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Florian Eckstein & Ulrich R  th

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Adventure-based experiential therapy with inpatients in child and adolescent psychiatry: an approach to practicability and evaluation

Florian Eckstein* and Ulrich R  th

KBO-Heckscher-Klinikum, Deisenhofener Stra  e 28, D-81539 M  nchen, Germany

This article examines the use of adventure-based experiential therapy (AET) with child and adolescent psychiatry inpatients. AET environments, indications, practicality, therapeutic effects and research are outlined and clinical findings are reported. Activities such as rock-climbing, exploring a creek and caving are discussed and the limitations of AET in the hospital setting are addressed. AET activities range from leisure-time activities and activities that facilitate change to actual therapeutic work. Case studies showing the effects on individuals and groups, with and without specific processing of the activity, are surveyed and the similarities to mentalization-based psychotherapy are touched upon. Possible future research directions are suggested. As AET treatments are not commonly discussed in child and adolescent psychiatry, this article seeks to be a catalyst for further discussion and research.

Keywords: child and adolescent psychiatry; adventure therapy; experiential therapy; inpatients; mentalization

Introduction to adventure-based therapy

In general, inpatients in child and adolescent psychiatric units are severely ill youngsters. Multimorbidity covering the range of child and adolescent psychiatry (CAP) diagnoses, such as conduct/hyperactivity, disorders, obsessive/compulsive, eating, personality, emotional disorders and depression, is a contributing factor to the need for inpatient care. Problems leading to inpatient care are usually numerous, and treatment is multimodal because of the severity of the impairments.

There is some confusion as to what constitutes adventure therapy. Williams (2000) defined adventure therapy as taking place outside as opposed to inside or, more specifically, in a wilderness environment as opposed to an institutional one. This definition may be one of the reasons that CAP or adult psychiatry inpatients are seldom addressed in articles on adventure-based experiential or adventure therapy programmes, unlike juvenile offenders or drug addicts. The value of adventure therapy programmes for youth offenders has been challenged by Wilson and Lipsey (2000), as their meta-analysis showed little evidence to support the effectiveness of such approaches. However, Gillis, Gass, and Russel (2008) stated that adventure therapy programmes are effective with youth offenders and that differing findings are due to variations in interventions and treatment environments.

Addressing CAP patients in particular, Bergman and Anton (1988) published a paper on a wilderness therapy programme as an alternative to adolescent psychiatric

*Corresponding author. Email: florian.eckstein@kbo.de

hospitalization. As a result of the programme, withdrawn adolescents showed greater positive changes in their behavioural symptomatology when compared with patients with conduct or attention-deficit disorder. Gilliam (1993), although not referring specifically to adolescent psychiatry, described in his findings how rope courses can be used at psychiatric hospitals to build trust and cohesion and to more quickly raise unconscious issues. However, Gilliam stated that the precise therapeutic gains as well as any influencing factors still needed to be investigated.

Eisenbeis (2003) reported three cases of using climbing activities with CAP inpatients as part of an interdisciplinary treatment environment. Eisenbeis stressed Bacon's approach of metaphorical learning (Bacon, 1983) and suggested that symbolic connections between the adventure-based intervention and the adolescent's everyday life can be established spontaneously. He also noted that the use of adventure activities proved to be helpful with youngsters who were initially non-cooperative.

In their paper on wilderness therapy with psychiatric patients, Crisp and O'Donnell (1998) outlined four possible adventure-based therapeutic approaches with CAP patients: behavioural therapy; psychodynamic interventions; systemic interventions; and occupational therapy. Behavioural approaches involve skill development and emotion management as well as conflict-solving and problem-solving capabilities. A corrective experience is central in psychodynamic approaches, which include provocation, assistance and consistent confrontation. Systemic approaches can be directed toward the patient's family and toward the patient's group within the institution. Occupational therapy utilizes the planning and completing of activities to target the patient's ability to organize everyday life.

In discussing the range of experiential approaches, including experiential education, experiential therapy and adventure therapy, Gass (1993a) outlined a rationale for using adventure experiences as part of the therapeutic process. He noted that the client undergoing adventure therapy, which introduces stress in a manageable but challenging manner, experiences increased motivation and involvement through participation in activities that are meaningful in terms of their natural consequences. Gass defined adventure-based therapy as a therapeutic experience at or very close to the client's therapeutic facility and, in fact, quite often restricted to the grounds of the facility. The therapies discussed by Gass tended to be inpatient programmes and were only one part of a complex therapeutic intervention.

Priest, Gass, and Gillis (2000) differentiated adventure programmes according to their primary focus: recreational programmes focusing on changing the client's feelings; educational programmes focusing on changing the client's thinking as well as feelings; developmental programmes aiming at changing the client's social behaviour in addition to feelings and thinking; and treatment programmes focusing on all of the other targets but also focusing on decreasing dysfunctional behaviour.

Depending on the depth of intervention, adventure therapy programmes can be understood as a primary therapy, an adjunctive therapy, an enrichment therapy or simply as a recreational activity (Gass, 1993b). Adventure-based experiential therapy (AET) programmes at the hospital level are, of course, adjunctive, as they do not stand alone and are part of an already outlined multidisciplinary intervention. However, the treatment goals are blended into the adventure activity, and information about the patient gained during adventure activities will in turn be integrated into the overall treatment process.

In analysing the therapeutic value of adventure programmes, Williams (2004) endeavoured to elaborate the key differences between 'therapy' and 'therapeutic actions'. He contended that therapy requires, among other things, clear problem identification, a

therapeutic design based on a theoretical body of knowledge, specification of the remedial outcome intended, description of the therapeutic process and an evaluation of both process and outcome. Williams added that findings from a sample of about 2400 Australian youngsters showed that frequent participation in outdoor adventure activities had a protective effect against depressive and anxiety symptoms, confirming that outdoor adventure activities are therapeutic without being an actual therapy.

Nadler and Luckner (1992) gave a very valuable description of how to process the adventure experience, which is directly applicable to CAP patients in basic approaches. First, awareness of patterns of behaviour, of feelings and of perceptions is fostered in a non-threatening way. Second, the facilitator or therapist encourages participants to take responsibility for actions that were previously done automatically. Third, experimentation leads to the creation of new options and choices. Finally, generalization and transfer maximize what was learned during the course so it can be used in everyday life.

Classic psychoanalytic approaches deal with conflicts between fantasies and wishes and reality. However, this is only possible if a person can perceive such conflicts, a perception usually underdeveloped in serious disorders. In more recently developed mentalization-based psychotherapy, patients are guided in ‘mentalizing’ their experiences, or creating coherent narratives of intentions, affective experiences and social interactions. This type of therapy encourages the sense of agency and the capacity to postpone, modulate and regulate emotional reactions (Verheugt-Pleiter, Zevalkink, & Schmeets, 2008). Social and self-cognition are normally acquired in a dyadic situation with an attachment figure. When this interpersonal exchange of mirroring and modulating intentional and affective states is disturbed, the capacities to make judgements about subjective states and of perspective-taking and perceiving behaviour as related to intentions and feelings are also disturbed (Bateman & Fonagy, 2006). Fonagy (2008) emphasized that a secure attachment situation enables generation of coherent narratives of turbulent interpersonal episodes, whereas attachment trauma undermines the ability to understand personal mental experiences. In adventure-based experiential therapy, a secure attachment situation is created that could be described as a turbulent but somehow attractive personal and social experience. While sharing the experience with others and with a soothing, secure attachment figure, the perception of the patient’s own and others’ affective and intentional experiences is enhanced. Such an approach might be seen as quite similar to what Loynes (2010) described as the role of narratives in an outdoor retreat project.

Basic framework of adventure-based experiential therapy with CAP inpatients

Clinical approaches within the framework of AET with inpatients are outlined in this section, followed by descriptions of clinical observations and experiences.

Professionals from diverse fields collaborate to achieve therapeutic goals with CAP inpatients. These professionals include psychologists and psychotherapists, teachers, medical doctors, nurses and youth workers on the units, social workers and creative therapists like art and dance therapists or music therapists (Eisenbeis, 2003). As a result, CAP inpatient treatment is the treatment of an individual within a group of patients by a group of distinct professionals.

Unlike more common types of adventure therapy programmes lasting from days to weeks, AET with CAP inpatients is only one part of a multimodal and multifocal interdisciplinary treatment programme and is performed as either adjunct or enrichment therapy. Outdoor activities done for recreation should be considered experiential activities rather than therapy, but AET activities can also be done indoors, such as climbing on an

indoor steep wall. AET in the hospital setting should be defined as an approach using special adventure or experiential activities, such as climbing or going to a creek or a cave, to achieve a therapeutic impact that is otherwise unlikely.

AET with CAP inpatients as part of a full range of treatment requires a special therapeutic environment. The AET practitioner and the clinical team must share a thorough knowledge of the patient's history, symptoms and underlying problems, as well as of the patient's family history (with the exception of acute crisis intervention patients). Full-time programmes of short duration (even only a few days) are usually not suitable. The severe disorders of these patients can interfere with group processes, thus making successful interventions much more difficult in this population. Therefore, only one activity—for example, climbing—is usually conducted on a one-to-one basis or in a small group. If possible, the activity is regularly repeated in order to accustom participants to the experience and make successful interventions more likely.

Therapeutic approaches

A range of AET approaches with different purposes are used in the hospital environment:

- (1) Leisure-time activities are frequently led by nurses and youth workers of the unit who are qualified to conduct adventure activities. Such leisure-time approaches make patients feel more at ease during their stay and can strengthen motivation to cooperate in other therapy interventions.
- (2) Special activities that focus on educational (behavioural) intervention are aimed at facilitating change in individuals or the group.
- (3) A genuine individualized (psycho)therapeutic treatment approach is focused on defined symptoms and is conducted by specialized facilitators, usually in a one-to-one or small group environment. In genuine therapeutic treatment, interventions are modelled on a specific theory of understanding, usually either behaviour therapy or psychodynamic therapy.

The framework and structure of AET for inpatients is partly determined by the experiential space available to the therapist. Common environments are an indoor or outdoor climbing wall, a creek or a cave. The therapist must also take into consideration the participants and the make-up of the group, which usually consists of the youngsters living together on the unit. CAP inpatients usually take part in only one or occasionally two experiential actions per day. The therapist has to decide whether to use a one-to-one approach for individual problems, thereby consuming resources of time and personnel, or to lead a group activity with the goal of changing dynamics and interactions within the group.

Therapeutic work with groups demands a leadership style that is open, directing and structured. These qualities improve group dynamics, activating the model of a work group instead of a regressive group (Bion, 1961). Participants should be chosen according to already known as well as anticipated group dynamics and according to the changes intended. It is crucial that group members show sufficient motivation for positive cooperation and an openness to new perspectives.

The mechanisms of change with CAP patients will be similar to those usually found in adventure therapy programmes derived from psychodynamic and behavioural approaches, such as self-efficacy, metaphoric learning, the isomorphic structure of an activity, extinction, mirroring and flow. These mechanisms are applied to individual symptoms or

problems or are directed at changing group interactions. ‘Challenge by choice’ (Itin, 1997; Lissen, 2000; Neill, 2008) is essential with CAP inpatients to avoid destabilization. An approach similar to mentalization-based therapy (Verheugt-Pleiter et al., 2008) is used to name and describe what can be observed on a phenomenological level. Inner feelings and thoughts are then slowly and tactfully referred to, always taking into account the participant’s capacity to tolerate affective states. Waiting to observe which solution the patient will choose to adopt is another aspect of this type of therapy that is crucial to fostering self-efficacy.

Indications

The term ‘indication’ in this article refers to the rationale on which a medical intervention is based. To evaluate the indications for an experiential adventure therapy approach, the intended changes and targets are examined. The following are the main indications for AET:

- (1) To gain therapeutic rapport. This is especially useful with youngsters suffering from severe emotional and/or personality disorders who are otherwise difficult to reach.
- (2) To provide a direct experience of self-efficacy as an alternative to the verbal mode. Youngsters suffering from personality or anxiety disorders are quite often admitted to inpatient care because they are unwilling to collaborate in a regular behavioural treatment programme as outpatients. As inpatients, they again confront therapists with non-cooperation. From their point of view, undergoing treatment means passivity and being an object of the therapist’s action, and their non-cooperation is subjectively aimed at retaining some small degree of self-efficacy. Youngsters are less inclined to resist the adventure approach because it does not seem like typical therapy, and the desired experience of self-efficacy is therefore more likely to occur.
- (3) To model the group process on the unit. This is a common goal with hyperactive youngsters or children and adolescents showing conduct disorders.
- (4) To stimulate the mentalizing of experiences. This reflection on oneself and the interpersonal situation is intended to foster the regulation of both internal emotional and external social actions and, on an even higher level, to target special symptoms such as anxiety and depression.

With regard to specific psychiatric symptoms, AET can address the following:

- (1) anxiety, by allowing fears to be overcome outside a regular behavioural therapy environment;
- (2) depression, by helping patients leave behind depressive patterns of non-efficacy; and
- (3) obsessive-compulsive symptoms, by providing an experience of completely different circumstances that may break compulsive patterns.

The patient’s ability to make use of the experience in some way, even if only for passing the time or having fun, is essential at the beginning of the AET process. AET is a challenging part of a multimodal treatment approach; it ought to be implemented into the therapeutic process for specific goals at carefully chosen times.

Practicability

Practically speaking, an appropriate experiential space is needed for AET. For example, if an indoor climbing wall is not accessible at the hospital, patients will have to be transported to a nearby indoor climbing centre. If an indoor climbing centre is not readily accessible, longer excursions may be required to reach the needed experiential space. These logistical considerations make conducting such activities on a regular basis difficult. Furthermore, since qualified adventure therapy staff are not available in every hospital, increased financial disbursements may be necessary for training additional staff or providing AET training to existing therapeutic staff. More practitioners with the dual qualifications of psychotherapist and adventure therapist would allow for more comprehensive therapeutic treatment options.

The attitude of teams and organizations toward the AET approach is, of course, crucial. Staff meetings or case conferences should foster open discussion of and brainstorming about the adventure-based activities. Staff on the unit and the AET practitioner should schedule short meetings about every patient before and after the activity. These meetings would be in addition to weekly multi-professional meetings at the CAP hospital. Proper supervision and parental consent for the planned activities are further requirements of AET in the CAP population.

Adventure-based experiential therapy as applied in hospital environments

The following are short AET case studies covering a range of activities.

Climbing*Case study 1*

Peter, an 11-year-old boy diagnosed with an anxiety disorder, refused to attend school and was admitted to the hospital especially for that reason. He needed family therapy as well as medication.

At first, because of safety concerns, Peter was afraid of climbing. However, he attempted the hospital's indoor vertical climbing wall (seven metres in height) and succeeded by trusting the situation and equipment. He was then taken by car to an outdoor climbing area 40 minutes away with his climbing group. Although the pitch of the climbing area was much flatter than the vertical climbing wall, he was nonetheless afraid because of the greater height of the summit (28 m).

Peter was able to transfer his initial success at the indoor climbing wall to overcoming his fear of the higher outdoor challenge by using a new strategy he invented on his own: not looking down. After reaching the top, he helped a girl overcome her fear and reach the top as well. Later he was able to transfer his solution to his social environment. When his group went into town, Peter had to ride the subway. This meant that he needed to confront his fears on another level. Remembering that he had overcome his fear twice while climbing, he said, much to the surprise of his escorting peers, 'When the train stops, I'll get on'. This he did, gaining valuable independence. Peter had been required to use the subway to reach his previous school. Riding the subway without fear would eventually allow Peter to be released from the hospital and be of great benefit to him in his new life after treatment.

With Peter, therapeutic processing within the context of his disorder of abnormal anxieties was possible through the generalizing of his success at prevailing over his fear in

one context to other contexts. The steps Peter took facilitated change, which gave him a framework, an atmosphere of trust, and empowerment to control his anxiety on his own.

Case study 2

Anna, a 12-year-old girl, had several problems, one of which was refusing to go to school. For reasons concerning her family's resources, it was decided that she should be referred to a therapeutic children's home after inpatient treatment.

Anna went to the indoor climbing wall several times with her unit's group at the hospital. After a few of these sessions, tasks were assigned such as making a painting before and after climbing. The children were told that the paintings would be shown to others only on a voluntary basis.

The first task before climbing was to outline and paint the climbing route. The children were also asked to mark the points where climbing might be difficult for them. The second task was to think about difficulties in the future and to write them down next to the difficult climbing points in their painting. Anna listed 'to go to school' and 'to go to foster care' as her future difficulties.

After the activity, participants were asked to mark if and/or why they had experienced difficulty climbing. Anna wrote that 'the grips were too far apart'. The following questions were reflected on and then discussed within the group:

- (1) What helped you to pass the difficult points?
- (2) What helped you with your next steps in the climb and in your life?

Anna's reflections included the following:

- (1) sometimes small steps bring you forward better than big steps—especially when you have actually planned big steps;
- (2) feeling supported, one can reach goals that first seemed too difficult; and
- (3) an indirect way can be a good way as well.

Consciously reflecting on metaphors made Anna aware of different crucial points in her life and opened the way to solutions and general success. About a week later, Anna started to attend lessons at a neighbouring school outside the hospital grounds. In the weeks to come, she was able to make her way to her recovery house in a much more collaborative way instead of being forced.

Exploring a creek

Announcing a trip to a creek, motivation is easily achieved as patients are going to a well-known landmark. Compared with a climbing wall or a cave, fewer security questions arise in creek exploration. In addition, less equipment is needed and a larger group can be accommodated.

It takes only a short period of time at the creek for the participants to learn that mutual cooperation and support are necessary to go forward, helping each other to climb up the rocks or pass the water. From a clinical standpoint, being in pure nature among rocks and waterfalls is known to reduce symptoms and disorders. This is especially true for children with behavioural and hyperactivity problems, making cooperation without rivalry possible. There is also a strong effect on the group process. As with individuals, iteration is

needed in order to achieve lasting group effects. However, iteration may not always be practical, depending on how far the group has to go to reach the experiential space. Walking through a creek might thus be a single part of a complex AET therapy programme in which a number of activities are pursued over time to achieve long-lasting effects. As part of the multimodal clinical treatment, going to a creek is more of a recreational activity, and, as with other recreational activities, its therapeutic activity is aimed at improving group dynamics.

Case study 3

A group of five CAP inpatients aged 11–13 years were taken to the Heckenlaine Gorge, situated between Lake Kochel and Lake Walchen in the nearby Bavarian Alps. Two group members (Alex and Anja) had a combination of emotional and behavioural and hyperactivity disorders. Two others (Daniel and Dennis) were diagnosed as depressive, and the fifth (Conny) was obsessive-compulsive about keeping her clothes and skin tidy. Daniel and Dennis were the first to overcome their lack of motivation when they saw the gorge and the natural beauty of the surroundings. A special incentive for the patients was that they were allowed to walk directly into the stream. Alex and Anja went into the stream without worrying about danger. After a few steps, Alex stumbled and got his feet and pants wet, causing the pair to slow their pace and use more caution about where they put their feet. Conny, on the other hand, went very slowly, trying not to get dirty. She was further slowed because her attention was captivated by the surroundings. The group had to wait for her to catch up on several occasions, but they did so without impatience.

The group was forced to go one at a time through a very narrow and slippery passage in the stream. Without being instructed to do so, the group made their own plans on how to manage their way through the passage. Alex and Anja were able to wait and listen to the suggestions of others. The group members then succeeded in helping each other perform the planned task. Conny slipped on a stone on one of her last steps, getting her shoes and pants wet and muddying her fingers. This proved to be a real challenge for her, and her reaction at first was to stiffen and not move. However, after a few seconds she laughed and went on without worrying about getting even more wet or dirty, indicating that she was able to put her compulsive ideas aside. Any passer-by would have thought the group was made up of five ‘normal’ children having fun, playing in the mountain stream, teasing each other but also respecting limits, rather than a group of severely handicapped CAP inpatients. All disorders subsided and had less influence, or even no influence at all, on the children’s interactions, allowing them to feel at ease during the AET activity. The children were able to gain the valuable experience of functioning as their ‘normal’ peers would, despite the fact that they were inpatients of a hospital psychiatric unit.

Caving

The activity of caving requires more organization, equipment and planning than going outside and walking in a creek. Although the activity can therefore be done less frequently, caving leaves a powerful impression on participants.

The experiences of entering a cave and being in absolute darkness can evoke deep emotional feelings. One can see only what one shines a light upon; everything else remains invisible and unknown. Compared with other AET activities such as climbing, limited visibility during caving allows the group leader less complex observations of the

participants. While the leader might not be able to ascertain what the participants actually experience, the group process is more intense and less superficial. However, patients with severe panic or anxiety disorders may not benefit at all from caving, as anxiety may increase during the activity without the possibility to stop the challenge in due time. Medically, anxiety disorder would be a contra-indication for caving.

Nevertheless, caving is an experience that can allow the group to feel a strong sense of accomplishment as well as providing a foundation for shared reminiscence. Caving is thus more than a recreational activity, as it induces changes in the group process and in participants' self-experience. Entering a cave can also be part of individual therapy, and metaphoric transfer can aid the participant in addressing problems of trusting, waiting, cooperating and being helped. However, such an intervention requires much more verbalization and a very conscious use of metaphors. Giving words to the external real actions and the complementary internal processes during caving, or mentalizing the caving experience, would be the key target of such a project.

Theoretical considerations of AET as a mentalizing activity

Recent research in psychodynamic psychotherapy stresses the impact of attachment theory and supports the effectiveness of mentalization-based approaches (Busch, 2008; Fonagy & Target, 2008). In using AET with young people, the developmental task of living through new experiences and adventures can be addressed in the context of a secure attachment situation, provided the challenge is taken on by choice. Secure attachment fosters mentalization, which starts with attention regulation, continues through affect regulation, and ends with genuine 'mentalization' of the internal states and motivations of oneself and others (Verheugt-Pleiter et al., 2008).

One of the primary benefits of AET approaches is the fostering of attention regulation, the first step in mentalization. Attention is regulated toward the activity, the equipment, the security arrangements that have to be followed, and toward the other participants and the group leader. Without enough attention, dangers can arise.

The fostering of attention enables the naming and addressing of feelings and actions done or not done. Affect regulation, the second mentalization step, is supported by the fact that participants have to accomplish tasks on a timeline in order to manage fear and frustration and so forth. Examining one's own feelings, not just expressing them, is part of the AET process because of the 'here-and-now' aspect of the situations.

Genuine mentalization can be easily promoted by encouraging conversation about the completed activity. Behaviours are described, followed by a discussion of non-verbal communications observed by the facilitator and leading to descriptions of inner processes. Thoughts, emotions and motivations are named.

Through conversation about inner processes, metaphoric learning as a transference of patterns can take place and can confer lasting changes. However, if the disorder is too severe for positive affect regulation, metaphoric learning is hampered. However, affect regulation will slowly increase through repetition of activities, and mentalization of motivations and aims becomes easier.

Additional benefits and future research

AET can be used to verify previous diagnostic findings. This is especially true with hyperkinetic children on the climbing wall. These children climb with no fear, unconcerned about safety, paying attention only to what they do themselves, without taking

much care for rules or others. The effects of recreational activities, such as mood changes in individuals and the group, are frequently obvious, and group dynamics on the unit will be noticeably different. Mentalizing activity is generally enhanced, as can be observed in group discussions after the activity or in other therapeutic environments. Specific therapeutic transference of the experience can take place, but not necessarily as a result of explicit facilitating, as shown in the anecdotal case studies. When periodically repeated, AET can be of benefit in evaluating the patient's overall improvement by revealing different behavioural patterns.

There is still a need for research into the specific effectiveness of AET experiences in inpatient work. Evidence-based medicine seeks a significant change induced by a defined procedure. As there are no evidence-based trials for AET with CAP patients, clinical knowledge and experience are required to discern the indications for individual treatment components and applied AET activities.

However, research has proved some efficacy of outdoor adventure therapy programmes and pointed out the need for defined interventions and adherence to intervention strategies (Gillis et al., 2008). A thorough theory of the AET process and facilitation focusing on special disorders is still lacking in regard to inpatients. As experiences (e.g. climbing, rope courses, rappelling) and therapeutic procedures differ, research should be conducted by psychiatric clinicians and researchers together with AET practitioners, using as a basis what is commonly called grounded theory.

Grounded theory aims at the 'conceptualization of fundamental latent patterns occurring in action' (Glaser, 2007; Glaser & Strauss, 1967). It makes use of the cycle of describing actions and findings, evaluating them, explaining them by theory, changing the approach and then evaluating them again using theory, and so on. It is important to describe interactions, processes and findings and to discuss indications and evaluate effects according to behavioural, psychodynamic and systemic theoretical approaches. Using different theories to explain observations and clinical findings as well as to estimate or measure effects will allow clinical practice to progress and improve. However, gaining deeper theoretical insights concerning the use of AET with CAP inpatients is more crucial at present than attaining refined statistical results. Only after the gathering of thorough empirical and theoretical insights will evaluation and conceptual development be possible.

Author biographies

Florian Eckstein has been a practitioner in experiential education for quite a number of years, working on a unit at Heckscher-Klinikum Hospital for child and adolescent psychiatry, Munich, Germany.

Ulrich R  th, MD, had been senior consultant in child and adolescent psychiatry at the Heckscher-Klinikum Hospital for 18 years and is now working in a private practice in Munich.

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