

Chapter 4

Adventure Programming
Miles Priest (1999)
Venture Pub.
Pennsylvania

Adventure as Therapy

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Introduction

As psychotherapy differs from casual conversation, adventure therapy differs from recreational, educational, or developmental adventure in the way in which activities are used to bring about change. In this chapter, the basic elements of adventure therapy are described and the broad uses of therapeutic programming commonly practiced throughout the world are outlined. While little is known through research as to how program types differ, some speculation is offered from the writers' experience and from earlier writings that can help characterize clients who participate in these therapeutic experiences. Principles that distinguish the therapeutic use of adventure from other forms of adventure are then followed by a discussion of some of the problems and benefits that arise from conducting therapy outside the clinician's office. Finally opportunities for research into the effectiveness of adventure programming in therapeutic contexts are examined.

An Overview of Adventure Therapy

Adventure therapy is the deliberate, strategic combination of adventure activities with therapeutic change processes with the goal of making lasting changes in the lives of participants. Adventure provides the concrete, action-

based, experiential medium for therapy. The specific activity used is (ideally) chosen to achieve a particular therapeutic goal. For example, having two persons who have difficulties in their relationship, such as a father and son or husband and wife, paddle a canoe will require them to cooperate in order to be successful. A 14-day backpacking trip for a group of adjudicated youth provides a self-contained purposeful therapeutic community where tasks such as erecting tents, reading a compass, or cooking a meal provide challenges in communication and discipline which can be utilized for therapeutic outcomes. These are just small examples of how adventure can be programmed for therapeutic ends.

Adventure activity approaches have much of their documented history in the philosophies of experiential learning inherent in Outward Bound, a wilderness-based program teaching self-discipline and teamwork through adventure activities (Bacon, 1983). Some might even say that Kurt Hahn, who helped shape the foundations of the Outward Bound movement might be one of the first adventure therapists, due to the work he did in molding young soldiers to develop a "will to live" (Thomas, 1980). Indeed, the use of outdoor, adventure experiences for therapeutic purposes is documented with such clinical populations as substance abusers (Gass and McPhee, 1990; Gillis and Simpson, 1991), adjudicated youth (Bacon and Kimball, 1989; Kelly and Baer, 1968; Kimball, 1983; O'Brien, 1990), clients served in private practices (Berman

and Davis-Berman, 1989) and psychiatric hospitals (Schoel, Prouty, and Radcliffe, 1988; Stich and Senior, 1984; Stich and Sussman, 1981).

While we use the term *adventure therapy* (e.g., Gass, 1991; Stich and Senior, 1984) in this chapter, do note that many terms have been used historically to describe the therapeutic use of adventure programming. These terms include *adventure-based counseling* (Maizell, 1988; Schoel et al, 1988), *outdoor-adventure pursuits* (Ewert, 1989), *therapeutic adventure programs* (Wichmann, 1991), *therapeutic camping* (Rice, 1988; Walton, 1985), *wilderness therapy* (e.g., Bacon and Kimball, 1989; Berman and Davis-Berman, 1993; Levitt, 1982), and *wilderness-adventure therapy* (e.g., Bandoroff, 1990). While there may be subtle differences in how authors describe these various approaches goals appear to be the same to most people who read the literature or listen to therapists describe what they do.

Types of Adventure Therapy Programs

Gass (1993) observed, and Crisp (1997) confirmed, that at least three areas of adventure therapy exist. They include adventure-based therapy, wilderness therapy and long-term residential camping. These types of programming are characterized by where adventure therapy is taking place, for what length of time, and the type of programming being utilized.

The activity-based group work, or what Gass calls "adventure-based therapy" centers on team games, problem-solving initiatives, and sometimes with the addition of low- and high-challenge ropes course activities. This approach takes place near a facility and rarely in "remote" settings. Adventure-based therapy programs appear to be most popular in the United States. In other areas such as Europe, Australia, and New Zealand more reliance is placed on using natural settings and journey-based adventure activities (Crisp, 1997).

Wilderness therapy appears to come in both short- and long-term expedition formats. The short-term formats are often associated with Outward Bound's model (Bacon, 1983). Programs derived from the Outward Bound model utilize an expedition format that has elements of teaching and practicing wilderness skills. Expeditions range from 7 to 31 days and are mainly conducted in remote settings as the word *wilderness* implies.

Longer wilderness expeditions (60 days or longer) appear to differ from the Outward Bound model but have not been studied with as much clarity to be able to clearly highlight their differences here. From observation, it would appear that many of these programs focus on survival skills.

The long-term residential camping programs appear to be flourishing in the southeast and mid-Atlantic regions

of the United States through programs designed by Eckerd Family Wilderness and Three Springs, Inc. It would appear from available literature that published efficacy studies have not been as abundant as the reported growth of these programs. There do not appear to be any long-term residential adventure therapy programs outside the United States.

Research results indicate that outcomes of adventure therapy programming are still mixed. It remains difficult to tell just what is taking place in these various settings that falls under the label of adventure therapy. It is difficult to definitively categorize studies exclusively into the three areas described here. Indeed, many programs are a mixture of an activity base that highlights ropes course activities and some form of an expedition.

There is little literature to date that describes the rationale for choosing one particular approach over another. For example, why does one program use 10-day expeditions with adjudicated youth while another uses mainly adventure-based therapy for what appears to be the same client group? There remains much research work to do in finding answers to this question.

Common Characteristics of Adventure Therapy Activities and Programs

Adventure therapy activities are most often group-based, and interventions are derived from principles underpinning psychology, sociology, education, and other disciplines that inform the process of human change. The goals of adventure therapy interventions are developed in response to client needs; sometimes those needs are from individual clients within the group, and other times the needs are those of the entire group. Common goals of adventure therapy include resocialization, reducing criminal offending, treating substance abuse, providing remedy for dysfunctional interaction with others, and improving clients' management of their own emotional and social lives. Adventure therapy targets participants' cognition, affect, behavior, and personality. The purpose of many adventure therapy programs is to remedy dysfunction in the client. Although adventure therapy is primarily a group-based process, some one-on-one therapeutic techniques and family therapy techniques are used in most programs.

Some clients are referred to programs on a voluntary basis, but others are offered placement on programs as a trade-off for reduced prison sentences or a reduction in other sanctions. Examples of such client groups are young offenders (Gillis and McLeod, 1992). Successful indoor adventure activities have been used for treating substance abuse with adjudicated adolescents and incarcerated adults (Gillis and McLeod, 1992), victims and perpetrators of

abuse (Simpson and Gillis, 1997), clients with eating disorders (Maguire and Priest, 1994) and difficult populations in school settings (Handley, 1993).

Adventure therapy involves both the use of traditional therapeutic interventions and the strategic use of an activity perceived as being very risky by the client as a therapeutic milieu. The additional factor in adventure therapy as compared to conventional therapy programs is the potential to harness the physical environment and the adventure activities themselves for therapeutic outcomes. The adventure therapist needs to be a strategist who is constantly asking, "How will this next activity and its associated physical conditions create opportunities to create therapeutic movement in this group of clients?"

For the sake of keeping it simple, this chapter will use *adventure therapy* as a generic term to denote an active, strategic approach to working with people with a variety of abilities utilizing adventure activities, which involve some form of perceived risk, as the primary therapeutic medium. The "depth" to which programs work with clients determines whether or not an adventure program is adventure therapy or some other form of adventure such as recreation (Ringer and Gillis, 1996). This difference is explored next.

The Difference Between Recreational Adventure Programs and Adventure Therapy Programs

General-purpose adventure programs seek to entertain or educate their participants although they may provide opportunities for personal growth. Adventure therapy programs however focus *specifically* on creating circumstances likely to engender change in participants. Adventure activities are used because of their powerful therapeutic leverage. Both recreational adventure programs and adventure therapy programs need to be physically safe, responsive to participants' needs, and purposeful. Effective adventure therapy programs have the following *additional* features:

1. Potential clients are assessed and screened prior to their being accepted into a program. Such assessment is intended to screen out persons who have a strong tendency towards behaviors that make them unmanageable in wilderness and remote settings and settings with high levels of potential physical danger. Examples of such behaviors included current substance abuse, sexual (abusing) aggression, physical violence, and psychosis. Programs with restricted admission, specially designed activities and highly skilled staff

may still be able to target clients with these "unsuitable" behaviors, but general-purpose adventure therapy programs are not equipped to do so (Cline, 1993; Tippet, 1993).

2. Persons of psychological significance to the clients, such as relatives, friends and mentors are often involved in the program. Since most adventure therapy programs are relatively short term, the persons who comprise the client's social system are involved so that the changes in the clients persist after the adventure therapy program has ended (Barrett, 1994; Stainton and Balston, 1995).
3. Programs incorporate "treatment" plans for each client as well as plans to suit the development of each *group* of clients (Bacon and Kimball, 1989; Berman, 1995; Gray and Yerkes, 1995).
4. Multidisciplined staff teams are usually deployed because the combination of outdoor activity of skills and therapeutic skills required is usually beyond the capacity of any one leader. Leader teams are made up of persons who have a proven capacity to work together and who can communicate clearly with each other about their own areas of expertise (Berman, 1995; Ringer, 1997; Ringer and Berman, 1995).
5. Interventions are constantly "fine tuned" because the complexity of human systems suggests that progress is not predictable for any part of the system (Gass and Gillis, 1995). Regular reviews are conducted on program effectiveness from the point of view of each client, the group as a whole, and each leader or therapist.
6. Program design and implementation includes follow-up, clear termination with each client, closure of each group, and referral of clients to other agencies where applicable (Gerstein, 1994).

Those six "quality" criteria could well apply to community-based psychotherapy programs, but they still do not answer the question, "On what therapeutic principles or principles of human change do you base your interventions?" In our research into adventure therapy programs we have found that the nature of the intervention depends heavily on the client-presenting problem, the goal of treatment and the type of diagnostic issues on which programs focus.

In broad terms it is possible to view adventure therapy programs as applying principles from four different psychological orientations. These are, existential or humanistic, psychodynamic, systemic and behaviorist. The behaviorist forms of intervention are generally applied to

impulsive and nonreflective clients. Programs of a more humanistic, psychodynamic, or systemic nature tend to cater to developmentally mature client groups (Ringer and Gillis, 1996). Two examples will be used here—one that illustrates the application of psychodynamic principles in adventure therapy and the other that integrates behaviorist principles with an adventure activity.

An Example of a Psychodynamic Approach in an Adventure Setting

Larry was referred to an adventure therapy program because he was "beating up" his wife. He was placed in a group that met for one day's activities each week. The therapist's assessment was that Larry exhibited aspects of narcissistic personality (Cline, 1993; Meares, 1992; Tippet, 1993), and so required long-term treatment where attention was paid to enabling him to repair deficits in his early development and construction of his self-structure. This goal was achieved by careful sequencing of fun activities so that group members slowly built up trust in each other while the challenge level and risk level was still low. Close attention was paid to the quality of the relationship between the therapist and the participant(s), and outbursts of anger and frustration were dealt with firmly but without isolating or rejecting the participant.

Larry was a strong, fit young man who took pride in his body. For instance, he would strip off his shirt and dive into cold water if it would help the group achieve a goal. He made a show of helping the less physical members of the group—in particular the women. Larry soon began to challenge the expertise of the group leader and talked at length about how he (Larry) had been an instructor for the helicopter evacuation team, and hence had excellent skills in rappelling and climbing.

Core elements of psychodynamic interventions are the use of transference, countertransference and projection amongst group members as sources of information that can lead the participants to useful insights. Susan, the group leader, often felt herself withdrawing from Larry and becoming angry with his dismissive behavior. She used this information by reflecting to Larry how, despite the fact that she saw him being "helpful" at a factual level, often when he spoke she struggled to find a place for herself in the group. She also wondered aloud what it was like for other group members to have just one person (Larry) who took on the role of helper, organizer and instructor. At one point Larry had an angry outburst and accused Susan of mocking him and not appreciating what he had to offer. Susan mused aloud that this seemed like a familiar feeling to him. She maintained this "neutral" reflective theme in the group and later followed up in one-on-one therapy sessions with Larry.

Following a psychodynamic-based adventure approach to adventure therapy involves using the relation-

ship with the therapist and the activity itself to unearth previously repressed or out-of-awareness patterns of thinking and behavior in participants. Adventure therapy has a group component where clients' habitual pattern of interaction become visible. The addition of stress arising from risk cuts quickly through some clients' defenses. Intense focus on learning and applying new physical skills can also distract clients from erecting their usual "false selves." Once these patterns are visible, psychodynamic therapeutic processes gradually enable clients to identify the origins of these dysfunctional patterns in their early life. The clients' internal representation of themselves as worthwhile people is gradually restored by repeated occasions where they find the therapist and other group members attentive and affirming. However, psychodynamic approaches are not suitable for all client groups. For example, male adolescents who have been referred because of repeated criminal offending often exhibit such extreme impulsive behavior that they need to be placed in programs that create strong containers. On entry to programs these clients are more suited to behaviorist-oriented interventions.

An Example of a Behaviorist Approach in an Adventure Setting

It is late afternoon, cold, and a sudden down-pour accompanied by strong wind catches our group on an exposed hillside. Packs are thrown to the ground and we all pull our rain-coats from the top of our packs. Soon we are on our way again. But Jason is not with us. He is back where we stopped. He has pulled everything out of his pack to reach his rain-coat at the very bottom. His sleeping bag lies in a stream of water and he now angrily rams equipment back into his pack. His tears mix with the rain on his cheeks and his face is locked into a grimace of rage and shame. Here, Jason is learning that his choice to ignore this morning's instructions on packing a pack has unpleasant consequences. Maybe he will generalize this learning to his home life.

Behaviorist-oriented interventions use both the natural environment and the human interaction to provide concrete "natural consequences" and "logical consequences" for participants' maladaptive behavior. The hope is that participants will internalize new behaviors and continue to behave in new ways that are likely to be appropriate for the environment to which they will return after the therapy program has ended. Sometimes behaviorist interventions are used to establish a stable climate in the group for more humanistic and psychodynamic styles to be introduced later.

The application of behaviorist principles to adventure interventions is most suitable when clients' internalized sense of responsibility is diminished, when they are constantly "acting out," and when they have a limited capacity for self-reflection. Because of the suitability of these "black box" therapies to lawbreaking clients, many programs for criminal offenders use behaviorist-oriented strategies.

Difficulties in Working With Adventure for Therapeutic Purposes

Introducing adventure activities to therapeutic settings can raise challenges that are not experienced in traditional office-based therapeutic programs. In the office setting, therapists tend to have a single role—that of therapist—whereas in adventure settings therapists often also take the roles of instructor and of safety supervisor. These multiple roles lead to the therapist being quite visible to clients as a whole person and hence change the therapeutic dynamic.

Multiple Roles: No More Blank Screen

For the psychodynamic therapist working one-on-one in an office-based setting the therapist's stance approaches that of a "blank screen" (Maxwell, 1996) onto which the client projects his or her internal world. In adventure settings the therapist has multiple roles and so may be simultaneously the therapist, the setter of limits on physical safety, and the outdoor skills instructor. The screen is far from blank (Larned, 1996). This necessitates a different mode of working and adventure therapists are still grappling with this issue. There may be equally powerful therapeutic opportunities in the therapist being more visible to the client but this has, as yet, been poorly explored.

Power Relationships Are Changed

Power relationships can be reversed in adventure settings. The person at the rear of a canoe controls the direction of the boat. Shooting the rapids with the client in control or climbing a cliff while the client provides the belay may result in new things happening in the therapeutic relationship. The significance of this change in power has yet to be researched in the context of adventure therapy. Further power issues arise when physical activities are conducted that require high skill levels. In these cases the psychotherapist seldom has the technical outdoor skills or the safety skills to take charge of the activity. So the less therapeutically minded practitioner may be "in charge" and setting limits on clients' behavior. Sometimes the adventure therapist may see therapeutic potential lost through the outdoor pursuit instructor's lack of awareness of psycho-

logical issues. This problem can be partly overcome through adequate preplanning when therapist and instructor share information and perspectives on their tasks and develop role clarity before starting with the group.

Opportunities for Psychotherapists

Although some psychologists are enthusiastic adventure therapists (Crisp, 1996), there is a scarcity of clinically trained psychotherapists who currently practice adventure therapy (Ringer, 1997). Adventure therapy is becoming better organized and more popular throughout the world. Many adventure practitioners have shared their vision for developing adventure therapy programs; some realize their lack of clinical skills to turn this vision to reality. For those therapists who do take to the woods to try adventure therapy there are some spectacular rewards. Wonderful things happen when you spend 10 days in the wilderness with dysfunctional adolescents. The experience of working in radically new structures of time and space is illuminating. For example, on a 10-day expedition the therapist is "on call" for 240 hours on end and therapeutic sessions seldom begin and end as they do in an office setting. Outdoor adventure activities also create opportunities for exploration of therapeutic techniques. Have you ever wondered how the therapeutic dynamic would shift if you were walking alongside your client on a long hike? The communication in the dyad becomes very rich as variations in pace and space create a new therapeutic context. The campfire is another powerful therapeutic milieu, as is the mountain top as you contemplate the clouds catching on fire when the sun sinks to the west.

While the attraction to practicing therapy using adventure appears to continue to grow, the evidence that what is happening in the field is indeed working remains mostly anecdotal. Therapists who wish to introduce adventure into a traditional setting are hindered by a lack of credible research that confirms the effectiveness of adventure-based approaches. Formal research is most often the concern of aspiring students and much of what is done never reaches professional journals. Thus the credibility of adventure therapy suffers and will continue to do so until the field produces an improved base of published research.

Research Opportunities in Adventure Therapy

Available reviews of the literature (Bandoroff, 1990; Burton, 1981; Ewert, 1987, 1989; Levitt, 1982; Shore, 1977) appear to agree with the later findings of Hattie, Marsh, Neill, and Richards (1997) and Cason and Gillis (1995) that globally measured self-esteem has been found to increase following participation in adventure programming,

though the longevity of such change and its transfer to other settings has not been empirically validated. These mentioned reviews along with writings of Bacon (1983, 1987, 1988; Bacon and Kimball, 1989), Chase (1981), Gass (1991), Kimball (1983, 1991), Haussman (1984), Roland (Roland, Summers, Friedman, Barton, and McCarthy, 1987), Schoel et al. (1988), Stich (Stich, 1983; Stich and Gaylor, 1983), and Witman (1989) support the fact that primarily adolescents have been positively impacted by adventure activities in therapeutic settings. Additional dependent variables have been studied including self-reported changes in locus of control and problem solving, staff observations of behavioral change, and other measures such as grade point average and attendance. Results of changes on these measures have been less conclusive.

Authors of available literature do not clearly indicate the population that the writer is working with, or the presenting problem(s) of that population. In many cases they do not even clearly state the outcome of the research. Trying to determine the difference between the use of therapeutic challenge activities, wilderness activities, and expeditions is difficult at best. Clearer and "cleaner" standardization of nomenclature will allow us to more clearly refine our ability to discuss benefits of different approaches to therapeutic adventure programming.

There is still no *one clearly defined and researched* method of conducting therapy with adventure activities. An increasing problem is how programs that are primarily based on challenge ropes courses or using only group initiatives are combined in the literature with programs that are primarily wilderness- (outdoor pursuit-) based. What is more troublesome is that the majority of research studies are not specific enough in their methodology so that the reader can determine if one program's findings can be compared with another's. Even practitioners from different programs, in conversations with one another at a conference, will use terms like adventure therapy or wilderness therapy interchangeably often assuming they know what each other means. The need for specificity regarding method used, as well as an accurate description of the techniques employed or protocol being followed, is long overdue in the field of adventure therapy.

The field of adventure therapy has everything to gain from putting together results of our work into a *collective document* that addresses accomplishments and effectiveness. Secondly, by *examining clinically significant events* in adventure therapy programs that are or were deemed to be of importance *by the consumer* and by communicating in language that is understandable to mental health, adventure therapy can achieve greater credibility with the more traditional field of mental health and those who hold the purse strings and benefit our potential consumers who may then be able to access adventure therapy as a viable approach to treatment.

A comprehensive analysis is needed that can address the efficacy of adventure therapy across populations, problems, and settings. We know very little of how our work stacks up collectively.

A survey is needed to highlight similarities and differences in activity-based, expedition, and residential camping that falls under the rubric of adventure therapy. As a field of practitioners, adventure therapists wait around as if someone else will do the research that will keep them in the field. Adventure therapists are their own worst enemy in that they do not value evaluation of their work or spend the time necessary to share what they do collect.

To answer the question of which approach works best with which population, researchers must make better attempts to clearly describe activities they are assessing, for how long, and with what population. A common set of information needs to be specified in writing about adventure therapy programs. Such information should include specifics about the type of programming (activity-based, expedition-based, camping-based), demographics of the population (including age, gender, and problem or diagnosis), the measurement instruments employed, and the goals of the program. A good place to start such definitions is within the titles and abstracts that are available to researchers over accessible databases.

Numerous questions also exist about competence of leaders in adventure therapy and what competencies are needed to call oneself an adventure therapist (Ringer, 1994). Once adventure therapists have gained more clarity about what works with which client groups, there will be an urgent need for the field to clarify the nature of skills and knowledge required by practitioners in order to provide quality leadership.

These are but a few of the opportunities that the field of adventure therapy must grasp in order to gain credibility and have more to say to colleagues in mental health than "we know it works, we see the impact of adventure activities on our clients, that's all we need to know."

Conclusion

Adventure therapy is a generic term that encompasses a myriad of approaches to the integration of adventure and therapy. There is great potential for group-based outdoor adventure to provide an innovative context for therapeutic interventions. Adventure offers an active experiential orientation. The natural setting offers concrete and consequential environment and the potential for meaningful practical tasks that can be harnessed for therapeutic outcomes. There are significant challenges in the application of adventure for therapeutic outcomes. First, therapists are forced into multiple roles with clients, some of which may be countertherapeutic. Second, therapists must be multiskilled. Third, the blocks of client contact are usually much longer than in conventional clinic-based therapy.

Fourth, there is much work to be done in order to demonstrate the effectiveness of adventure therapy to the larger world of mental health.

Effective programs are carefully designed, integrated with other interventions, and run by highly skilled practitioners who have an understanding of the psychology of human change as well as a practical ability to use adventure for personal change. Furthermore, professional-quality programs are constantly evaluated as to how they are working and how they can be improved. Good quality practice arises from practitioners paying close attention to the link between client group needs, activities carried out, program goals, and the model of human change implicit in the intervention. The relative youth of the field of adventure therapy offers a rich opportunity for psychotherapists who are attracted to the use of adventure for personal change and to adventure practitioners who wish to develop their expertise in human change processes.

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