Adventure Therapy
Adventure Therapy
Theory, Research, and Practice

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Names with metaphorical connections are often given to individuals for attributes they possess or societal roles it is hoped they will fill. Such an action is not a dictatorial mandate, but a gift given with the hope and support that the individual can achieve this objective in a manner that best suits her and the needs of a particular culture and society.

In an article in Science (1977), amaranth was described as “the crop of the future.” In many cultures in the Americas, the grain amaranth not only represented the actual staple in the diet of these civilizations, but also served as an interpretive symbol of being nurtured by growth and strength. Any item, concept, or person with the name amaranth represented the idea of holding a critical nurturing role in society.

Serving as a nurturing food source for the Incas, Aztecs, Mayans, and other cultures, amaryth holds modern significance as an entity that is highly productive, tolerant in difficult environments, contains large amounts of strength building elements, and requires small amounts of support to grow rapidly. Adding honey or chocolate to amaryth makes a treat called alegria, meaning “joy” in Spanish.
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A Psychotherapeutic Foundation for Adventure Therapy

In *The Wizard of Oz*, Dorothy and her companions embarked on a journey to a faraway land to retrieve the broom of the Wicked Witch of the West in order to satisfy a challenge imposed by the Wizard (Baum, 1900). Dorothy thought achieving this task was required in order to accomplish her goal of returning home to Kansas. In her expedition to retrieve the broom, her small group engaged in numerous challenges where they needed to demonstrate cooperation, communication, patience, kindness, and decision making to be successful.

On the surface, this well-known allegory (mostly known through the movie) appears to be quite isomorphic for adventure therapy. It certainly contains the following elements: a small group of somewhat doubting individuals unable to achieve their goals alone, an expedition with a clearly stated goal, and a facilitator who prescribes a task that appears, in the end, to help each individual find what they sought. Although Dorothy had her own purpose for embarking on the journey, Dorothy’s fellow travelers also possessed their own interrelated goals of seeking knowledge (Scarecrow), feeling (Tin Man), and courage (Lion)—that is, cognition, affect, and behavior. The group’s success in achieving their overall goal also required each group member’s issue to be addressed. In rising to the various challenges—some of which appeared impossible to them at the time—each group member was able to learn valuable insights, skills, and processes they could transfer to other parts of their lives. This archetypal story highlights how adventure therapy can:

1. Assess and capitalize on a group member’s individual strengths and perceived or real limitations
2. Provide appropriately challenging experiences in a group context that are integrated with well-accepted psychotherapy methods

3. Combine all of this into an experience that values, honors, and recognizes how a sense of belonging aids the change process

These three highlights are considered by many professionals to be some of the key foundations of adventure therapy.

Unfortunately, this story falls short. The “facilitator” in the person of the Wizard is a fraud. Clients may sometimes feel their therapist is a fraud when there is no rapport, no match, or the clinician lacks the training to be effective. Granted, the small group is directed to go see the Wizard by most everyone in Oz as someone who can help them. Like the Wizard, adventure therapists have people come to them (or be referred to them) with some expectation that change will ensue. But as Murphy (1996) warns, therapists who believe they are wizards are not only egotistical and unrealistic, they are also highly unlikely to be effective in the long run because the therapy is too much about them and not about the client. As many of us know, real change only comes when clients act for themselves; therapists can guide, direct, and clarify, but it is ultimately the client’s actions and changes that produce intended outcomes—although there is a skill set related to these tasks.

Adventure therapists are intentional in their prescription of activities and challenges. They are trained to diagnose problems; assess clients’ strengths, potentials, and perceived limitations; and match appropriate challenges to aid clients in the change process. The Wizard prescribed an activity to Dorothy and her band of seekers to simply get rid of them so they would not bother to him, just as some therapists attempt to remove symptoms instead of addressing the problem or opt for a solo experience when they are fed up with some of the clients. These therapists act without a theoretical basis for how change could occur or how engagement in the activity might help the clients. This chapter provides a theoretical underpinning for adventure therapy so that experiences can be matched to clients’ needs in a manner that is more likely to be successful.

A focus on group activity (facilitated by a trained leader) is central to the birth of group therapy. Following World War II, Slavson and Moreno, who were pioneers in group psychotherapy, used activities in their group work as a method of change (Scheidlinger, 1995). The activity base for group work was generally forgotten for many years in favor of more extensive use of conversation. Some may say that psychodrama (Moreno, 1972) and Gestalt therapy (Perls, 1969) embraced a kinesthetically (physically) active way of working with groups, but not quite in the same manner as adventure therapy does. Still, in both of these approaches, participating in the experience is the therapeutic process (as will be discussed in Chapter 4).
ANSWERING THE QUESTIONS OF ADVENTURE THERAPY

Whether they are focused on curing mental illness or promoting mental health, adventure therapists are in a clinical relationship with their clients to seek or support positive changes in their thinking, feeling, and acting. Toward that end, the key question (Paul, 1967, p. 111) asked of therapists in creating psychological changes is “what treatment, by who, is most effective for this individual, with that specific problem, under what circumstances?” For the purpose of this book, this question can be expanded to ask the following questions:

1. What is the most effective way to work with clients who come to an adventure therapist or an adventure therapy program?
2. How are traditional psychotherapies able to interact with adventure therapy to make treatment effective?

This chapter examines these questions as they relate to the psychotherapeutic foundations of adventure therapy and discusses what is meant by treatment, how adventure therapy approaches are matched to specific problems, and how certain circumstances affect the success of the adventure therapy processes. These questions also examine how adventure therapists can assist clients in their change process toward more functional and appropriate behaviors. This chapter discusses the change processes used in adventure therapy and proposes an integrative approach to adventure therapy using what a client brings as the starting or access point for therapy, using the ABC-R triangle: emotional response (Affect), acting out or withdrawn Behavior, or irrational or problematic thoughts (Cognition), integrated around the systemic Relationship(s) of the individual and their therapist, field staff, peer group, family, and community. This integrative approach links the affective-behavior-cognition elements together, symbolizing that their relationships are isomorphic with the theoretical dimensions of the model.

What types of treatment work the best for adventure therapy clients? Who is best suited to treat clients through adventure therapy? What type of adventure therapy treatment is best for a particular individual with a specific problem? And what set of circumstances best suits the treatment of a particular individual with a certain set of accompanying circumstances? Obviously, if we knew the complete answers to all of these questions, the treatment of individuals in adventure therapy settings would be much more refined than current practices. Examining each of these factors may lead us closer to this objective.

What Treatment?

The history of adventure therapy presented in Chapter 2 was framed around significant movements, programs, and individuals that helped shape what we know today as adventure therapy. There are a variety of current settings where
Adventure therapy takes place: outpatient private practice, inpatient hospitals, residential treatment centers, therapeutic camps, and in backcountry or wilderness settings. Adventure therapy does not operate exclusively as a psychodynamic-based approach, a cognitive behavioral approach, a humanistic/interpersonal approach, or a systems approach—it can work with any or all of these orientations. The beauty of adventure therapy—as Dr. Bobbi Beale, a clinical psychologist at Child and Adolescent Behavioral Health of Canton, Ohio, would say—is its plasticity (personal communication, December, 2010). Therapists with different theoretical approaches who value the active engagement of their clients through wilderness or adventure experiences use adventure therapy to connect, access, treat, and work with their clients, especially when traditional talk therapy approaches are not as successful.

The goal of adventure therapy is to assess client needs and meet them where they are by (1) being intentional in choosing and tailoring the activity that engages the client(s), and (2) achieving outcomes that allow them to function more successfully in their family, school, and work life. For example, when adventure therapy is used with adjudicated youth, many of whom present with acting-out externalizing behaviors, treatment might consist of presenting experiences that allow for natural or logical consequences to help clients learn to choose more functional behaviors. This procedure removes the adult or therapist from the clients’ projection by moving out of the way of the clients’ dysfunctional behaviors and allowing them to contend with the responsibility invoked by these consequences. When working with anxious or depressed clients, (internalizing), treatment might consist of intentionally designing quiet solo time in a natural setting, while practicing mindfulness techniques can help clients find a “place” they can go in the future when feeling similarly. Clients with distorted views of themselves or their actions (e.g., clients with eating disorders) might be presented with treatment experiences that bring their “thinking errors” to light for everyone to witness and process. All of these treatment experiences point to the central concept that the goal of adventure therapy is to mold the treatment to meet the client or client group.

In this book, an integrated transtheoretical approach to adventure therapy is presented that is appropriate across all of the described settings, while recognizing that various aspects of the approach need to be emphasized in different contexts. It is essential to note that the impact of the natural environment, as a significant and unique setting, is also seen as providing a tremendous benefit for specific aspects of adventure therapy. Chapter 5 examines the varying impact that nature provides when it is used in adventure therapy.

By Whom?

In a study asking psychotherapists what they looked for when choosing a therapist for themselves, the top five qualities listed were competence, warmth,
caring, clinical experience, and openness (Norcross, Bike, & Evans, 2009). Three of these qualities—warmth, caring, and openness—are key characteristics of a therapist’s ability to form a relationship with a client (note these may or may not be skills within a therapist that can be enhanced). The other two—competence and clinical experience—have historically been very contentious issues in adventure therapy. There have been key historical figures who possessed little formal training in mental health yet helped “discover” the field, and by all accounts they performed competently. Furthermore, history has shown that any person (or organization) who can attract enough paying clients to be financially profitable can call himself or herself an adventure therapist, get a business license, and “hang out their shingle” to practice. If they are perceived by the public to be competent and can sustain their business with a steady stream of paying customers in good and difficult financial times, they may never be questioned unless they violate the ethical standard of “do no harm.” (Ethical issues in adventure therapy are dealt with specifically in Chapter 12).

However, most people are currently unable to radiate competence and clinical experience to the public without some measure of formal training. For many, competence in mental health practice results from obtaining a graduate degree from a recognized (and accredited) program and subsequently becoming licensed as a mental health practitioner in the state or province where they are working. Few programs exist that focus specifically on adventure therapy or wilderness therapy training in mental health. While a more formal model explaining five levels of professional development with adventure therapy is presented in Chapter 10, most current adventure therapy practitioners obtain a licensable mental health degree along with acquiring additional training in adventure skills from other sources. Some view the interpersonal skills required to conduct therapy as “soft” skills compared with the “hard” technical skills of working safely in the backcountry or on a challenge course or paddling, for example. Others believe the soft skills can take time to teach and may not always be possible to acquire if the therapist in training does not already possess some fundamental level of this quality. This debate will continue, perhaps not so much with programs that separate the adventure from the therapy, but certainly with programs that integrate the adventure as therapy.

Competence in adventure and wilderness technical skills for use by the adventure therapist is typically not as clear as obtaining a graduate degree in a licensable mental health field. Granted, there are a few dual-degree graduate training programs, workshops, and on-the-job training at reputable programs, but it is rare to see “one-stop shops” to obtain competence in hard skills in adventure therapy. This is especially true considering the different environmental conditions available to adventure therapy and different populations served. Many adventure therapists often partner with facilitators who are technical experts, although clearly the responsibility of providing a psychologically and physically safe therapeutic environment lies with the therapist.
Most Effective?

Most of what we know about effectiveness is covered in Chapter 13 on research and evaluation. To date, there have been no randomized control trials of any approach to adventure therapy that would measure up to the gold standard (e.g., saying a particular drug might be more successful than a placebo using a double-blind study). It should be noted that very few traditional psychotherapies live up to this standard, but many therapeutic approaches do have a body of knowledge that comes closer than adventure therapy to proving effectiveness seen in Chapter 13. At the present time, there are very few studies comparing adventure therapy approaches to traditional therapeutic approaches with specific populations. This is an area ripe for research.

For This Individual With That Specific Problem?

Many practitioners in the field of adventure therapy have used an integrative approach, but may not even know it. In illustrating this approach, the ABC~R triangle provides a visual representation of a system that helps adventure therapists initially assess and subsequently intervene with a client or client population (see Figure 3.1). As noted, the A domain of this model represents affect (e.g., feelings, emotion), the B domain represents behavior (e.g., actions, conduct), and the C domain represents cognition (e.g., thinking, knowledge). These various modalities provide access points (represented by the arrows in Figure 3.1) for this integrated approach to adventure therapy. However, there is no single, standardized sequence or modality to engage the client after entering the model through the access point provided by the clients story. The client’s actions, feelings, or thoughts help determine the “proper” path; some may need to start on the cognitive road, others on the affective road, while still others may need to be on the behavioral road. The selected path should be the one that best meets the client’s needs.

This integrative approach presupposes that the therapist meets the clients where they are and with what the clients offer as an access point (whether it be affect, behavior, or cognition) instead of fitting the clients into an existing program or theory. This means that the therapist will, in most cases, help to co-create the client’s path. Tailoring challenges to the clients fits more closely with Milton Erikson’s nontheoretical approach—or perhaps in more modern terms, transtheoretical approach (Haley, 1993). Our approach is transtheoretical in the spirit of DiClemente, McConnaughey, Norcross, and Prochaska (1986) and Prochaska and Norcross (2002). It acknowledges, values, and uses techniques and skill sets from five foundational psychotherapy approaches in the way they match clients’ presenting issues: psychoanalytic, interpersonal, cognitive, behavioral, and solution/systemic/narrative. We cover these five foundational therapies later in this chapter.

Note that relationships are central and critical to this model. This model include a general systems approach and views individual clients through the lens of their environment. The term system not only includes nature but also
peers, programs, family, schools, and community. A successful therapeutic alliance (Bachelor, Meunier, Laverdière, & Gamache, 2010; Horvath & Symonds, 1991) is critical for effective treatment. Similarly, the relationship between the therapist and the client or client group/family is directly related to the success of treatment (Pos, Greenberg, & Warwar, 2009). How the client and the adventure therapist, or the client and the field staff, connect is critical to the success of the adventure therapy process (which will be discussed further in Chapter 4). The long-term success of this process is often dependent on how the client integrates into the family and community posttreatment systems.

Adventure therapy is primarily a group and family treatment that views the peer and family group relationships as foundational to the process of how the therapy works. A high value is placed on the milieu of the peer group, using the impact of a positive (and negative) climate of peers. A solution, choice, and positive psychology focus (Gass & Gillis, 1995b) is also embraced in adventure therapy. This approach stresses what is working for the client and attempts to increase these feelings, actions, and thoughts instead of focusing on eliminating negative thoughts, feelings, and actions.

INTEGRATION OF TRADITIONAL PSYCHOTHERAPY INTO THE ABC-R MODEL

Affect

Foundational for much of psychotherapy are approaches emanating from the psychoanalytic and psychodynamic theories. Psychodynamic theories are
thought to require more insight than behavioral theories. Ringer and Gillis (1996) presented an overview of the thinking at the time and examined theories of psychotherapy based on how much insight was required on the part of the participant. They advocated matching psychotherapy theories to the capability of insight on the part of the client. The authors felt that a more psychologically mature client might benefit from either a psychodynamic or humanistic/interpersonal approach to psychotherapy where insight was considered necessary for behavior change.

Psychoanalytic approaches generally help clients move from concerns about what others think of them to living by their own set of rules (Luborsky, O’Reilly-Landry, & Arlow, 2007). There is a predominance of therapist direction in helping clients uncover issues that were previously beyond conscious awareness. In this therapeutic approach, there is a focus on re-experiencing early family issues or trauma and uncovering buried feelings that may be related to any current anxiety or depression that the client is experiencing. This approach relies on the ability of the client to have insight into their issues as the therapist guides them. There is an assumption that insight into the source of the issue can lead to understanding and therefore a change in behavior.

Following a psychodynamic-based approach to the ABC~R model involves using the relationship (or alliance) with the therapist and the activities themselves to unearth previously repressed patterns of thinking and behaving in clients. Because adventure therapy traditionally has involved a group component, the client’s habitual patterns of interaction may become more visible during this type of intervention. They may replay the way they interact in their family of origin with their adventure therapy group. For example, the addition of stress arising from being placed out of one’s comfort zone through a challenge course activity or wilderness experience may reach some clients’ defenses quicker than in a traditional talk therapy format. An intense focus on solving many of the initiative problems in a group format may also prevent clients from presenting their usual false selves, and thus will allow their true selves to be utilized in the novel experience. Once these real patterns are visible, psychodynamic therapeutic processes gradually enable clients to identify the origins of these dysfunctional patterns in their early lives, which are deeper levels of psychological depth. The clients’ internal representation of themselves as worthwhile people is gradually restored by repeated occasions when they find the therapist and other group members attentive, affirming, and providing reparation. Some might consider this approach as creating a corrective experience.

Interpersonal and humanistic therapies also emphasize insight on the part of the client, but also place more importance in the therapeutic relationship and less on the expertise of the therapist. The therapist is seen as more of an equal in this approach, but there is still the reliance on the clients gaining insight into why they feel or act as they do in order to make changes in their lives. The emphasis in this approach is on gaining a deeper understanding of
self and a desire to be more interpersonally authentic. This approach stresses mental health over mental illness and places importance on the clients’ experience and understanding of how they make sense of the world and embrace wellness. The emphasis on the client’s experience provides some confusion when adventure therapists are searching the literature for the terms *experiential therapy* due to techniques of some forms of interpersonal therapy approaches being labeled as experiential. The focus on developing openness and an ability to honestly express feelings in an accepting (nonjudgmental) environment is why many use this approach when working with clients who have emotional or affective issues.

Some adventure therapists also stress that clients focus on the “here and now” in order to stay fully present in the moment (i.e., being mindful) and guide them away from speaking or dwelling on the past or future. In some cases, programs do not allow clients to have watches or other references to the current time in order to facilitate being mindful of the current situation and their place in it (e.g., not focus on what they might be doing at this time if they were back in the environment they came from before therapy). This focus on the here and now is a therapeutic technique that has its roots in Gestalt therapy (Perls, 1969).

Another concept or technique borrowed from the humanistic tradition of transactional analysis is the no-discount contract (Medrick, 1977). In current experiential education and adventure therapy, it has been renamed the full value contract. Project Adventure changed the name (but not the intent) of this contract to put a positive reframe on it (Schoel, Prouty, & Radcliffe, 1988). The intent of the full value contract is a set of positive agreements the group agrees to, such as be here, be present, be safe, let go, and move on.

Gillis and Bonney (1986) drew parallels between the stages of the psychodynamically oriented psychodrama (Moreno, 1972), the phenomenological principles of Perls’ Gestalt therapy (humanistic), and adventure therapy. Instead of identifying a protagonist following warm-up activities as is done with psychodrama, an adventure therapist would use icebreakers to identify an issue common to the group and then present the activity to the group as a way to bring individual issues to the forefront and act upon them. The idea of the most pressing needs of the individual and group being right below the surface (consciousness) is consistent with the phenomenological principles of Gestalt therapy (Perls, 1969). Given the proclivity in Gestalt therapy for action/experiences, it is a natural theoretical fit for many group-oriented adventure therapists.

Hilsenroth, Blagys, Ackerman, Bonge, and Blais (2005) developed and tested the Comparative Psychotherapy Process Scale, which is based on distinguishing qualities of psychodynamic-interpersonal and cognitive behavioral therapies. Psychodynamic-interpersonal actions from their scale are listed below (note the word *patient* has been changed to *client* to be consistent with the ABC-R model). The following list provides examples of how an adventure
therapist might approach clients psychodynamically and interpersonally when working in the affective and cognitive domains of the ABC~R model:

- Encourage the exploration of feelings regarded by the client as uncomfortable (e.g., anger, envy, excitement, sadness, happiness)
- Link the client’s current feelings or perceptions to experiences of the past
- Focus attention on similarities among the client’s relationships repeated over time, settings, or people
- Focus discussion on the relationship between therapist and client
- Encourage the client to experience and express feelings in the session
- Address the client’s avoidance of important topics and shifts in mood
- Suggest alternative ways to understand experiences or events not previously recognized by the client
- Identify recurrent patterns in the client’s actions, feelings, and experiences
- Allow the client to initiate the discussion of significant issues, events, and experiences
- Encourage discussion of the client’s wishes, fantasies, dreams, or early childhood memories (positive or negative)

Psychodynamic and interpersonal techniques or interventions are suitable approaches to access clients who present with affective (emotional) issues because they are more process and relationship oriented, especially when the client is willing to participate and is cognitively able to gain insight.

Behavior

While one axis that might be used to match psychotherapy theories with client populations could be the level of insight the participants are judged to be capable of, another axis might be how willing the participants are to be involved in adventure therapy. For example, adolescents who have been sent to adventure therapy tend to be more resistant or reluctant to receive therapy than participants who choose to come voluntarily. These clients are more likely to benefit from psychotherapy approaches that initially access the behavioral aspect of the triangle.

An approach to the ABC~R model that uses the initial access point of behavior typically takes advantage of implementing both the natural environment and the human interaction to provide concrete consequences (both positive and negative) for participants’ maladaptive behavior. The hope is that participants learn to identify the triggers of their negative behaviors, as well as new or even forgotten prosocial behaviors. Through this process, they begin
to behave in ways that are likely to be appropriate for the environment where they will return after the program has ended.

Purely behavioral approaches have been used with clients with impulse control issues who wish to gain rewards without consequences. Little to no insight is expected on the part of the client beyond understanding that if they engage in certain negative behaviors, consequences will follow; as well as if they engage in other positive behaviors, there will be rewards. Often the black-and-white, “no excuses accepted” approach to working with resistant adolescents provides behavioral boundaries in response to their actions in a way that helps them understand how the therapy approach works. As feedback is given to clients about their behavior and they are able to understand it, a cognitive dimension is entered and the connection between what the client is doing and the thinking (or cognitions) behind their behavior becomes the focus of treatment.

Sometimes behavioral interventions are used to establish a stable climate in the group. As an example, a wilderness therapy group may agree to meet a time limit in order to receive a special reward (e.g., dessert) that evening. The application of behavioral principles to adventure interventions is more 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. Many programs for offenders use behavior-oriented strategies (group applied consequences) with the intent of the externally applied rewards and consequences transferring to internalized rewards by group members. One example of this type of programming is the Behavioral Management through Adventure (BMTA) program associated with Project Adventure (Gillis & Gass, 2010). BMTA programs use a form of the full value contract. This form of the full value contract asks the group:

1. To understand and/or create safe and respectful behavioral norms under which it will operate
2. To make a commitment to those norms (by everyone in the group)
3. To accept a shared responsibility for the maintenance of those norms

The key to using the BMTA model with adolescents is structuring the peer group in a formal, constructive way for clients and staff to confront behavior, express feelings, or address the consequences of breaking behavioral rules. The group process follows a model of “control to empowerment” (Simpson & Gillis, 1998). In this model, clients are taught a process of discussing and voting for logical consequences for violations of the group contract. This move toward empowerment allows group members to conduct their own groups, with staff serving as consultants. The control-to-empowerment philosophy employs Bandura’s concept of modeling (Sermabeikian & Martinez, 1994) to turn over control of the group (under staff’s supervision and when appropriate) to the clients as the group demonstrates appropriate capacity.
In this process, group norms are developed by the clients, with staff adding vital elements the clients may have missed. The whole group (staff included) commit to upholding these norms, being individually responsible as well as holding the group responsible. The group checks in with their commitments through the full value contract once a day to see how they are doing. In this way, the whole group understands what behaviors are expected by hearing their peers describe their commitments in behavioral terms; group members are held to these behaviors through regular check-ins.

One overriding principle in the BMTA model is the concept of “calling group.” Clients and staff may call group at any time. When group is called, all members stand in a circle, listen as the caller presents his issue, discuss the issue, and decide if a consequence is needed, and, if so, what consequence would be appropriate. Calling group enables the therapeutic cohort to learn functional behaviors by providing clients the power to care for themselves and others. Calling group is a way to explore feelings, praise peers, praise oneself, or just check-in.

Another core element of BMTA programs is the use of adventure activities. The activities are developmentally structured (e.g., a group that has just met would not do an activity that requires trust, but would build trust incrementally through activities). They also are often enjoyable (but not just fun) and require real assets that direct BMTA clients to learn skills such as patience, listening, seeing another’s point of view, leading, following, planning, and acknowledging consequences.

BMTA staff often use the behavioral scanning technique called GRABBS when working with groups (Schoel et al., 1988). The acronym GRABBS was developed by Project Adventure as a scanning device for helping facilitators to remember important domains when assessing their groups in the moment. GRABBS stands for Goals, Readiness, Affect, Behavior, Body, and Stage (with an additional S added later for Setting; Schoel & Maizell, 2002). The acronym evolved from BASIC-ID (Lazarus, 1981), a mnemonic device to help therapists be thorough in their assessments of clients that stands for Behavior, Affect responses, Sensory reactions, Images, Cognitions, Interpersonal relationships, and Drugs. The GRABBS scanning device has proved invaluable to many leaders in the moment-to-moment microassessment of their groups, the individuals within their groups, themselves, and their clients (i.e., whoever is paying the bill for the service, such as parents or a government agency). Other assessment models exist for facilitators of adventure experiences, such as the wave model (Lung, Stauffer, & Alvarez, 2008).

Cognitive

Cognitive therapies use an approach that involves understanding thinking that is not correct (or is irrational), and changing it as well as the behavior that is
connected to that thinking. Homework is often prescribed in which clients test beliefs they have about the world to see the accuracy and functionality of their assumptions. By identifying and understanding the distorted and unrealistic beliefs, clients are able to change the way they act upon them.

Glasser (1965) developed a cognitive behavior approach widely used in some adventure therapy programs called reality therapy. Reality therapy was an approach that could be taught to paraprofessionals and, perhaps because of the word reality being in the title, was thought by some to correspond with the natural and logical consequences inherent in adventure therapy. The use of natural and logical consequences, however, has its origins in the work of Alfred Adler and parenting training programs based on the work of Rudolph Dreikurs, who was a student of Adler’s (Dreikurs, Greenwald, & Pepper, 1982). The reality therapy approach to problem solving focuses on the here-and-now that the client is experiencing and helps the client create a better future. It is based on the idea that humans have five basic needs: survival, love and belonging, power, freedom, and fun. An environment that embraces these five needs helps clients to get their needs met and enables them to develop a plan focused on what works. Another concept of reality therapy that appeals to many adventure therapists is the focus on no excuses, no punishment, and never giving up. This approach is still in use today, as evidenced by its explicit mention on the website of Eckerd Youth Alternatives (http://www.eckerd.org/services/out-of-home/juvenile-justice-residential/).

Cognitive behavioral strategies, as presented by Hilsenroth et al. (2005), include:

- Give explicit advice or direct suggestions to the client
- Actively initiate the topics of discussion and therapeutic activities
- Focus discussion on the client’s irrational or illogical belief systems
- Suggest specific activities or tasks (homework for the client to attempt outside of session)
- Explain the rationale behind the therapist’s technique or approach to treatment
- Focus discussion on the client’s future life situations
- Provide the client with information and facts about his or her current symptoms, disorder, or treatment
- Explicitly suggest that the client practice behavior(s) learned in therapy between sessions
- Teach the client specific techniques for coping with symptoms
- Interact with the client in a teacher-like (didactic) manner

Again, in the previous strategies, the term patient was changed to client to be more consistent with adventure therapy approaches. The interventions are provided here as appropriate for intervening with clients in their behavioral and cognitive domains.
Behavioral and cognitive interventions are suitable approaches to access clients who present with behavioral or cognitive issues because they are more outcome and results oriented. This is especially true when the client is initially unwilling to participate and is not necessarily able to gain insight into why they are acting as they do. Starting with behavior and proceeding to cognitive base is a common path for many adventure programs. But in the timeless words of the ever-centered Mark Ames (personal communication, October, 31, 2009), “It’s really all about the relationship.”

Relationships

Systemic therapy attempts to address people in a relationship with others in their sphere (e.g., peer group, program staff, family, school, community) and how they interact. The field has its roots in the interactions of a client’s family of origin. Systemic therapy approaches problems in a practical manner, much like cognitive behavioral approaches (whereas many psychodynamic approaches use a much deeper manner). Systemic therapy attempts to identify dysfunctional patterns of behavior and directly work with those patterns. There may be a focus on how tight or loose the boundaries were within the family, which can be determined by examining questions such as the following:

- Did everyone know everything that occurred with the family (complete permeable boundaries and an enmeshed family), so that there was no privacy?
- Was the family full of secrets, so that no one knew anything about anyone else and no one from the outside knew anything that occurred within the family (an abusive family pattern)?

These are ways of describing how family patterns influence clients (and their families) in their relationships with the adventure therapist, the staff, and peers in their group. It is not uncommon to hear an adventure therapist say the phrase “meet the parents and meet the problem” when working with adolescents. Experience tells us that there is some level of truth to this comment when examining this concept through a systems lens.

An understanding of how a client perceives relationships—especially clients who have family histories that include such things as trauma, substance abuse, divorce, and stepparents—is helpful in understanding how they will interact during the adventure therapy program. Much of the understanding of the family system, especially when the group is a family, can help the adventure therapist determine how and why the client is entering adventure therapy and how resistant or willing they are to embrace change.
WHO PARTICIPATES IN ADVENTURE THERAPY?

Using the CHANGES model (Gass & Gillis, 1995a) we described in Chapter 7, the context of how a client views their need for change and their level of insight are important factors in how they initially respond to adventure therapy. Russell (2008) examined adolescents admitted to outdoor behavioral healthcare programs. The clients in his sample were found to exhibit the characteristics listed in Table 3.1 upon admission. Participants who answered questions placing them in an uninvolved category were the largest group, followed by those deemed reluctant to engage in therapy, and finally those who were willing to participate were the minority. These figures mirror the clients being treated in adventure therapy programs. Russell’s categorizations are by-products of a measurement of the stages of change by Prochaska and DiClemente (1983). This theory rings true to many adventure therapists as a way of conceptualizing how clients enter and engage in treatment. The stages of this model are presented in Table 3.2.

The original Stages of Change theory comes from smoking addiction research and led to a transtheoretical model of psychotherapy (Prochaska & Norcross, 2002), which has been built upon in the design of the ABC~R model. It is one way to conceptualize where clients are as they approach treatment and allows the therapist to best match a treatment approach to the client’s particular frame of reference.

Russell and Gillis (2007) also found that most clients entering adventure therapy programs meet the criteria for a substance use disorder. If this is correct and most clients who come into an adventure therapy session/program are reluctant or resistant adolescents who have substance use issues, how can the adventure therapist be most effective? Based on actual client experiences, several fictionalized case studies are presented in the following sections to illustrate the ABC~R approach.

<table>
<thead>
<tr>
<th>TABLE 3.1 Stages of Change Clusters</th>
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<tr>
<td>Cluster Name</td>
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| Uninvolved | • Not contemplating change  
• Not engaging behaviors to change  
• Maintaining the status quo | 44.1 |
| Reluctant | • Reluctant to take action on a problem  
• A sense they might be thinking about it  
• No commitment to change | 28.7 |
| Participating | • Not ignoring the presence of a problem  
• Engaged in thinking about the problem  
• Taking some action in changing the problem  
• Maintaining some of these actions | 27.2 |
CASE STUDIES

Three case studies are used here to highlight how adventure therapy can be tailored to clients when given their presenting issues.

Jamie

Jamie, a 17-year-old who is suffering from a mood disorder, is perhaps dealing with a combination of depression and anxiety. Jamie is referred to an adventure therapist’s group who operates in an outpatient private practice. Jamie has not experienced any success in traditional one-to-one “talk-only” treatment and has been noncompliant with taking prescribed psychotropic medications. Jamie is angry at seeing yet another therapist—especially one who uses groups. The feelings that Jamie is having may provide initial access through the access point of affect. Developing an intervention through the use of an adventure experience that allows access to other feelings (e.g., going to the top of a challenge course element and having to make decisions about jumping to hit a large red ball or not) may be what the therapist chooses to tailor to Jamie’s affective issues. The therapist may also intervene using the following techniques:

- Encourage the exploration of feelings regarded by Jamie as uncomfortable (e.g., anger, envy, excitement, sadness, or happiness)
- Address Jamie’s avoidance of important topics and shifts in mood
- Suggest alternative ways to understand experiences or events not previously recognized by Jamie

Taylor

Taylor, age 16, has a history of outbursts with his parents, substance use issues, failure in several schools, and a lack of progress in working with his most recent counselor in an outpatient setting. Taylor would appear to present behavior as an access point to beginning adventure therapy in a wilderness program. One could initially say that nature was a behavioral therapist, focused on rewards and natural consequences. If the tent was set up securely,
the stove functioned properly, and the weather was cooperative, the rewards of food and shelter would follow. If food was left in a pack or it was too dark, windy, or wet to cook, the natural consequences would be immediately obvious. Experience has shown that many adolescents like Taylor are angry at having been sent to therapy by their parents; this anger might come up when Taylor must take responsibility for the natural consequence. Therefore, identifying what triggered Taylor’s angry/hurt feelings and providing more functional alternative ways to respond may result in learning that lasts. Using positive letters from parents can also work toward beginning to rebuild family relationships after Taylor has learned the boundaries (rules) of the program.

Taylor exhibits behaviors that need to be brought under control in order for the adventure therapy process to take place. The therapist may intervene using the following techniques:

- Provide Taylor with information and facts about his current symptoms, disorder, or treatment
- Explicitly suggest that Taylor practice behavior(s) learned in therapy in the coming days
- Teach Taylor specific techniques for coping with symptoms

Jordan

Jordan is a 15-year-old at a residential treatment center struggling with mood regulation related to attachment and trauma issues. Jordan is adopted and struggling with questions about being adopted. Jordan’s issues are primarily cognitive. In addition, Jordan is having self-worth and identity issues. As a result, Jordan is acting out sexually and defiantly, as well as having a past dominated by substance abuse. Jordan presents with the cognitive dimension as the initial access point. Jordan wants to know why.

In the first phase of the program, Jordan should work on self-disclosure of painful past deeds and expressing anger, frustration, and sadness about being placed in treatment. As a substance abuser, Jordan is often engaging in thinking errors about the ability to maintain sobriety or lower the risk for using upon leaving treatment. Jordan is planning to return and live with the same drug-using peer group as prior to treatment. These thinking errors or errors in cognition provide an entry to this integrated approach to adventure therapy. Perhaps the adventure therapist can design an activity that will match Jordan’s thinking errors and allow Jordan to understand how “rational lies” will impact the success of staying sober while going back to the same environment. The therapist can also use the following approaches:

- Give explicit advice or direct suggestions to Jordan
- Focus discussion on Jordan’s irrational or illogical belief systems that are revealed in response to challenging activities
• Tailor the activities to draw out or highlight Jordan’s belief systems and thoughts about the future

OTHER CONTRIBUTIONS TO UNDERSTANDING THEORY

In addition to the work of Project Adventure with adventure-based counseling (Schoel et al., 1988; Schoel & Maizell, 2002), Newes (2001) provided an extensive description of how adventure therapy intersects with several traditional psychotherapeutic theories, especially the psychodynamically oriented object relations theory and cognitive behavioral therapy. The reader is encouraged to read her full descriptions.

In her conclusion to these descriptions, Newes noted that the benefits of group experience, problem-solving activities with tangible outcomes, the use of the unfamiliar environment, immediacy of the therapeutic relationship, the opportunity to disprove negative self-evaluations, the success associated with increases in self-efficacy, and the power of modeling both therapist and peer behavior are critical factors of adventure therapy. Combined with object relations-based processing and cognitively based processing over a period of time, this combination is believed to help develop a unique and beneficial process for therapeutic change.

SUMMARY

This chapter presented an adventure therapy response to Paul’s (1967) ultimate question—“What treatment, by whom, is most effective for which individual with what specific problem, under which set of circumstances?”—by offering an integrative approach to psychotherapy. This approach begins where the client is, with what they present to the therapist in terms of affect, behavior, and cognition. It then connects this information to the relationship of therapist to client, client to peer group, and client to larger systems (e.g., family, school, community) that are part of the change maintenance process.

In many ways, in The Wizard of Oz (Baum, 1900), the real wizard of facilitating change for Dorothy and her colleagues may have been Toto the dog. In the story, there is seemingly very little attention paid to Toto. But at critical times throughout the movie, Toto provides facilitative guidance of affective, behavioral, and cognitive support for the characters, similarly to how the adventure therapist guides clients. In addition, Toto helps to facilitate their individual as well as group development through different yet purposely structured relationships, which serves them well in strengthening their resolve for the challenges they face. Most importantly, as each group member accomplishes their goals, their success is attributed to themselves and not to Toto, the therapeutic facilitator of change.
A COOPERATIVE SAILING CHALLENGE

Lorri Hanna

A wilderness therapy program located in the Midwest enrolled six girls into their summer adventure program due to their difficulty coping with certain challenges in their lives (e.g., poor school performance, depression, low self-esteem, underachievement, family discord). As part of admitting circumstances, the girls displayed social withdrawal, poor coping, ineffective communication skills, and distorted thinking patterns. A personal development plan (treatment plan) was created with each student to include three focus areas (e.g., relationships, communication, boundaries) and action steps. The program consisted of three phases totaling 6 weeks of backpacking, rock climbing, service learning, and canoe expedition balanced with an emotional growth curriculum consisting of structure, consistency, and accountability. It was important as a group to initially establish a set of agreements (norms) as a foundation for building trust and an emotionally safe environment that would encourage the girls to take responsibility for their own process and healing. Prior to graduation, individual family sessions added to their efforts to repair and restore their family relationships and prepare for transition.

The final phase of the program was the canoe expedition. After several days on the lakes honing canoe, paddle, and portage skills, the girls were presented with a group challenge. Using only three paddles, two canoes, a large tarp, cordage, and life jackets, the group was to build a vessel to transport them as a team across the lake to their campsite. Instructors provided water-based supervision and only intervened when safety warranted.

After 45 minutes of observing old behavior patterns (e.g., activity refusal, ineffective communication), combined with their newly learned tools of problem-solving and listening, the girls created a sailboat using the tarp as their sail and a paddle as their mast to successfully make their way across the bay. During the debriefing of the activity, the girls attributed their success to implementing newly learned problem-solving skills and using intentional dialogue as a way to give each girl a voice to contribute to solutions and work as a team (family). Discussion ensued as to how these behaviors could help them at home, school, and in their families. The girls expressed enthusiasm and pride in their accomplishments, and this experience became a turning point in the group cohesion and future personal processes for the remainder of the canoe expedition.

At the conclusion of the 6-week session, the girls were anxious yet excited to share their learning with their parents and took emotional risks during their 2.5-hour family sessions that demonstrated effective dialogue skills, increased confidence, accountability, and solution-focused transition goals. This ability to work cooperatively through challenging activities while demonstrating and recognizing positive behavioral change is an example of what I call adventure therapy.

I became an adventure therapist in the early 1980s while working as a wilderness counselor with at-risk and adjudicated adolescents in Virginia, my first employment during graduate school. I was passionate about backpacking and climbing and valued the self-exploration I found in the wilderness. It was important to me to share that passion with others because I believed in the therapeutic value of wilderness travel. My graduate studies in therapeutic recreation, combined with outdoor leadership and wilderness medicine courses (e.g., Wilderness

http://www.routledgementalhealth.com/adventure-therapy-9780415892902
Education Association, Outward Bound, Wilderness First Responder) and my personal experiences, paved my way toward adventure therapy.

In various professional positions, resourcefulness was essential to adapting adventure activities for individuals with cognitive or physical challenges. I saw the therapeutic value of using “lobster claws” and old mattresses inside a low-element Burma bridge for clients with muscular sclerosis so that they too could have a success-oriented physical challenge while trusting the process, access skills they thought they lost, and feel empowered to make decisions. The adjudicated and high-risk youth I worked with needed to experience healthy recreational activities and a sense of belonging and connection. Adventure therapy activities provided the structure to bring about change, develop group cohesion, encourage cooperation, and create a feeling of self-worth.

I have since become a Licensed Professional Counselor and founded a wilderness therapy program providing adventure therapy practices to clients of all ages. My passion continues and is shared with colleagues, clients, and interns entering the field of adventure therapy.