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ADVENTURE THERAPY WITH GROUPS

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Slavson and Moreno, pioneers of group psychotherapy, used activities as a primary method of change in their group work (Scheidlinger, 1995). Gillis & Bonney (1989) noted that if adventure-based activities were known during Moreno’s heyday, he would probably be an adventure therapist as well as a psychodramatist. While the activity base for group work was generally abandoned for many years for the extensive use of “talk therapies,” it has been “rediscovered” by art, music, wilderness, recreation, and other experientially based group therapies. The purpose of this chapter is to introduce the concepts of adventure therapy and provide readers with a rationale for the use of adventure experiences in group therapy.

Gillis & Thomsen (1996) presented a global view of adventure therapy, placing it within the larger field of experiential therapies. In this view, adventure therapy is an active and experiential approach to group psychotherapy, utilizing an activity base (e.g., cooperative group games, ropes courses, outdoor pursuits or wilderness expeditions) and employing real and/or perceived risk (physical and psychological) as clinically significant agents to bring about desired change. Clients make meaning through insights that are expressed verbally, nonverbally, or unconsciously and lead to behavioral change. This is done from both verbal and nonverbal introductions prior to the experience as well as discussions following the experience (e.g., debriefings).

Advanced techniques of adventure therapists include the use of metaphor, where the reality of the adventure experience is linked with the clients’ issues. The use of metaphor is rooted in the psychotherapy work of Milton Erickson (Haley, 1973). Bacon (1983) and Gass (1993) advanced the use of metaphors in the presentation of therapeutic adventure experiences. Most of the therapeutic interventions used by adventure therapists are grounded not only in Erickson’s work but also in the experiential approaches of Moreno (Blatner & Blatner, 1988), Perls (1969), Satir (1972), and Whitaker (Whitaker & Keith, 1981). Thus, many of the origins of adventure therapy can be traced to the stress-challenge experiences associated with taking groups into wilderness environments for recreational purposes (Bacon & Kimball, 1989) and the activities associated with team building through the use of challenge course experiences (Rohnke, 1989; Schoel, Prouty, & Radcliffe, 1988).

The object of this chapter is to (a) present a brief history of adventure therapy, (b) provide examples of adventure activities used in group work, (c) outline the rationale behind adventure therapy processes, (d) present a case study depicting adventure therapy assessment techniques and interventions, (e) summarize the research supporting adventure therapy, and (f) discuss ethical guidelines and professional issues for those who use adventure therapy with groups.

Brief History of an Adventure Approach to Group Work

Gillis & Ringer (1999) noted that adventure therapy has much of its documented history in the philosophies of experiential learning inherent in Outward Bound, a wilderness-based program teaching self-discipline and teamwork through adventure experiences (Bacon, 1983). Kurt Hahn, who helped shape the foundations of the Outward Bound movement, may be considered one of the first adventure therapists, due to his work with young soldiers in the 1940s and his attempts to develop within them a “will to live” through the use of challenging adventure experiences (Thomas, 1980). Kelly & Baer (1968) demonstrated that a 21-day standard Outward Bound course for groups of adjudicated youth was more effective in reducing recidivism and less costly than traditional treatment for adolescents in correctional programs. This finding alone led many states to invest in this therapeutic way of working with groups of youth in wilderness environments.

Davis-Berman and Berman (1994) documented the therapeutic use of the outdoors as early as the 1900s, when groups of hospitalized tuberculosis patients were taken out of doors to camp in tents on the hospital grounds as a way to quarantine them. These reports of dramatic physical and attitudinal improvements from the patients regarding the outdoor therapeutic experiences were like the tenting of the tuberculosis patients. Behavioral change was seen from the impact of the environment where the groups were conducted.

The field of therapeutic uses of adventure experiences, however, suffers from semantic confusion (Roland, Keene, Dubois & Lentini, 1988). The multiplicity of terms used to define adventure therapy can include adventure therapy (Gass, 1993); adventure-based counseling (Maizell, 1988; Schoel et al., 1988), experiential-challenge (Roland, Summers, Freidman, Barton, & McCarthy, 1987), outdoor-adventure pursuits (Ewert, 1989), therapeutic adventure programs (Wichmann, 1991), therapeutic camping (Rice, 1988; Walton, 1985), and wilderness therapy (e.g., Bacon & Kimball, 1989; Davis-Berman & Berman, 1994; Levitt, 1982; Russell, 2001). For simplicity, we use the term *adventure therapy*.

Adventure Therapy Settings

There are three primary locations in which adventure therapy operates: (1) on challenge/ropes courses and through the initiative experiences associated with adventure therapy approaches, (2) in wilderness settings (e.g., Outward Bound, 20-60 day wilderness travel programs), and (3) through residential camping (e.g., stationary, primitive living programs) (Crisp, 1998; Gass, 1993). These adventure therapy group experiences are primarily characterized by the length of time involved and the type of programming used. In this chapter, we focus on the use of adventure therapy in traditional group work. However, readers should be aware that the other two approaches have demonstrated interesting and often effective psychotherapeutic approaches,

particularly with youth at risk (e.g., Hattie, Marsh, Neill, & Richards, 1997).

Based on a survey of 47 programs, Gillis and colleagues (1991) identified adventure therapy programming in terms of the overall goals of programs and the characteristics of participants. Therapeutic programs were described as focusing primarily on educational or enrichment goals (i.e., where change was attained through a focus on generic issues of the target group) or on adjunctive parts of larger treatment systems (i.e., where change was achieved through adventure experiences in combination with other therapies), or were involved in primary therapy (i.e., where change was obtained solely through adventure experiences in lieu of other psychotherapies). Programs with enrichment goals were typically offered to a wider range of groups with (relatively) less specificity in treatment objectives, while primary therapy programs generally involved smaller, more dysfunctional groups with greater amounts of time spent in assessment and design of interventions.

An Adventure Experience

One adventure therapy experience that served as adjunctive therapy was Walk the Talk. It was developed for a coed relapse prevention group of adult substance abusers in the recovery process. The group was a traditional group for relapse prevention, and this activity was added during the last 45 minutes of a one time per week, 3-hour relapse group session with approximately 15 people. The title of the activity was selected to punctuate the experience's connection to what group members face once they leave the therapy room. Naming activities for clients to fit the objective of the experience is common practice for isomorphically framed adventure therapy experiences (i.e., experiences with parallel processes with treatment issues).

The experience presented emphasized the following treatment goals: (a) maintaining a drug-free lifestyle, (b) identifying, staying connected to, and having a strong focus on the elements maintaining abstinence, and (c) strengthening clients' resistance to the social pressures that tempt them to begin using drugs again.

The adventure experience used for the treatment objectives was the Stepping Stones activity (Gillis & Simpson, 1994; Rohnke & Butler, 1995). The equipment included (a) two ropes to mark the "beginning" and "finish" or "end" lines, (b) a flat, unobstructed distance of 60 to 100 feet, and (c) one prop per person on which words could be written. Examples of props could be rug pads, rubber or plastic circles, or paper plates about the same size as a client's foot. The objective is to get from one end line to the other without touching the ground in between the beginning and end lines. Group members are positioned behind the beginning line and provided with approximately 25 minutes to get to the finish line. Anyone touching the ground between the lines was required to return back to the beginning. If at any time during the experience anyone lost physical contact with any prop, the group lost the use of that prop. For physical safety considerations, the group was told not run, jump, or throw props. Participants could not climb on one another's backs to make it across to the finish line.

The presentation of the activity to the group was stated in a circle where everyone could see one another and the group leader. The leader said:

It's been good to be together for the last couple of hours and share your triumphs as well as your concerns about your recovery process. And even though we've addressed some hard topics, it actually is almost too comfortable here in this room! I say this because while it's tough looking at the things we've addressed today, it is almost certainly going to be tougher for all of you when

you step through the door of this room at the end of our group meeting. You know it is not a matter of **if** you will be tempted to use drugs again, but **when** you will face this decision. And this decision may not come from strangers, but a lot of times from people you know best and who may be close to you.

One of the great things we have gone over in treatment were the qualities, commitments, and elements you feel will help you stay drug-free. And in our discussions, it seems the more committed and connected you stay to these elements or qualities, the more likely you are to make it back into this room next week drug-free.

Here is what the final activity of our time here today is about: (1) how to make it back to this meeting next week drug-free, (2) how to stay connected to those things helping you maintain your abstinence, and (3) how to strengthen your resistance to the temptations that try to get you to use drugs again.

Before we begin, I want you each to take a plate (prop) and write on the back of it one to three words describing a quality or element you think will help you stay drug-free over the next week if you stay connected to and focused on it. After you've done this, let's go around the circle and have each person share what they've written and briefly describe the reason why they feel staying connected to and focused on this quality is so important.

(After everyone has shared their quality) Okay, please join me over here on this flat stretch of ground behind this line. Behind this line represents us right now in this room: Confronting in some ways, but in others pretty safe and comfortable. The truth is we can't stay in this room forever! In 45 minutes or so we are all going to walk out that door and be in places over the next week that are going to challenge our abilities to stay drug-free. There is probably no better time than now to start practicing for those challenges. After explaining the rules of the activity, I am going to give you 5-7 minutes to plan and talk as a group on how you might want to consider going about this process.

Here's the deal. You need to get from this beginning line over across the line 90 feet away, just like you need to get from where you are today back to this room next week. As you go from line to line, you cannot touch the ground. If you do, you need to return to the beginning of this line. The only way you can cross from "today" to "next week" is by using your qualities (i.e., plates) as protection to step on and get across to the other line. As long as your foot remains on your plate and no other part of your body touches the ground (e.g., arm), you're fine.

You also must stay in constant contact with your resources. If at any time you lose connection with your plate, even for a split second, I (representing addiction) will get to take your resource from you. I may even tempt or trick you into giving it to me, so just as you need to be on a constant vigil throughout this coming week, you also need to have that level of attention to these qualities during the activity.

As a group, you have 25 minutes to get over the finish line. If anyone touches the ground between the ropes, they must return back to the beginning. At any time or instant a person loses physical contact with any resource, the group loses that prop to me. If there are no questions, your five minutes of

planning begins. Good luck.

The group began the experience. Some members were diligent in literally hanging on to the paper plates with the recovery elements written on them. They also were incredibly attentive when placing their plates on the ground to step on them. While slow but sure, individuals in this subgroup advanced slowly toward the end line with a few minor slip-ups along the way. Others were less diligent in paying attention to their task, and their progress was hampered by losing plates when they did not maintain physical contact and they became distracted by other group members' needs. Several members lost so many plates it became impossible for them to complete the task.

With this group, debriefing this experience focuses on (a) the therapeutic objectives of the activity (i.e., maintaining a drug free lifestyle, (b) staying connected to abstinent behaviors, and (c) strengthening clients' resistance—and how they relate to the clients' coming week. Key to this process is punctuating the isomorphic (i.e., parallel) connections between the insights and learnings during the activity to the parallels existing within clients' lives. One reality is the literal "walking of their talk" of staying drug free by being in contact with the very concepts they have identified as key elements of their sobriety. In a different yet important and similar reality, "walking of their talk" means staying drug free by implementing these concepts in their lives for the coming week. Hence, successful resolution of adventure therapy experiences mirrors and provide guidance and meaning to successful resolution of the therapeutic issues. This concept is critical to all successful adventure therapy frameworks.

A Rationale Behind Adventure Therapy

Based on over 30 years of evolving practices and research with adventure therapy, the following six points provide a generally accepted rationale to support the use of adventure therapy in groups:

1. Multiple and corroborating representations of reality.

Using adventure experiences with clients often turns passive therapeutic analysis and interaction into active and multidimensional experiences. Didactic and verbal processes are augmented in adventure-based groups by concrete physical actions and experiences. Clients' behaviors are viewed from another perspective; they are asked to "walk" rather than merely "talk" their behaviors. Therapeutic interaction becomes observed and holistic, involving physical and affective as well as cognitive interaction for the purposes of examining client patterns and beliefs.

As seen in the previous therapeutic experience, clients are literally on one level and figuratively on another level walking the talk of their therapeutic issue and potential resolutions to issue. As illustrated above, insight is received from personal actions, language, thoughts and belief systems, and feelings and perceptions.

2. Contrasting experiences.

The unfamiliar adventure experience created provides a medium that is "contrasting" to a group member's current reality state. Contrast in adventure experiences is utilized by clients to see elements of their lives that tend to be overlooked and gain new perspectives. Group members' entry into a contrasting experience is often the first step toward reorganizing the meaning and direction of their life (Priest & Gass, 1997b; Walsh & Golins, 1976). It is important

to remember that what is unfamiliar for one person may not be for another. Therapists using adventure experiences work to ensure that the quality of unfamiliarity is met to achieve the goals of this concept.

Obviously, most people don't go around stepping on plates or rug pads as part of their everyday life, let alone as a step in their recovery process. This "unfamiliar difference" provides the engaging contrast described earlier while still maintaining structural similarity for treatment effectiveness.

3. Production of "eustress" as a motivational agent for change.

When properly implemented, adventure experiences introduce eustress, or the healthy use of stress, into the group member's system in a manageable yet challenging manner. This type of stress places individuals into situations where the use of certain positive problem-solving abilities (e.g., trust, cooperation, clear and effective communication) is necessary to reach a desired state of equilibrium. The process of striving to attain this state of equilibrium is sometimes referred to as "adaptive dissonance" (e.g., Priest & Gass, 1997b; Walsh & Golins, 1976), where group members must change their behaviors to achieve desired states. The adaptive processes used to create change are often healthy and functional structural patterns for rectifying group members' dysfunctional behaviors. These patterns and processes (as seen in the case study to follow) often provide the processes and means for clients to achieve therapeutic objectives.

Combined with the activity's contrast is the appropriate use of physical and emotional eustress. This quality differentiates this therapeutic process from other experiential therapies, often serving as a catalyst in the client change process.

4. Conflict resolution patterns to structurally implement change.

Adventure experiences are usually designed with internal mechanisms of resolvable conflict. These mechanisms use experiences that are organized, incremental, concrete, manageable, consequential, and holistic (Priest & Gass, 1997a; Walsh & Golins, 1976). Adventure experiences are organized to meet the needs of the group and are sequenced progressively (e.g., conducted incrementally in terms of complexity and consequence). Groups begin with easier tasks and gather senses of competency and mastery from accomplishing these tasks, then attempt more difficult tasks with an established base of increased skills and confidence. Adventure experiences are concrete and easy to define in terms of content (e.g., tasks are easily recognizable and typically visually stimulating; tasks generally possess a definite beginning and end). While initially appearing insurmountable to many clients, adventure experiences can be managed or accomplished by groups with the resources they possess. Initially, resources and the method in which the resources need to be coordinated may be unclear to some groups, but their abilities to accomplish the task are based on their abilities to manage these resources with personal skills. Adventure experiences are consequential, and the results, positive or negative, generally have an immediate, nonarbitrary, and direct effect on clients. Adventure experiences address a variety of learning domains, including cognitive, social, emotional, and psychomotor learning. Combinations of these learning domains provide a holistic perspective on how to help clients change.

5. Solution-oriented structures.

Entering therapy can be extremely threatening, heightening client defense mechanisms and resistance to change. Most adventure experiences possess the natural occurrence of solutions in their structure. With unfamiliar adventure experiences, group members are presented with

opportunities to focus on their abilities rather than on their dysfunctions. This type of orientation diminishes initial defenses and leads to healthy change when combined with the successful completion of progressively difficult and rewarding tasks. Rather than being resistant in therapy, group members are challenged to stretch perceived limitations and discover untapped resources and strengths. Group member efforts are also framed by the therapist to center on the potential to achieve self-empowerment by establishing and maintaining functional change.

Walk the Talk engaged clients in their search for elements leading them to the successful resolution of issues concerning the maintenance of their sobriety. This search possessed elements related to the solution to this issue, not reasons why sobriety could not be achieved or maintained. Problems are not “ignored” in such a process, but handled in a way that focuses clients on their abilities to place themselves in situations where the problems don’t exist or are not as strong in certain circumstances. Such a process leads to the engagement of resources and strengths, which often diminishes the problem focus even further.

6. Changes in therapist’s role.

Adventure therapy experiences change the role of therapists from passive and stationary to more active and mobile. Therapists are encouraged to actively design and frame adventure experiences around critical issues for group members, focusing on the development of specific treatment outcomes. When utilizing adventure experiences with groups, adventure-based therapists are removed from serving as the central vehicle of functional change. The “experience” takes on the central medium for orchestrating change, freeing therapists to take on a more “mobile” role (e.g., for supporting, joining, confronting) in the coconstruction of change processes with the group. Combined with the informal setting of adventure experiences, the dynamics of this approach remove many of the barriers limiting interaction. While still maintaining clear and appropriate boundaries, adventure therapists often become more approachable and achieve greater interaction with group members when compared to traditional group therapists.

Like other appropriate adventure therapy experiences, the Walk the Talk activity is so engaging that it often permits the therapist to step aside and observe behavior more closely, align themselves with certain belief systems at different times during the experience, and empower clients to take on more of a self-education process in the experience. Rather than the direct medium for change, this initiative takes this role and permits the therapist to achieve a more mobile, neutral, and curious state in the process.

[Is this para. part of #6, or is it a new section NEW SECTION?] All six of the components for how adventure therapy works exist in the Walk the Talk experience. The experience was (1) organized around treatment objectives, (2) sequenced or incremental in reference to the path clients would need to go through to make it back to the next meeting with their sobriety in place, (3) concrete in terms of substance abuse issues clients might face, (4) manageable when appropriate coping strategies were utilized, (5) consequential in relation to supporting functional strategies and providing valid feedback for negative decisions, and (6) holistic in terms of cognitive, social/emotional, and psychomotor learning. Each of these qualities contributed to the ability of the adventure therapy experience to assist the client achieve a more functional change process. These strategies can also be seen in the following example of a counseling group conducted in a traditional group room at a university counseling center that involved four single parents and their four adolescent sons

Another Example of Adventure Therapy Interventions

A group of single mothers with adolescent sons had responded to an announcement for an eight-session enrichment group focused on parenting. The group was conducted in a university counseling center and had progressed into the third session using adventure experiences as a group warm-up as a technique to focus the group on parenting issues with their sons. To this point, the group sessions had centered on various aspects of living together more peacefully. In order to structurally represent the struggle many of these parents had described in previous sessions, an experience was introduced in this session requiring each parent-adolescent pair to face one another about 10 feet apart. A 15-foot piece of sturdy rope was placed between them, with each person holding on to the remaining 2 feet of rope at their end. The experience, titled Gotcha, was introduced, with the objective being to cause one's partner to fall off balance by manipulating the rope. After numerous times of literally being jerked around by her son, one mother dropped the rope in frustration, exclaiming "*This is exactly what goes on in my house every afternoon after school.*" The son smiled sheepishly as if he had been "caught" in his after-school ritual of arguing with his mother, but he did not say a word.

Group therapists know that this mother and her son do not literally get out a piece of sturdy rope and jerk each other around every afternoon. However, for the mother, at some level of insight and knowledge, the feeling attached to the experience with the rope (figuratively) felt like what she experienced each day after school.

The experience led to some coaching by the group leader regarding the mother's strategy with the rope. She had been holding the rope tight in an attempt to resist her son and occasionally jerking the rope to try and overpower him. This strategy was not working, and she was experiencing the consequences of this interaction. With strategic intervention and her own insight, she found that when she gave her son some slack when he jerked, he literally was caught off balance. The mother's new actions with the rope led to a discussion among the other mothers as to how they could use different strategies to avoid after-school power struggles.

The goals for this therapeutic session were to redirect the interaction between parents and their adolescent sons by (a) providing an experience structurally paralleling the reality of the mother-son interaction, (b) offering new perspectives and potential solutions when new behaviors were tried, (c) creating a safe atmosphere for change offering similarities to as well as contrast with the "normal" home environment while acknowledging and empathizing with the mother's and son's thoughts and feelings, (d) changing the parent-son interaction to be more functional and less dependent on the adolescents' abilities to win the power struggles, and (e) moving out of a traditional group therapist's role and being seen as more active and available by the parents and sons during the co-creation of the adventure experience.

Assessment Capabilities and Treatment Planning

One critical piece of utilizing adventure experiences in therapy room situations is to determine when one actually implements adventure experiences in a group session. The CHANGES model (Gass & Gillis, 1995b) is organized into interactive steps designed to acquire information for developing functional client change. The seven steps make up the acronym CHANGES: Context, Hypotheses, Action, Novelty, Generating, Evaluation, and Solutions.

- ◆ *Context.* In preparing for the group experience, the therapist gathers all the information he or she can about the clients. Why has the client group entered into this experience? How long will they be involved? What are their stated goals as a group and as individuals?
- ◆ *Hypotheses.* - After gathering this assessment information, the adventure therapist establishes

hypotheses about what behavior(s) might be expected from the group. These hypotheses are “tested” through engagement in carefully designed adventure experiences.

- ◆ *Action.* Much of the material used for constructing change is obtained from the actions of group members as they involve themselves in adventure experiences. Kimball (1983) and Creal and Florio (1986) relate this process to the psychological concept of “projection.” Based on this premise, group members project a clear representation of their behavior patterns, personalities, structure, and interpretation onto the adventure activities because they are usually unfamiliar with what is being asked of them in the experience.
- ◆ *Novelty.* - As noted above, actions that are unfamiliar or new to the group cause group members to struggle with the spontaneity of an adventure experience. As a result, group members do not always know how they are expected to act, and this prevents them from hiding behind a false or “social” self, leading them to show their true behaviors and provides additional information to the group therapist.
- ◆ *Generating.* By careful observation of the group member’s responses to a multitude of “actions,” the skilled adventure therapist identifies lifelong behavior patterns, dysfunctional ways of coping with stress, intellectual processes, conflicts, needs, and emotional responsiveness. When properly observed, recorded, and articulated, this data can be the basis for therapeutic goals (Kimball, 1983).
- ◆ *Evaluation.* When information has been generated from observations of the group’s behaviors, it can be compared with working hypotheses once again. Do group actions fit the working hypotheses? Are these hypotheses supported or refuted? What new knowledge now exists to revisit action, novelty, and generating in the next experience?
- ◆ *Solutions.* Finally, and most important, when the evaluation provides a clear picture of the group’s issues, it leads toward solutions of those issues. Integrating and interpreting information gathered in previous steps helps in making decisions about how to construct potential solutions to the groups’ concerns.

The CHANGES model provides one useful way to acquire and organize information to systemically structure a change experience. One powerful technique for accessing the strength of adventure experiences is when group members are utilizing meta-communication patterns in their dialogue.

Metacommunication in Adventure-Based Groups

The concept of metacommunication, eloquently outlined by such therapeutic pioneers as Bateson (1972), de Shazer (1982), Watzlawick, Beavin, & Jackson (1967), and Watzlawick, Weakland, & Fisch (1974), provides a clear understanding of how adventure experiences can heighten therapeutic effectiveness. In the group members’ reality, there really are two meanings to words used in the adventure experience: one for the reality of the adventure experience and one for the group member’s real-world reality. The joining of these two realities can be heard in their words. Such metacommunication provides a valuable link for group members reaching deep and valuable meaning in adventure experiences (e.g., Gass & Gillis, 1998, Gillis & Gass, 1993).

The case example presented represents how many who use adventure activities in group work fall into the “right” activity. However, it can serve as an example of how metacommunication works in adventure-based groups. When the mother experienced being

jerked around by her son and expressed such to the group, she was joining two realities: the actual experience of the activity and the experience she had at home almost every day after school.

In the use of metacommunication to create an adventure experience, the adventure therapist, in listening to the mother in the example above describe her situation at home during the context phase of the CHANGES model, may have heard her say, “I feel like my son jerks me around all the time.” Or she might comment to the group, “I feel like I am at the end of my rope.” The skilled adventure therapist, listening to the mother’s metacommunication, would then *hypothesize* about an *activity* that involved getting jerked around. Would this activity be *novel* enough to *generate* information in order to *evaluate* the mother-son relationship and begin to cocreate some *solutions* in their treatment plan? Once the mother was able to connect with the activity, the therapist could begin to offer metacommunication language, such as coaching her to give her son some slack (in order for him to lose his control of the after-school situation.)

The key to a solution for the mother-son relationship was to have an activity that matched or was isomorphic with their home experience. In addition, the activity needed to offer strategies whereby the mother could engage in new behaviors (giving slack) more functional for her relationship with her son and offering a different outcome. This outcome of the activity (causing the other to fall off balance) needed to be a natural consequence of the adventure experience to have the greatest chance of leading to a more lasting behavioral change. The son would need to experience something familiar (jerking his mother around) and new (falling off balance) in order for a discussion to take place that could lead to an awareness that “things would be different after school.”

Listening to common metacommunication from clients such as “get over,” “give up,” “stepped on,” and “get around” helps create hypotheses for the group therapist about activities that will be most useful in connecting with group members’ issues. Note that literal experiences where clients are put in dangerous or unethical situations are unnecessarily risky and unprofessional. There are numerous books offering adventure activities for recreational purposes (Rohnke, 1989; Rohnke & Butler, 1995) that have been adapted for therapeutic use due to the inherent structures of the activities that connect to the language of the group members. The language used by group members can help in the cocreation of powerful adventure experiences that can aid clients to walk their talk.

Research Supporting Adventure Therapy

The use of outdoor adventure experiences for therapeutic and counseling groups is documented with numerous clinical populations, such as parents and adolescents (Gillis & Gass, 1993), couples (Gillis & Lindsay, 1991), those treated for substance abuse (Gass & McPhee, 1990; Gillis & Simpson, 1991 [Should be 1994?YES]), adjudicated youth (Bacon & Kimball, 1989; Kelly & Baer, 1968; Kimball, 1983), clients served in private practices (Berman & Davis-Berman, 1989) and psychiatric hospitals (Schoel et al., 1988, Stich & Senior, 1984; Stich & Sussman, 1981).

Cason & Gillis (1993), Ewert (1989), Gillis, (1992), and Gillis & Thomsen (1996), have provided reviews of research into adventure programming that include references to therapeutic populations. Many of these reviews indicate that there is a lack of research in the therapeutic use of adventure. They are also critical of the experimental methodology used. Most studies lacked control groups, and few had any follow-up data. These earlier reviews agree with the findings of

Hattie, Marsh, Neill, & Richards (1997) that globally measured self-esteem has been found to increase following participation [“following” OK YES?] in adventure-based groups, although the transfer of these changes to other settings has not been empirically validated. Note this study was based on 1,728 effect sizes from 96 different studies of adventure programs. The Hattie et al. (1997) meta-analysis of adventure education programs found the strongest effect sizes for constructs related to self-control: independence (0.47), confidence (0.33), self-efficacy (0.31), and self-understanding (0.34). Interestingly enough, these effects were found to increase when individual follow-up assessments were conducted. The authors note that “adventure programs appear to be most effective at providing participants with a sense of self-regulation” (p. 70). Such findings speak to the power of this group approach—even as a recreational and educational vehicle—in enhancing individual group members’ ability for self-control in adventure therapy experiences.

Newes’s (2001) recent critique of the literature specific to adventure therapy highlights the difficulty in empirically supporting adventure therapy. As Gillis & Thomsen (1996) noted, there is still no one clearly defined and researched method of conducting therapy with adventure activities; thus, the group therapist is left with little guidance for what type of adventure activity or setting is most effective with which client group. The researched programs offer confusing findings, since they utilize different adventure activities (wilderness expeditions versus ropes courses) and methods (educational, adjunctive, and primary), making comparisons among programs difficult. More troublesome is that the majority of research studies do not specify methodology (what they actually did that was considered therapeutic), so that the reader can determine if one program’s findings can be compared with another’s. There is no way to measure integrity of adventure therapy at this point in time. Newes (2001) provides some direction for researchers into adventure therapy, such as the use of dismantling and additive designs instead of comparative designs. Such direction is especially helpful to graduate students seeking different ways to improve and expand the use of adventure as a recognized treatment approach.

In addition to strengthening research methodologies, we support a focus on significant change events in adventure therapy. A database for collecting case studies and results of therapeutic interventions across different adventure therapy groups remains a dream. Adventure therapists tend to be doers and not writers. There are few practitioners evaluating programs in order to inform practice through research that is both clinically relevant and statistically accurate. Graduate students are encouraged to put their energies into this promising field of group work.

Ethics in Using Activities in Groups

Group workers are ethically bound to perform within their area of professional competence (ASGW, 2000). Physical activities, even the ones described in this chapter, have the potential to be dangerous in traditional group work settings (Gillis & Bonney, 1986). It is surprising to us that the classic “trust fall” is still listed in current editions of some group development textbooks (Johnson, 2001) without any disclaimers to its potential risk. Readers are advised to only do activities that they have been trained to facilitate or activities with which they have considerable experience. Adventure therapists share the goals of group counseling and other helping professions to “do no harm” and act responsibly and competently.

Not one group therapy “skill” is more important than the responsibility to competently conduct safe adventure practices. Adventure therapy is a field that utilizes powerful techniques that are often perceived as risky and can be dangerous. The reality is that people can be injured

or die in this approach to therapy. Adventure therapists cannot afford to lose one life, nor can those who entrust us be fearful of our practices.

With the death of Aaron Bacon (a troubled adolescent whose parents enrolled him in an expedition-based wilderness program with questionable practices), a harsh light has shown on the unregulated growth of programs *claiming* to be operating by principles of adventure therapy or wilderness therapy (Morgenstern, 1995). Numerous questions are raised about the militaristic methods and survivalist mentality of such program philosophies. Competent and accredited programs have sought to distance themselves from the wilderness expedition programs masquerading as wilderness or adventure therapy (Russell, 2001). The field of adventure therapy must continue to educate the public as well as other mental health colleagues on how to distinguish competent programs from those that pretend to be such.

Current Issues in Adventure Therapy

In an article describing critical questions in adventure therapy, Itin (2001) identified many of the current issues facing adventure therapy. These issues include what type of educational degree an adventure therapist should have, whether a certification process is needed for those who wish to call themselves adventure therapists, whether recognized mental health practitioners must be involved in group work that is labeled “therapy,” how the work of wilderness or adventure therapy is documented and evaluated, how labels like “therapeutic adventure” and “adventure therapy” help distinguish or confuse the public about what is actually happening during the group experiences. All of these professional struggles might sound familiar to those who have been involved with group counseling and group therapy, because they are issues that many mental health professionals have gone through in the past 30 years.

Much of the debates in adventure therapy have taken place in forums and workshops held by members of the Therapeutic Adventure Professional Group (TAPG) of the Association for Experiential Education (AEE) (2003). This group is comprised of “those AEE members who use adventure-based practice and the philosophy of experiential education therapeutically within the fields of health, mental health, corrections, education, and other human service fields” (AEE Therapeutic Adventure Professional Group (TAPG) (2003). The group has been in existence since the late 1970s and adopted a professional code of ethics in 1992, but has yet to agree on minimal competencies for who can call themselves an adventure therapist. The TAPG serves as both an entry point and a place for continuing education for the group practitioner interested in using adventure experiences in group work. As a professional group, TAPG also has helped launch an international conference on adventure therapy. The first of these conferences was held in Perth, Western Australia, in 1997, the second in Augsburg, Germany, in 2000, and the third in Victoria, British Columbia, in 2003. Group counselors interested in learning more about the use of adventure experiences in therapeutic settings are encouraged to join those of like mind in the TAPG and at international gatherings.

Summary

In a time of increasing expectations, changing conditions, and growing complexity of group member issues, group counselors may be searching for therapeutic approaches and techniques that actively empower group members’ lives. Adventure therapy offers a means to reach those

ends through an approach to group work that provides a contrasting experience to “the problem,” offers multiple and corroborating representations of reality, fosters the development of change through active eustress experiences, uses experiences that have internal mechanisms of resolvable conflict with structures focused on the production of solutions, and changes the role of the therapist to be more active and mobile. This approach to group work should be ventured into by those wanting to ethically and competently use experiences that enhance the therapeutic process and encourage positive and lasting change.

References

AEE Therapeutic Adventure Professional Group (TAPG). (2003). Retrieved from http://www.geocities.com/aee_tapg/tapg.html.

Association for Experiential Education (AEE). 2003. Retrieved from www.aee.org.

Association for Specialists in Group Work (ASGW). (2000). Association for Specialists in Group Work: Professional standards for the training of group workers. *Journal for Specialists in Group Work*, 25(43), 327-342

Bacon, S. (1983). *The conscious use of metaphor in Outward Bound*. Greenwich, Denver, CO: Outward Bound. (ERIC Document Reproduction Service No. ED296848).

Bacon, S. B., & Kimball, R. (1989). The wilderness challenge model. In R. D. Lyman, S. Prentice-Dunn, & S. Gabel (Eds.), *Residential and inpatient treatment of children and adolescents* (pp. 115-144). New York: Plenum.

Bateson, G. (1972). *Steps to an ecology of the mind*. New York: Ballantine.

Berman, D. S., & Davis-Berman, J. L. (1989). Wilderness therapy: A therapeutic adventure for adolescents. *Journal of Independent Social Work*, 3(3), 65-77.

Blatner A., & Blatner, A. (1988). *Foundations of psychodrama: History, theory, and Practice*. New York: Springer.

Cason, D. R., & Gillis, H. L. (1993). A meta-analysis of adventure programming with adolescents. *Journal of Experiential Education*, 17(1).

Creal, R. S., & Florio, N. (1986). The family wilderness program: A description of the project and its ethical concerns. In M. Gass & L. Buell (Eds.), *Proceedings Journal for the 14th Annual AEE Conference: The season of ingenuity: Ethics in Experiential Education*. Boulder, CO: Association for Experiential Education.

Crisp, S. (1998). International models of best practice in wilderness and adventure therapy. In C. Itin (Ed.), *Exploring the boundaries of adventure therapy: International perspectives*. Boulder, CO: Association for Experiential Education.

Davis-Berman, J., & Berman, D. S. (1994). *Wilderness therapy: Foundations, theories and research*. Dubuque, IA: Kendall Hunt.

de Shazer, S. (1982). *Patterns of brief family therapy: An ecosystemic approach*. New York: Guilford.

Ewert, A. (1989). *Outdoor adventure pursuits: Foundations, models, and theories*. Worthington, OH: Publishing Horizons.

Gass, M. A. (Ed.). (1993). *Adventure therapy: Therapeutic applications of adventure programming*. Dubuque, IA: Kendall Hunt.

Gass, M. A., & Gillis, H. L. (1995b). Constructing solutions in adventure therapy. *Journal of Experiential Education*, 1 (2), 63-69.

Gass, M., & McPhee, P. (1990). Emerging for recovery: A descriptive analysis of adventure therapy for substance abusers. *Journal of Experiential Education*, 13(2), 29-35.

Gass, M. A. & Gillis, H. L. (1998, November). *A room with a view: Adventure therapy programs in traditional office settings*. Paper presented at the [OK? YES] Association for Experiential Education 26th Annual International Conference, Lake Tahoe, Nevada.

Gillis, H. L. (1992, January). *Therapeutic uses of adventure-challenge-outdoor-wilderness: theory and research*. In K. Henderson (Ed.), *Proceedings of Coalition for Education in the Outdoors Symposium*. Martinsville, IN: Bradford Woods, Indiana University.

Gillis, H. L., & Bonney, W. C. (1986). Group counseling with couples or families: Adding adventure activities. *Journal for Specialists in Group Work*, 11(4), 213-220.

Gillis, H. L., & Bonney, W. C. (1989). Utilizing adventure activities with intact groups: A sociodramatic systems approach to consultation. *Journal of Mental Health Counseling*, 11(4), 345-358.

Gillis, H. L., & Gass, M.A. (1993). Bringing adventure into marriage and family therapy: An innovative experiential approach. *Journal of Marriage and Family Therapy*, 19(3), 273-286.

Gillis, H. L., Gass, M. A., Bandoroff, S., Rudolph, S., Clapp, C., and Nadler, R. (1991). Family adventure survey: Results and discussion. In C. Birmingham (Ed.), *Proceedings Journal of the 19th Annual AEE Conference* (pp. 29-39). Boulder, CO: Association for Experiential Education.

Gillis, H. L., & Lindsay, J. F. (1991, April). Pair-enting: Adventure-based counseling for parent and adolescent wellness. Paper presented at the Annual Conference of the American Association of Counseling and Development, Reno, Nevada.

Gillis, H. L., & Simpson, C. A. (1994). Working with substance abusing adolescents through Project Adventure. *Addictions Looseleaf Notebook*. Aspen, CO: Love Publishing.

Gillis, H. L., & Thomsen, D. (1996). A research update (1992-1995) of adventure therapy: Challenge activities and ropes courses, wilderness expeditions, & residential camping programs. Paper presented at the [OK?] Coalition for Education in the Outdoors Symposium Proceedings, Martinsville, IN: Bradford Woods, Indiana University.

Gillis, H. L., & Ringer, T. M. (1999). Therapeutic adventure programs adventure programming. Simon Priest & John Miles (Ed.), Venture Publishing, State College, PA [Not a complete citation]

Haley, J. (1973). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson*, M.S. New York: W. W. Norton.

Hattie, J. A., Marsh, H. W., Neill, J. T., & Richards, G. E. (1997). Adventure education and Outward Bound: Out-of-class experiences that make a lasting difference. *Review of Educational Research*, 67, 43-87.

Itin, C. (2001). Adventure therapy: Critical questions. *Journal of Experiential Education*, 24(2), 80-84.

Johnson, D. (2001). *Reaching out* (7th ed.). Boston: Allyn & Bacon.

Kelly, F. J., & Baer, D. J. (1968). *Outward Bound schools as an alternative to institutionalization for adolescent delinquent boys*. Boston: Fandel.

Kimball, R. (1983). The wilderness as therapy. *Journal of Experiential Education*, 5(3), 6-9.

Maizell, R. S. (1988). Adventure-based counseling as a therapeutic intervention with court-involved adolescents. *Dissertation Abstracts International*, 50(06-B), 2628. (University Microfilms No. AAD89-21901)

Morgenstern, J. (1995, January 15). A death in the wilderness. *Los Angeles Times Magazine*, pp. 14-18.

Newes, S. L. (2001). Future directions in adventure-based therapy research: Methodological considerations and design suggestions. *Journal of Experiential Education*, 24(2), 92-99.

Perls, F. S. (1969). *Gestalt therapy verbatim*. Moab, UT: Real People Press.

Priest S., & Gass, M. A. (1997a). *Effective leadership in adventure programming*. Champaign, IL: Human Kinetics.

Priest, S., & Gass, M. A. (1997b). An examination of “problem-solving” versus “solution-oriented” facilitation styles in a corporate setting. *Journal of Experiential Education*, 20(1), 34-39.

Rice, S. (1988). A study of the impact of long-term therapeutic camping on self-concept

development among troubled youth. *Dissertation Abstracts International*, 49(07-A), 1706. (University Microfilms No. AAD88-19365)

Rohnke, K. (1989). *Cowstails and cobras II: A guide to games, initiatives, ropes courses, and adventure curriculum*. Hamilton, MA: Project Adventure.

Rohnke, K., & Butler, S. (1995). *Quicksilver*. Dubuque, IA: Kendall-Hunt.

Roland, C., Summers, S., Freidman, M., Barton, G., & McCarthy, K. (1987). Creation of an experiential challenge program. *Therapeutic Recreation Journal*, 21(2), 54-63.

Roland, C., Keene, T., Dubois, M., & Lentini, J. (1988). Experiential challenge program development in the mental health setting. *Bradford Papers Annual* (Vol. 3). Martinsville, IN: Bradford Woods Outdoor Center.

Russell, K. (2001). What is wilderness therapy. *Journal of Experiential Education*, 24(2), pp. 70-79.

Satir, V. (1972). *Peoplemaking*. Palo Alto, CA: Science and Behavior.

Scheidlinger, S. (1995). The small healing group: A historical overview. *Psychotherapy*, 32(4), 657-668

Schoel, J., Prouty, D., & Radcliffe, P. (1988). *Islands of healing: A guide to adventure-based counseling*. Hamilton, MA: Project Adventure.

Stich, T. F., & Senior, N. (1984). Adventure therapy: An innovative treatment for psychiatric patients. In B. Pepper and H. Ryglewicz (Eds.), *Advances in treating the young adult chronic patient* (pp. 103-108). San Francisco: Jossey Bass.

Stich, T. F., & Sussman, L. R. (1981). *Outward Bound An adjunctive psychiatric therapy: Preliminary research findings*. (ERIC Document Reproduction Service No. ED239791).

Thomas, J. (1980). Sketch of a moving spirit: Kurt Hahn. *Journal of Experiential Education*, 3(1), 17-22.

Walsh, V., & Golins, G. (1976). *The exploration of the Outward Bound process*. Denver, CO: Colorado Outward Bound School.

Walton, R. A. (1985). Therapeutic camping with inpatient adolescents: A modality for training in interpersonal cognitive problem-solving skills (self-esteem residential treatment). *Dissertation Abstracts International*, 47(08-B), 3549. (University Microfilms No. AAD86-28822)

Watzlawick, P., Beavin, J., & Jackson, D. (1967). *Pragmatics of human communication*. New York: Norton.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change*. New York: Norton.

Whitaker, C. A., & Keith, D. V. (1981). Symbolic-experiential family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of family therapy*. New York: Brunner/Mazel.

Wichmann, T. F. (1991). Of wilderness and circles: Evaluating a therapeutic model for wilderness adventure programs. *Journal of Experiential Education*, *14*(2), 43-48.