes. Neill proposes standardizing future research by researching specific aspects of AT utilizing standard measurements, the completion of research looking at specific “clinically significant moments and processes which occur” and for sharing data with the international AT community (Neill, 2003, p. 320). Burg (2001) suggests researchers need to better define the parameters of programs such as the length of the program, goals, intensity and what level training practitioners have in therapy and adventure programming. The ultimate

goal is to gain a database of research studies that can easily identify the appropriate adventure therapy treatment for a particular population or diagnosis.

Adventure Therapy Studies

A national survey of 31 wilderness programs found these programs lacked information about how therapy is applied, lacked research evaluation, and also lacked follow-up to the programs. The study also found a lack of universal application and definition of the term “therapeutic” for a program that was called a “therapeutic program”. Very few programs that identified as being therapeutic programs actually integrated psychotherapy. The programs ranged in scope from adventure therapy (AT) activities utilizing a ropes course to wilderness therapy programs with time spent in wilderness environments. The types of programs also varied in setting and length. Some programs stated they do both group and individual therapy. Only about half of the programs had a supervisor with a masters degree or higher in therapy or counseling fields. For the programs that did have qualified professionals, staff doing direct work with participants often had a bachelors or no degree and were simply supervised by a credentialed professional (Davis Berman, Berman, & Capone, 1994).

A meta-analysis study by Cason and Gillis (1994) examined 43 studies that had empirically based statistics. The study coded seven measurements which included: self-concept; behavioral assessment by others; attitude surveys; locus of control; clinical scales; school grades; school attendance. This analysis found that adolescents improved by 12.2% from the application of AT and participants also improved 62% more than non-participants. However, the studies reviewed did not have standard variables such as the levels of training by program staff. Programs also lacked definitions of how the therapy

was applied in the form of activity performed, duration, identification of the exact participants and what type of facilitating is provided (Cason & Gillis, 1994, p. 41).

Project Adventure is a program developed for court referred adolescents who were identified as having problems with drug abuse. The study included 170 youth who completed a long term treatment program that consists of four phases. The program incorporated both residential living and camping as a part of the treatment process. The program was successful in incorporating adventure therapy and wilderness therapy as a part of its curriculum. The outcome of Project Adventure found 72% of participants did not re-commit a crime over a three year period. This rate is similar to the percent of adolescents that are successful in going through a separate program through the Department of Children and Youth Services (DCYS). The study is considered to be a successful implementation of a multi-mode treatment plan that incorporates adventure therapy (Gillis, Simpson, Thomsen, & Martin, 1995).

The Family Wheel is a wilderness therapy program that was established for families with teenagers aged 13 to 18 years old. The teenagers had substance abuse or behavior problems at school. The Family Wheel program was used as an intervention method for 27 families as an attempt to provide adolescents with a method to gain skills, responsibilities and as a way to bond with their parents. During the first phase of the program, the adolescents participated in a 21 day survival program. After the adolescents completed the survival program, parents of the kids were then introduced into the program. The teenagers had to use their newly learned survival skills to teach their parents basic survival techniques that would be used throughout the program.

The study found 95% of the participants as rating the program as helpful. The study also found participants identified the activities, metaphors and debriefing of the activities as highlights of the program. The effects The Family Wheel had on families included more positive family communication in the form of conflict resolution, negotiating and expressing feelings. The adolescent participants experienced less legal trouble than the comparison group. This study was limited in the number of participants. The sample population also was not completely random due to participants needing to have the resources to be able to take time off from work in order to commit to the program. The financial and time constraints may have limited the potential pool of participants. Furthermore, this is a wilderness therapy program, not AT which utilizes day activities in a contrived environment. The study did provide promise for the use of wilderness therapy with families challenged by adolescent behavior problems or families with alcohol problems (Gillis & Gass, 1993).

Families and Couples and Adventure Therapy Benefits

Family members have been found to experience increased self-esteem and an increase in overall family health and wellness in adventure therapy (AT) (Bandoroff & Scherer, 1994, p. 178). In a program with multiple families, participants form support networks with other family members that can be beneficial during the activities (Swank & Daire, 2010). Traditional therapy for families and couples often address issues of “trust, support, risk, challenge, leadership, problem solving, cooperation, competition, or communication” (Gillis & Bonney, 1986, p. 213). The issues addressed in families through traditional therapy are a match to the issues and approaches used in AT. AT uses metaphors for families to connect activities to their lives at home to expand self-

awareness for individuals and the family, while increasing self-esteem and intimacy (Mason, 1987). Families can also benefit from AT by longer therapy sessions, being able to play together while revealing important family dynamics and dedicating time away from the home with a focus on the family (Newes & Bandoroff, 2004).

All family members can participate in the therapy together. If one member of the family cannot do one of the challenges, they can participate in the outdoor experience by helping family members with cooking or with their gear thus contributing to heightened self-esteem (Mason, 1989).

Wilderness Family Therapy Principles

Several different theories are used in therapeutic adventure to guide program development and interventions (Burg, 2001). One theory of wilderness family therapy follows eight principles as defined by Mason in her work titled *Wilderness Family Therapy: Experiential Dimensions* (1987). Mason's theories are based on work by Carl Whitaker which incorporates an experiential education background (Burg, 2001). Mason's principles guide the programming through the use of activities contributing to individual empowerment. The eight principles described by Mason have a focus on family therapy and family dynamics. The principles include: (1) unlocking of the unconscious, (2) conversion of energy, (3) building family strengths through individual growth, (4) egalitarian relationships, (5) valuing the metaphors, (6) right hemisphere brain expansion, (7) role flexibility, (8) content, process and circulatory (Mason, 1987, 98-103). Mason's theory lacks a focus on therapy targeted towards a client's individual diagnosis or need.

A more relevant theory compared to Mason's (1987) is a family systems framework developed by Gillis and Gass (Burg, 2001). The framework by Gillis and Gass is more relevant to adventure therapy (AT) because of the strong focus on customizing a therapy program to the needs of individual clients or family groups. The framework includes five parts: assessment, structuring, interventions, debriefing and follow up.

Assessment. A proper assessment of a client's presenting problem is the starting point of an AT program. The therapist needs to understand the issue and how it affects family dynamics. The assessment can be done through traditional therapy means or through the use of AT (Gillis & Gass, 1993).

Structuring. Adventure programming needs to target the identified need of each individual family and structure the program around those needs. The critical component of adventure programming is to have a transfer of learning that makes it possible for clients to apply what they learn doing activities in their daily life at home (Gillis & Gass, 1993). Structuring includes several sub-components to assist in targeting specific therapeutic issues as defined by Gass (1991):

- (a) state and rank the goals of the therapeutic intervention based on the assessment of the clients' needs
- (b) select an adventure experience that possesses a strong metaphoric relationship to the goals of therapy
- (c) identify how the experience will have a different successful ending/resolution from the corresponding real life experience
- (d) adapt the framework of the adventure experience so participants can develop associations with the concepts and complexity of the experience
- (e) design the structured metaphor to be compelling enough to hold participants' attention without being too overwhelming
- (f) make minor adjustments to highlight isomorphic connections during the adventure experience

- (g) use appropriate processing techniques following the experience to reinforce positive behavior changes (p. 11).

Interventions. The activities begin with the therapist playing an active role facilitating the activity. Strategies used may include punctuation, reframing and circular questioning. As an example, circular questioning is often used in cognitive behavioral therapy to connect thoughts to emotions to behavior and back to thoughts again. Each piece of the circle keeps the cycle in motion. The therapist also needs to maintain a safe environment in terms of intensity, duration and direction to maximize a client's benefit towards their goals (Gillis & Gass, 1993).

Debriefing. The purpose of debriefing is to help clients self-reflect on the activities, their accomplishments and how the activities affected the individual and the group. Families are encouraged to look at the identified behavior they experienced and to make a determination if that is behavior they want to change or keep in their life. Debriefing is a crucial component in maximizing the potential for clients to apply the lessons they learned with the adventure activity to their life at home (Gillis & Gas, 1993).

Follow Up. After the adventure program ends, there needs to be a plan to follow up with participants. This could be in the form of a family therapist integrating the language and lessons the family learned on their adventure experience in the family therapy sessions (Gillis & Gas, 1993).

Gaps

The field of adventure therapy is working to gain support and acceptance among mental health practitioners. Standards in the field of adventure therapy have not been agreed upon as to what makes an evidence based program in the same way more established mental health interventions, such as cognitive behavioral therapy (CBT). A

universally accepted theory needs to be established to guide practice in adventure therapy. The field needs to use a theory to guide the adventure activity and debriefing, individual treatment plans, program design, and implementation (Burg, 2001).

Sufficient training in both adventure activities and therapy techniques need to be completed before a professional practices the field of adventure therapy (AT). Few practitioners are cross trained in both family therapy and adventure activities (Gillis & Gass 1993; Burg, 2001; Newes & Bandoroff, 2004). Clinicians, counselors and experiential education professionals need to recognize their boundaries for ethical, legal and safety reasons. Burg (2001) also had concerns that programs built for families may experience family blowups during an activity. Staff needs to be properly trained to diffuse a family crisis. Improperly trained counselors may be caught off guard during a blow up situation.

Practitioners considering implementing an AT program also need to evaluate legal issues and the scope of practice they are qualified to implement. Criminal charges could be imposed due to oversight of legal requirements for a program that combines adventure and therapy (Burg, 2001). Gass and Gillis cautioned adventure therapy interventions with families need further research and they called for professionals to be sufficiently trained clinically and in outdoor experiential activities before implementing a program (1993).

Research Question

How is adventure therapy and wilderness therapy being used by LICSW's for couples and families and how are LICSW adventure therapists contributing to the field's knowledge base?

Conceptual Framework

Theoretical Lens

Adventure therapy (AT) can utilize different theoretical lenses depending on the population and the focus of the therapy being applied. Examples include cognitive behavioral theory, humanistic theory and the object relations theory (Newes & Bandoroff, 2004). Prominent researchers in the AT field have stated a need for an integrative framework for AT. Integrative framework addresses the systems as well as providing individuals with the style of therapy that works for them. An integrative approach mixes cognitive, systems and psychodynamic theories (Gass, Gillis & Russell, 2012). Social workers using AT may be more attracted to the integrated Generalist Model (IGM). IGM is based on systems theory, is one of the major theories frequently used in social work.

Systems theory is used in AT for families by exploring family contexts and relationships in a natural environment, allowing family members to experience greater intimacy (Mason, 1987). Families may have problems surface, or individuals may respond negatively to a challenging activity. Systems theory shows connections between two things that seem to be separated but in reality are connected (Taylor, Segal, Harper, 2010). Using systems theory the facilitator may help a participant identify why they responded negatively and find out the reason for the stress was due to pressure from another place in the family system. Family dynamics are discovered through increased communication and self-reflection during an adventure therapy activity. As a result the family system experienced increased intimacy from the intensity of adventure activities (Fletcher & Hinkle, 2002).

The integrative generalist model (IGM), the theory this research is focused on, uses interventions for an individual who is interacting with an external system such as an activity to promote change in another system such as a family (Hoyer, 2004). Included in the integrative generalist model are the following components quoted from Hoyer (2004):

- The behaviors of the individual are a normal and purposeful response to stress given the individual and the stressor.
- Effective interventions must target the problem, not the individual.
- Problems are interactional between the individual and the environment. A “problem” is the dissonance between the individual and the system. Either can be changed to resolve the problem.
- A clinician may intervene with a system, an individual, or the intersection of system and individual, confident that change will occur in each area.
- The clinician is an educator and mobilizer of resources including skills, motivation, and environmental supports to aid the process of change. The clinician’s role is to promote competency and empowerment because the individual may not recognize that his or her experience can be different. This view draws upon the work of Friere (1972).
- Differential role taking, teaching problem-solving models, networking, team building, mutual aid, and self-help are the basic tasks of the clinician. It is the aim of the clinician to transfer the knowledge, skill, and motivation to perform these tasks to the participant or system. As cited by (Hoyer, 2004) citing (Parsons, Hernandez, & Jorganson, 1988, p. 59-60).

The integrative generalists theory can be applied to AT. The theory recognizes the therapist has an active role in working with clients, rather than passive as in a traditional therapy session. The therapist has the opportunity to work on different parts of the system to resolve issues and recognizes the individual is not the problem. The goal of the therapist is to work on the client’s goals and to help the individual, family or couple to implement the lessons learned at home after participants leave the program (Hoyer, 2004).

Like systems theory, integrative generalists theory is strength based in that a problem is not an individual rather the system. Systems theory views the need for

interventions as being where an individual and a system meet. However, an Integrative Generalists recognizes a problem may be within an individual, within a system, or where the individual meets a system (Hoyer, 2004, p. 60).

Methods

Research Design

This study is a qualitative study that focused on locating participants who have earned their Masters of Social Work (MSW), Licensed Clinical Social Worker (LICSW) or other mental health credentials to interview them about their use of adventure therapy (AT) in working with families or couples. Qualitative interviews were chosen to identify how adventure therapy is implemented in the field by mental health professionals and open ended questions were used to permit participants more freedom to discuss their experiences. Data was compared and contrasted to identify any commonalities implemented among adventure therapy programs in how therapy is integrated with adventure to create an adventure therapy programs. The open ended questions allowed for participants to go in depth in expressing their viewpoint of the status of the field of adventure therapy as an accepted mental health therapy practice. The study also allowed for an exploration regarding participant ideas on the future of the field.

Sample

Research participants were recruited based on their mental health credentials and they needed to use or have used adventure therapy for families or couples. The professional requirements preferred for this study were clinical social work credentials such as a MSW or LICSW. Other mental health practitioners would have been acceptable for a small portion of participants; however all participants in this study did

have a MSW or LICSW. A goal of eight to twelve participants was chosen to provide a broad yet manageable sample size considering the time constraints and resources available for the research project.

To find the social workers a sub-group associated with the Association for Experiential Education called Therapeutic Adventure Professionals Group (TAPG) was contacted. Internet keyword searches were also used to find research participants who fit the requirements for this study. Approximately 17 professionals were contacted through e-mail or phone resulting in eight responses. Half of the participants had an affiliation with the Therapeutic Adventure Professionals Group and half did not have any connection. All participants were contacted directly by the researcher. None of the participants were found through the use of snowball sampling. Each participant was identified as a candidate by the researcher based on their professional credentials and the use of adventure therapy in the present or past practice.

Protection of Human Subjects

Research participants were supplied with a consent form that is included under Appendix A of the paper. The consent form advised the participants that they would be asked questions about the use of adventure therapy (AT) for couples or families in their practice. The consent form outlined the interview as being a 30-60 minute session that would be audio recorded. A portion of the questions were asked in a written format to insure the time spent on the phone would be focused on the most important open ended questions. Participants were advised there were no risks and no benefits in the study. The consent form stated the study is voluntary, and confidential. To insure confidentiality, data from the interviews was stored on the researcher's personal computer and will be deleted

by June 1, 2014 or at the completion of the project. Finally, participants were advised of the professor and committee chairs overseeing the research project and as well as the role of the University of St. Thomas Institutional Review Board (IRB). Phone numbers were provided to participants in case there are questions regarding the research project. The consent form was provided and reviewed before the start of the interview (See Appendix A).

Data Collection

Participants agreed on a particular date to be interviewed through a phone or e-mail response. Once a participant agreed to an interview, a consent form and pre-interview questionnaire were sent to the participants prior to the day of the interview. The interviews consisted of ten open ended questions asked over the phone. During the interview sessions, a cell phone was placed on speaker phone for recording purposes. Two external recording devices were used to record the phone interviews. The list of the pre-interview questions and the questions asked during the phone interviews can be found under Appendix B. The questions asked during the interviews are also listed below:

1. What activities do you use for adventure or wilderness therapy?
2. Can you describe your experiences with adventure or wilderness therapy?
3. Do you do an assessment at the start of the program for participants?
4. Briefly describe your program in terms of: length of time, location, participants, activities, interventions, time with therapists, time with counselors and the debriefing process.
5. How often do you work directly with the clients on the programs?

6. How do you measure successful client progress?
7. How do you ensure the lessons learned on the adventure transfer to the home or other settings to model transfer of learning?
8. During the program, does anyone else work with the participants? If so, in what capacity? What are the credentials of the staff?
9. What is your opinion on the status of the field of AT?
10. Are you contributing to the movement for the field of adventure therapy to become accepted as an evidence based practice? If so, how?

Data Analysis Plan

This study used a semi-standardized interview approach for the structure of questions asked during the interview (Berg, 2009). A set of questions was reviewed for approval by a research committee. Clarifying questions are allowed during the interviews under the criteria for semi-standardized interviewing. Literature collected and reviewed guided this study and the questions asked during the interview process.

All of the interviews were transcribed by the researcher. The strategy for analyzing the interviews is based on grounded theory (Berg, 2009). The researcher used open coding to identify specific codes throughout the first three transcripts. Following completion of identifying codes in the first three transcripts, a tentative identification of larger themes was developed. Finally, an outline of themes and sub-themes was created and all interviews were coded based on the sub-themes identified during the process. The coded text was then copied into an excel spreadsheet and sorted by the themes and sub-themes. The codes were then analyzed to see what codes fit together and what codes

were outliers. The coding process was sensitive to whether one or multiple authors were contributing to a code or theme. The researcher was careful to maintain a representation of all diverse perspectives from the interviews. Member checking was completed by having a peer provide a reliability check. A new outline was created for the findings section reflecting the most relevant and interesting information that provided answers to the research questions.

Findings

Demographics

For the purposes of the paper the term participants is referring to the professionals interviewed by the researcher, not the clients of the adventure therapy programs. Eight professionals were interviewed; six males and two females. Seven participants had a LICSW certification. One participant is currently working towards earning their LICSW. Two participants have their PhDs. Seven participants worked for agencies when they provided adventure therapy programming and one participant worked at a school.

Five of the programs included adventure therapy as a module of the program and three of the programs focused on adventure therapy or wilderness therapy as being the focus of the program structure. Half of the programs integrated family therapy into their programming with the other half focusing on work with youth and adolescents. The therapy framework really varied, but there were common themes in using strength based, solution-focused and CBT therapy. Family systems and psychodynamic methods were also stated as therapy used during programs.

Participants shared a common interest in pursuing the outdoors on their own prior to their pursuit of becoming an adventure therapy facilitator. Their experiences ranged

from being active growing up with their friends and families to participating in formal outdoor programs such as Outward Bound, National Outdoor Leadership School (NOLS) or similar experiential programs.

Social Work Connection

The field of social work now has a dual degree program offering both an MSW and an M.S. degree in Kinesiology with a concentration in Outdoor Education. The need for the integration of formal training is evident based on the response of participants regarding the field. One participant described their clinical program as lacking bodywork in their MSW program:

I really valued the clinical education I was receiving at the same time I felt like there was less integration of the body into that work. So I became curious about the ways I could explore that.

The following quotations identify the need to have specific texts or guides and programs for social workers during their education if they wish to include adventure therapy in their practice:

From a therapeutic model because there is no social work assessment piece from beginning to end (participant is referring for the need to have a structured adventure therapy guide for social workers in the field).

How do you do clinical first response out in the wilderness when these kids are freaking out emotionally and you are on stage?

Social workers like to hike, and then they bring kids up. And they don't know what it's like to have. Ok. You brought a group of kids on a hiking trip, oh my gosh. Unfortunately you know, they are just not trained.

Populations

Diagnosis. Participants reported working with clients identified as having a range of mental health diagnosis including anxiety, pervasive developmental disorder, autism,

cognitive difficulties, trauma and substance abuse. Clients most often identified were adolescents with adolescent and family system problems:

You know whether it is substance abuse or crime or anxiety or school focus you know you name it. Whatever issue an adolescence in today's world is facing our staff is dealing with that across the board.

Organization. Clients were reported to have been referred from a number of different organizations. Several participants reported working with the justice system. One respondent said their agency did a lot of family work providing services to adolescents and their families:

We do work a lot with the Juvie kids, some are definitely coming because their probation officer told them to come. So there is not always the most willing participants.

We do a lot of family work and multi-family group as well.

Other organizations that provided referrals included child welfare, primary health care, residential treatment, alternative schools. Another participant said many of the families worked with were low income families.

Adventure Therapy Activities

Activities facilitated by participants for adventure therapy included game initiatives, team building, team challenges and adventure activities. One participant described wilderness survival skills as the basis for their program.

Team building and team challenges. Zoon, Moonball, Speed Rabbit, The Captain is Coming, Fire Ball, Tennis Ball Transfer, Spoon Jousting, Almost Infinate Circle, trust leans, and blind trust walks are all examples of team building and team challenges facilitated by participants. Some participant responses are listed below:

I primarily do what I call adventure therapy or activity therapy. And I use a combination of team building challenges and some improv games.

I would call challenges that allow people to look at their roles and how they tolerate frustration.

Ropes course. Participants described ropes course initiatives, challenge course, low ropes course, high ropes course, zip line, duo dangle as being common activities used for their adventure therapy work.

Adventure based activities. Adventure activities such as canoeing rock climbing, orienteering, hiking, snow shoeing, ice skating, kayaking, swimming, yoga, running, cross country skiing and snowshoeing, backpacking, sea kayaking, ice climbing, winter camping were all listed as adventure based activities used by several participants.

Wilderness based activities. Wilderness therapy was used by just one participant:

[...] primarily utilizing the survival skills, primitive living skills, skills that you might experience in Native American or aboriginal material culture. How do you setup a shelter, how do you build a fire?

Adventure Therapy in Practice

Adventure therapy program or module. Adventure therapy programs are often just a module of a larger program. That was the case for most of the participants. However there were a couple of programs that were strictly adventure therapy programs, but they were the minority of the group. Some excerpts from participants are included below:

[...] there are very few programs that do just adventure therapy, they do it as an augment.

We do a lot of things, adventure therapy is actually a pretty small part of our entire program.

Three of the programs had a focus on adventure or wilderness therapy without being a module of a broader program.

Program structure. Programs described by participants ranged broadly from games and initiatives taking place at the agency or a local ropes course to weekend excursions to extensive back-country trips. The programs typically involved therapy groups while in the field and integrated individual therapy sessions after the adventure activity is completed. Many programs had to respect their communities' school schedules having longer trips in the summer and over breaks or weekends. Programs for kids in the juvenile system may have had more flexibility as to when they would be able to participate in weekend or extended adventure therapy or wilderness therapy trips.

It was an adventure therapy program [...] there are very few programs that do just adventure therapy, they do it as an augment.

We have art module, we have a physical fitness module, an adventure module, we have an equine module and we also have an academic module.

We were fulltime and all we did was run an adventure therapy group. We had a couple of models. The one we used the most was a 9 week twice a week model closed groups.

I knew kids for three years and a part of that we did weekly groups, 3 hour groups. And then we ran anywhere between three to five day backcountry trips with these guys; probably 4 to 5 times a year, both co-ed and single gender groups.

We believe so strongly in the use of experiential education and experiential therapy and adventure therapy and all the different forms of that wilderness therapy and what not, all of that gets infused in their treatment as they are coming.

Because they were court ordered usually 6-9 months for the program.

Facilitation. The amount of time clinicians spent with the clients in a therapy or a facilitator role during a program had a lot of variance depending on the type of program

and the clients. Programs are often structured with frontline staff who take care of logistics and help with some of the activities. The clinical therapists would join in on the programs for a portion of the day or trip to interact with their clients. The therapists would typically be involved in goal setting, facilitating the activities, debriefing the clients and integrating the activities into individual, group and family therapy sessions. The exact format varied for each program. One participant described limited interaction with their clients during a program:

It is me facilitating but I usually work with one of the primary therapists. So in other words the therapists know the clients better than I do. I just come in once a week so I don't get to know them very well.

Other participants reported integrated facilitation and therapy with their clients:

We don't have field guides per-se and therapists separately, they are one and the same. All of our field guides are in fact the same staff that are running individual counseling, group counseling, and family counseling work throughout the agency.

I operate as an advisor, support, or help, a person who is going through the same experience. So immediately that puts me on the other side of the desk with them so to speak.

Components of adventure therapy. Participants often referred to some crucial ideals they have found to make adventure therapy a therapeutic experience and not simply an experiential activity. The themes that were consistently discussed were challenge by choice, change, exposure and metaphors.

Challenge by choice.

We always offered challenge by choice. Most of the kids wanted to participate. We offered modifications based on what they were assessed as being capable of.

Change.

Change in families does not happen in a vacuum and it takes everyone's effort. Sometimes it means to make change to support change. Sometimes it means to do a little bit of both. That one no one person feels responsible for the success or failure of the family.

Exposure. Exposure is when clients are faced with a perceived risk. The client may be facing a challenge that creates a sense of fear of heights when rock climbing. The client then faces the fear with the support of program staff, the clinician, group members or a family member holding the rope for them. The risk is minimized with redundant safety precautions to reduce the actual risk of harm to creating more of a perception of risk.

We use these initiatives as diagnostic tools and assessment tools and also um as tools for change. I get to watch the families, I get to watch them, I tell them, I say by doing these initiatives, I learn a lot. I get to learn how they fight, how they play, how they solve problems.

With sexually traumatized teenage girls who are you know, 45 feet in the air and their mom is belaying them and these sexually traumatized girls don't have a lick of faith in their mother which is often the case because they blame their mom for the fact that they were sexually traumatized by mom's boyfriend or something like that [...] You can imagine how absolutely terrifying it must be for someone who has been traumatized to put their faith or trust in someone else's hands. Especially if they blame them for their victimization. You are not going to get that same level of um sort of um experience in a traditional four-walled office...not to say you can't get there. It is just going to take in my opinion a lot longer to get there.

Metaphors.

I'll take the dynamics that come out of the activity and talk to the group members about what that reminds them of in their life. I think Gass would call this a spontaneous metaphor. And occasionally they will be more highly structured from the onset.

[...] for example like climbing to the top of a butte and surveying the path we used to get up to that point and from that perspective or vantage point being able to peer off from the other side and look at successful ways we

might travel down the other side and talk about how you can do this in life.

They are living those metaphors out loud out there. At the end of the hike or going without water in between creeks and what not, there is always an opportunity to capitalize and reinforce the experience they just went through and explain how that might translate back to the community back home.

Here is a juggling activity with a couple of Koosh balls. Well lets add in a cup of water and give the instruction as you are now tossing multiple Koosh balls in a circle and try not to let them drop on the floor, we are also going to add this full cup of water that we are going to ask you to pass in a clockwise fashion and ask you to not spill that water. So now you have to manage multiple objects flying towards you while you also have to manage this cup of water that is coming towards you. And how does that relate to your life? Any graduate student can speak to how difficult it is to manage multiple assignment and maybe working full time or part-time and maybe engaging in a romantic relationship with someone and trying to keep all those things going while having an internship, writing a thesis all of this stuff. And now I'll say great and you are a healthy individual that probably has a fairly healthy sense of self-esteem and has had some decent success in life. Now let's apply all of the same stressors in life to a group of young adults or adolescence who don't have the same successes. And then engage them in the process of thinking through how a simple activity of throwing balls and passing a glass of water can build resiliency.

Family Therapy Integration

Approximately half of the participants worked for programs that intentionally integrated families into their adventure therapy program. The quotes pulled were very specific to the particular program it is referring to and not a broad generalization.

Family involvement.

We would have two family nights within a nine week cycle where we do adventure family therapy with them.

The kids experience; they get 5 hours of therapy per week. And one of those hours is family therapy.

Family therapy.

Once a month the parents came in and they were a part of the dinner. So they came to the facility, saw what was going. We did family therapy as part of the program.

Assessment.

Within the first week I am on the phone with the family doing a parent consult, doing a family therapy sort of orientation to let them know what they can expect. And I can find out what their experience has been with family therapy, what their hopes are, what their expectations are and maybe some preliminary goals. And then from that try to create a situation that is going to best serve their needs.

Psychoeducation.

[...] families can count on from the time they start therapy is anxiety psychoeducation curriculum that I deliver as part of the family therapy process. Again, we are not just demystifying anxiety for the kids, but we are also demystifying anxiety for the parents for the families.

The parents at that time are required to be going through a parenting course.

Goals.

We are working on improving communication, reducing the reactivity within the family. And talking about um stages of change as they apply to anxiety. We are talking about healthy motivating strategies. As I said improving communication the family. Improving safety, the emotional safety in the family. Looking at some of the cultural factors that happen in the families. Generationally speaking. Often times we'll get into the parents um experience that has contributed to the parenting styles.

The programs varied widely as to how they incorporated family involvement.

Some programs stayed in touch with families through phone and Skype while other programs had integrated weekly therapy with parenting classes and psychoeducation.

Benefits of Adventure Therapy

Adventure therapy needs to serve a purpose beyond regular therapy. What value does adventure programming bring to the clients? Some of the themes discussed by participants include adolescents' preference to work in groups, adventure activities act as

a catalyst presenting individual and relational dynamics, and the benefits of nature as a co-therapist.

Successful structure for adolescents.

Research clearly shows adolescents do better when working with their peers in group types of modalities than in traditional types of one on one counseling sessions.

Adventure therapy as a catalyst for identifying issues.

We are not necessarily solving a lot of issues on these trips. We are allowing them to be brought to the surface in a way that then their individual and family counselors can continue to work on those issues when they are back in the office and doing the individual work and family and group work in the office.

Nature as a co-therapist. Several participants spoke to how nature is a co-therapist as individuals or groups are active in the outdoors. They spoke to a natural effect of being in the outdoors that contributes to the well-being and growth of their clients.

There is a certain amount of that unpredictability of Mother Nature that creates that point of capitulation, that change that uh helps kids as well as staff gravitate from that pre-contemplative to the contemplative and even to the action phase.

We consider the environment the nature to be a co-therapist. We know full well that co-therapist can be way more powerful than anything we can do or say. You can't measure that, it is very difficult to measure that.

Impact of Adventure Therapy

Adventure therapy programs strive to focus on the transfer of learning.

Participants of the study often exclaimed “great question” when asked whether they implemented ways for participants to incorporate the lessons learned through adventure activities or challenges to their life at home. Programs often will assess an individual and

families for goals and their readiness for the activity and then evaluate the achievement of those goals towards the end of the session.

Transfer of learning.

We worked directly with a clients [sic] about how that was transferable to their world; like their school, or in the home but we also then would discuss what had happened for the client during therapy.

As I do a particular initiative, we never finish the day without debriefing it and find some deeper meaning. And I encourage them to take it home and to continue to talk about it. Um and make it relevant to their lives. In more real time without me there.

[...] you might provide a general feedback around how this is useful and might apply to relationships and families for example. And then try to get the kids to themselves to think about how communicating with the person who is belaying you is really important. And being able to verbalize what your internal state is when high up on the ropes course and how that is like being in an intense situation in your family where people emotions are elevated in some way and how we can use what we are learning here in a family situation.

Transfer of learning is a strategy program facilitators used both during an activity as well as after the activity in a group session, individual session and family therapy sessions. Some of the programs included family members or just an individual during the activity. Transfer of learning uses the tension from the perceived risk of an activity to apply the situation and the skills used by family or participant in their life at home.

Assessment. When participants were asked if they performed an assessment of their clients, the participants varied greatly in their use of assessments. Assessments were described as being in the form of a pre-trip or pre-program assessment to ongoing assessments throughout the program. Participants also included diagnosing and goal setting when they answered the question about assessing their clients for the particular program. Assessments may have involved the client, families, facilitator meetings and

client groups to discuss the appropriateness of activities, challenges, goals and progress both at the beginning and throughout the program. Some participants are quoted below in their response to the assessments used during their program:

We have people that will go to the kid's house and talk to them about their anxiety and assess their appropriateness of the program; and then when they get here, their assessment continues on my end to assess for what the family needs so I can design a strategy that can be accommodated by the adventure or experiential initiatives.

We would have a meeting at the beginning of that week with students and say these are our thoughts about the group, what do you think, does it make sense. Are these goals that you can sign on to? What would be the goals you would offer if you were to set your own?

We would consult with the teachers, um the team members, the administration; we would think collectively. What is the group working on now? What would be some timely interventions?

We do a pretty thorough clinical assessment; biopsychosocial if you will.

Evaluation. Programs also ranged in their evaluation procedures from not doing evaluations, to having program participants fill out formal questionnaires. Some participants did reported not using evaluations and another participant reported a verbal evaluation.

I do it very informally, I ask people when I go back the next program, did you get something out of it, what do you remember?

In response from an individual who facilitates specific activities for a program and then staff continue with the clients throughout the week, they stated they do not do an evaluation:

Not usually no.

Other programs reported a more formal evaluation process.

We did clinical, you know case conclusion stuff, recommendations for the future...Did they improve their social skills?

We use the NATSAP tools.

Russell developed a Youth Outcome Questionnaire OQ [that was used at the participant's program].

Acceptance of Adventure Therapy as a Treatment

Participants had diverse opinion regarding the status of the field of Adventure therapy as being recognized as an evidence based practice. During the interviews, participants shared their views on the field of adventure therapy as an evidence based practice, challenges and promise for future growth and acceptance.

Evidence based. Participants supporting the field as an evidence based therapy are quoted below.

Of course it is evidence based. We wouldn't be doing it at this point in time and you have to also look at the difference is it evidence based practice or practice based evidence?

[...] the adventure therapy continuum is the way we implement it and how we integrate it into the community. I think the wilderness therapy field is evidence based.

So right now there is a black box. We know kids come to our programs, they leave and they are better. So what is it about wilderness, what is it about adventure therapy that really makes them better. We don't know. It's really a black box.

Participants who stated a need for further research are quoted below:

I believe that programs do the best practice based on what they can find as best practice, empirical evidence and as practice based on their experience, but I am not sure that really makes it evidence based.

I think there is a need for more evidence based research I agree...it is behind like CBT which has a lot of evidence based research behind it.

When you are in the system and evaluating the system researching the system that is where it gets tricky.

Research challenges. Participants described challenges to doing research that is accepted throughout the mental health community.

It is difficult to setup clinical variables and control groups and measured outcomes you know. So it has to be more uh you know qualitative studies.

The answers we are looking for can't always be explained by numbers. So qualitative is going to be just as vital as quantitative. The numbers are important, but the numbers don't tell the whole story. The numbers don't say why it's working, the numbers just say it is working.

It is difficult to, in an experimental setting it is very difficult if not impossible to account for every variable that goes on.

If adventure therapy is such a small sliver of the mental health population that does that, who has any real knowledge about it. It is hard to get any kind of traction to be doing more research by more people in a variety of places.

You will have countless conversations with individuals who will downplay the impact of adventure therapy who believe that adventure therapy is sort of magic, smoke in mirrors so to speak. And traditional therapy is really where it is at.

A participant described their fear of adventure programming becoming too contrived if standard program structures are set into place by organizing bodies. The researcher inferred from the response of participants the creation of strict evidence based procedures could hinder the effects of adventure therapy such as the use of nature as a co-therapist.

I'm all for um you know helping it become more standardized to an extent but I don't want it to become so rigid that you lose some of that natural benefit that you are getting from um the outdoors. That compounding variable of Mother Nature.

Promising Future

Participants describe how the field of adventure therapy is making progress and gaining acceptance by mental health practitioners:

So think about the field of psychology, it was developed in the 1800's and 1900's. We were developed in 1987. We are only 30 years old as a profession, so I think we are doing pretty good.

We are getting less resistance from the clients themselves and the parents, which allows us to introduce them to these um activities while running parent groups, parent support groups and multi-family groups, we are bringing activities right into the room.

The quote directly above describes how families and clients are used to seeing climbing walls, ropes courses and hearing about backcountry trips and therefore the activities are accepted more frequently by families and participants.

The quotes below describe positive steps that are being made for the field of adventure therapy in terms of advocacy and research:

There is some incredible research going on right now in the use of adventure therapy with veterans and trauma um PTSD veterans right now and everyone is really excited about that. If that proves to be beneficial, now you've got a large branch of this government supporting adventure therapy.

We are working with SAMHSA (Substance Abuse and Mental Health Services Administration) right now to get active behavioral health care as a type of treatment in SAMHSA.

My dream is to have a continuum of care where someone who just had wilderness treatment will be covered by insurance.

Discussion

Adventure Therapy Standards

The programs facilitated by participants is reported to closely follow the criteria identified to be considered adventure therapy programming as identified by Kimball and Bacon (1993). The programs did however lack uniformity in how they were structured in

terms of therapy facilitation. Therefore, the research supports Newess & Bandoroff, (2004) findings that researchers in the field of adventure therapy should create uniform standards to promote the field into acceptance as evidence based practice.

For example, the programs described by participants included diverse methods of therapy and facilitation of the programming. The literature clearly suggests a lack of expertise in both therapy and the adventure activities as being problematic for effective and safe programming (Tucker & Norton, 2012). Clinical staff primarily provided therapy for some of the programs while other programs had the therapists also facilitate all of the adventure activities in an integrated approach to providing services. The literature also suggests the profession lacks standardization of training, certification or credential requirements for AT (Burg, 2001). Some programs completed full assessments to determine what kind of programming would be the most beneficial for the family participating in the adventure therapy; other programs had a limited assessment and mostly relied on paperwork provided from a referring agency or the court system.

Programs typically trained frontline staff and did not require certificates for adventure or wilderness training. One exception to a lack of training consistency was the requirement for clinicians to have earned licensed clinical credentials such as a LICSW. All programs required at least master's level licensure to provide therapy to clients on the programs. Many of the research participants obtained a first aid certificate, Wilderness First Responder (WFR) certificate and additional certifications relevant to their specialized adventure therapy areas of interest.

The researcher also explored how participants contribute to the field of adventure therapy in terms of research or helping the field gain acceptance. Participants had

varying levels of knowledge the current research for adventure therapy. A number of participants suggested they contribute to the field through contributing youth outcome questionnaire forms. Many of the participants stated they contributed to the field by advocated for adventure therapy in the community, in their program and by participating in professional organizational groups. One participant has published research and is contributing to macro level policy work. One challenge for the field is to advocate for consistent research knowledge and programming efforts among practitioners to insure a standardization of best practices in the industry.

Benefits of Adventure Therapy

The field of adventure therapy clearly is supported by the study participants based on their responses as having benefits that conventional therapy cannot offer. Participants were supportive of the premise that adventure therapy allows for clients to be in an environment with perceived risk. The facilitators reported the activities caused reactions that typically could not be duplicated in the same way through traditional therapy in an office environment. The participants that worked with families described seeing the value in working through the family dynamics that were present during the adventure activities.

Adventure therapy also provides a fun environment for participants to complete activities in groups. Multiple research participants suggested how group work is supported by research to be effective when working with adolescents. Several participants also supported the idea of nature working as a co-therapist in adventure therapy supporting the literature (Greenway, 1995). Several participants in this study cautioned critics of the field often will cite nature as a co-therapist as a large unknown

and therefore it can lead to a tarnished image of the field. However, this viewpoint may be overlooking the concrete benefits adventure therapy programming provides clients.

Family Integration

The integration of adventure therapy for families and couples also did not have standard programming. The programs ranged in populations from only serving individual adolescents, to providing full services for families in an integrated therapy program. Several participants expressed how challenging the integration of adventure therapy experiences into the family system can be due to a lack of resources. An individual would have a great experience on an adventure therapy program and then they go home to the same family system with the same challenges as when the individual left for their adventure therapy. Some participants reported that programs offering the integration of family therapy typically performed better in the transfer of learning component of adventure therapy.

Adventure Therapy Research and Clinical Acceptance

Participants had diverse opinions regarding the status of the field of adventure therapy and wilderness therapy as being evidence based. One participant stated the belief that wilderness therapy is accepted as evidence based. Some participants believed the field of adventure therapy is evidence based, one participant stated they were not current on the research and another participant stated the field is supported but not considered to be evidence based. This finding is surprising as previous research suggests the field needs to use a theory to guide the program design, individual treatment plans, and implementation adventure activity, debriefing (Burg, 2001; Neil, 2003).

The majority of the participants agreed that setting up classic control group studies with large sample sizes is difficult in the field of adventure therapy due to having an extreme amount of variables that are difficult to control. The literature supports these viewpoints based on the findings by Newes (2001) claiming a challenge to adventure therapy literature is a lack of empirical research that contains information that is both valid and reliable. Gas and Gillis (1993) also supports the need for more empirical research for using adventure therapy with families. Some participants questioned why it is important to have research with numbers and control groups in order to be considered an evidence based practice or to be accepted by insurance companies.

In contrast one participant critiqued the field of adventure therapy as having few qualified PhD researchers who also have the facilitation skills to be able to effectively research the field. The participant voiced concern over the competing interest of doing reliable research while having a distinct interest in gaining acceptance for the field as an evidence based therapy. The participant was careful to state this concern is not unique to the field of adventure therapy. In spirit of expanding the pool of researchers another participant stated excitement for research being completed by Veterans Affairs (VA). According to the participant, VA researchers are studying adventure therapy as part of a treatment for post- traumatic stress disorder (PTSD). Several participants explained how the study could open up more doors for the field of adventure therapy if the study has positive results for veterans.

Implications for Social Work Practice

The research suggested a need for adventure therapy practitioners to be professionally trained in both therapy and adventure programming. A dual program is

currently being offered at the University of New Hampshire that offers a Masters degree in Social Work (MSW) and a Master in Science (M.S.) in Kinesiology with a concentration in Outdoor Education.

One participant described a desire to lobby for insurance companies to allow billing for adventure therapy. Many of the populations on the adventure therapy programs were low income families. Having the ability to bill insurance would make a positive impact on the field and therefore to families social workers routinely support.

Social work often supports a systems approach to work with individuals. Recognizing the challenge of integrating the benefits of adventure therapy into the family system is an area social workers can make an impact. Social workers are trained to address the environment and the systems impacting an individual not just individual perceptions and thoughts under a systems perspective.

Implications for Policy

Researchers are working at the macro level to get adventure therapy accepted at the Substance Abuse and Mental Health Services Administration (SAMHSA). As previously stated, the ability for mental health workers to bill for adventure therapy would increase the reach of the field to offer services to more clients who may otherwise not be able to pay for services. For these changes to happen, there may need to be macro level policy work.

Adventure therapy programs could create a standardized certification process to create a baseline program structure that could easily be measured by the youth outcome questionnaire forms. The concept of forming standard program to create baseline research is supported by Neil (2003). Furthermore, adventure therapy programs should

work to integrate the adventure therapy lessons into the family systems to insure an adolescent client can be supported in their home environment. Programs could also be created specifically to work on family dynamics as a module or alternative to regular therapy rather than as a reaction to an adolescent in need of support through chemical dependency, court ordered situations or school programs that may have more focus on the individual and not the family or community support systems.

Strengths and Limitations

The research conducted utilized a range of participants who either currently work or have worked in adventure therapy or wilderness therapy. The participants had a wide range of adventure and wilderness therapy backgrounds that lent well to providing diverse perspectives on the field of AT. The range of credentials and experiences from front line clinicians leading wilderness survival groups to PhD scholars now doing research at universities allowed for expert opinions from professionals that together have had experiences at the micro, mezzo and macro levels of adventure therapy programs and research.

Most Participants reported implementing their adventure therapy in a way that is similar to the criteria that defines adventure therapy according to Kimball and Bacon (1993). As an example most participants described creating perceived risk, the use of metaphors, challenge by choice, having fun and creating a therapeutic alliance throughout the adventure therapy programs. The participants also came from a variety of adventure therapy and wilderness therapy backgrounds with varying degree of certificates and skill levels. Participants also ranged in their views of the state of the field, their knowledge of current research and in the ways they implemented adventure therapy.

Another strength to the study is many of the participants had worked in structured adventure therapy programs. Most participants had leadership roles within the programs and they had first-hand knowledge of the inter-workings of adventure therapy programs. Many of the participants were members of the Therapeutic Adventure Professionals Group (TAPG), but not all participants. By having such representation, the research participants had experience at well-respected programs and they had similar frame work.

The field of AT is a small and niche field that is mostly made up of programs working with adolescents and youth. The researcher was unable to find participants who strictly worked with families for their adventure therapy work. Family work was typically only integrated in with programs created to address adolescent issues and the system affecting the adolescent. Therefore, the research question was slightly compromised as some of the programs discussed during the interviews did not incorporate family therapy. Participants interviewed did not report the use of couple's therapy in their respective programs.

A second limitation to the study was a relatively small sample size of eight participants. A couple of the participants were affiliated with the same professional organization. A large sample size with a wider range of professional affiliations and credentials would potentially contribute to more diverse viewpoints, or provide additional support for the findings.

The research for this study did not focus on a specific type of adventure or wilderness therapy program, or have requirements for how the program was facilitated. The study also did not have standards how therapy was integrated to insure the transfer of learning from the adventure.

Implications for Research

Future research could explore the use of adventure therapy for the treatment of challenging family dynamics. Researchers could decide on a model to follow as described by Burg (2001) maintaining a consistent assessment, adventure activity facilitation model, debriefing, individual treatment plans, program design, and implementation. Future research could compare the success of an individual who completes adventure therapy without family therapy integration and compare that to individuals who do have family therapy integration in a longitudinal study that follows the families of a period of time. The study could then compare the results to other studies for a baseline comparison.

Future research could also compare adventure therapy that does not offer follow up therapy sessions to programs that do offer family therapy sessions for a certain length of time after the adventure module is completed. Lastly, there could be a study done to compare traditional family therapy to adventure family therapy to isolate the therapeutic benefits of adventure therapy. The adventure therapy component could be a module in the study that is integrated into the family therapy sessions. The research would ideally identify families and individuals who have similar needs, family dynamics and diagnosis based on assessments prior to the activity starting. Once the criteria is decided on, the sample populations should be randomly picked (Gass, Gillis, & Russell, 2012, p. 346). Once a baseline is established and accepted by the adventure therapy community then the therapy model could be compared to traditional therapy methods.

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Appendix A**CONSENT FORM
UNIVERSITY OF ST. THOMAS**

The Use of Adventure Therapy by Social Workers Working with Families and Couples

528300-1

I am conducting a study about the use of adventure therapy for couples and families. I invite you to participate in this research. You were selected as a possible participant because of your credentials and experience with adventure or wilderness therapy. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Jason Griswold, a graduate student at the School of Social Work, Catherine University/University of St. Thomas and supervised by Dr. Karen Carlson, MSSW, PhD, LICSW. My research committee also includes an adjunct professor, Franki Rezek, MSW, LICSW, LADC and Peter DeLong, LICSW. The institutional review board (IRB) will review my research plan to insure the research is conducted in an ethical manner.

Background Information:

The purpose of this study is: The purpose of this study is: To learn how adventure therapy and wilderness adventure therapy is being used by LICSW's for couples and families and how are LICSW therapists contributing to the field's knowledge base.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Review, sign and return the consent form by e-mail to me. I will also provide a short list of questions to be answered about the interview prior to beginning the interview. If you are uncertain about this process please contact me at (775-770-XXXX). This form should be completed prior to our phone call. We will then talk by phone for about 30 minutes to ask questions pertaining to your experience in using AT with your clients. The session will be audio recorded either online or through a recording device and using a speaker phone. The information you provide will be used in a student paper and a public presentation. Another student may be used to assist in the reviewing of the interview and data to insure quality data and to check for reliability of the way I present the data. The data will be de-identified to protect your confidentiality.

Risks and Benefits of Being in the Study:

The study has no risks to participants.

The study has no direct benefits to participants.

Compensation:

There is no compensation for this study.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include an audio recording, transcript and computer record. The data will be destroyed on June 15th, 2014.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations the University of St. Thomas. If you decide to participate, you are free to withdraw at any time up to the end of the interview process. Should you decide to withdraw at the end of this process data collected about you *will be destroyed at your request*. You are also free to skip any questions I may ask.

Contacts and Questions

My name is Jason Griswold. You may ask any questions you have now. If you have questions later, you may contact me at 775-770-XXX. My instructor for this project is Karen Carlson, MSSW, PhD, LICSW. Her number is (651) 962-XXXX. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to participate in the study and to be audio and / or video recorded.

Signature of Study Participant

Date

Print Name of Study Participant

**Signature of Parent or Guardian
(If applicable)**

Date

**Print Name of Parent or Guardian
(If Applicable)**

Signature of Researcher

Date

Appendix B

Schedule of Pre-Interview Questions Sent By E-mail

1. Do you have a private practice?
2. Do you work for a company or organization?
3. Where is your company located (city, state)?
4. What is your gender?
5. What is your educational credentials (degree / licensure)
6. What are your activity credentials (do you have any certificates?)
7. What are your medical credentials (first aid / first responder etc...)?
8. What are your specialties as a therapist (populations / diagnosis)?
9. How often do you Incorporate Adventure Therapy In Your Practice?
10. Do you work within a particular framework or theory when designing or implementing an adventure therapy program?
11. What therapy models do you use? For example, CBT, DBT, Narrative, Psychodynamic or any others? Please list all that apply:
_____.
12. What Populations do you work with when using adventure therapy?
13. For adventure therapy work do you work with couples and families?

Schedule of Questions Asked During Phone Interviews

1. What activities do you use for adventure or wilderness therapy?
2. Can you describe your experiences with adventure or wilderness therapy?
3. Do you do an assessment at the start of the program for participants?
4. Briefly describe your program in terms of: length of time, location, participants, activities, interventions, time with therapists, time with counselors and the debriefing process.
5. How often do you work directly with the clients on the programs?
6. How do you measure successful client progress?
7. How do you ensure the lessons learned on the adventure transfer to the home or other settings to model transfer of learning?
8. During the program, does anyone else work with the participants? If so, in what capacity? What are the credentials of the staff?
9. What is your opinion on the status of the field of AT?

10. Are you contributing to the movement for the field of adventure therapy to become accepted as an evidence based practice? If so, how?