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An Examination of the Scope and Variety of Adventure Therapy Services within the State of Maine

Donald F. Lynch

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**AN EXAMINATION OF THE SCOPE AND VARIETY OF ADVENTURE
THERAPY SERVICES WITHIN THE STATE OF MAINE**

By

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B.A. University of Maine

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A THESIS

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Education

(in Counselor Education)

The Graduate School

The University of Maine

May, 2005

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**AN EXAMINATION OF THE SCOPE AND VARIETY OF ADVENTURE
THERAPY SERVICES WITHIN THE STATE OF MAINE**

By Donald F. Lynch

Thesis Advisor: Dr. Sydney Thomas

An Abstract of the Thesis to be Presented
in Partial Fulfillment of the Requirements for the
Degree of Doctor of Education
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May, 2005

This study involved an examination of the scope and variety of adventure therapy services that are currently being offered by mental health agencies within the state of Maine. A review of related literature has shown that there were a number of closely related therapeutic modalities which could be subsumed by the term *adventure therapy* and an operational definition was proposed. The statistical conclusions of the study were compiled from the data collected by the use of a survey instrument which was designed and pilot tested before being mailed to 191 agencies and 56 responses were returned. Results of this survey were used to investigate the relationships between the types of mental health services being provided, the varieties of diagnosed populations being served, and the factors that either promoted or impeded the offering of adventure therapy programs. In this study, 33.9% of the agencies were offering adventure therapy services and that the majority of agencies that were not offering these services referred their clients out for them. The uses of descriptive as well as inferential statistics were employed in order to plot the frequency distributions and relative proportions of several

important qualitative variables and to allow the analysis of specific relationships among these variables. In this study, factors that influenced the likelihood of offering this kind of therapy were explored. Among the variables which were investigated were psychotherapists' perceptions of the utility of adventure therapy programs, the agency's access to required financial resources, and the availability of appropriately trained staff who possessed the technical skills necessary to conduct adventure therapy programs.

The findings of this study provided information about the extent of adventure therapy programs throughout Maine. This information will be valuable to mental health clinicians, social service caseworkers, and family members interested in either making or requesting referrals to those agencies offering adventure therapy services. The methodological contribution of a new survey instrument together with the development of an operational definition of the term *adventure therapy* will also allow subsequent researchers to conduct more empirical studies into the efficacy of this therapeutic modality.

DEDICATION

This work is dedicated to my parents who instilled within me a desire for life-long learning, a concern for the responsibilities of environmental stewardship, and a sense of compassion for the suffering of all living things.

ACKNOWLEDGMENTS

I would like to acknowledge the help and support of all of the individuals who contributed their time and energy to assisting with the successful completion of this project. I would especially like to recognize the expertise and selfless commitment of my thesis advisor, Dr. Sydney Thomas without whose help this work would never have been accomplished.

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TABLE OF CONTENTS

DEDICATION.....	ii
ACKNOWLEDGMENTS.....	iii
LIST OF TABLES.....	vi
Chapter	
1. INTRODUCTION.....	1
Statement of the Problem.....	1
Significance of the Problem.....	3
Researcher Reflexivity.....	9
Summary.....	12
2. REVIEW OF RELATED LITERATURE.....	14
History of Adventure Therapy.....	14
Theoretical Orientations.....	20
Definition of Terms.....	26
The Efficacy of Adventure Therapy.....	32
Summary.....	36
3. METHODS.....	38
Adventure Therapy Defined.....	38
Statistical Questions.....	44
The Survey Instrument.....	46
The Survey Procedure.....	47

Institutional Review Board Approval.....	48
Limitations.....	49
Delimitations.....	51
Summary.....	51
4. ANALYSIS AND RESULTS.....	53
Descriptive Statistics.....	53
Inferential Statistics.....	61
Analysis of Narrative Responses.....	66
Summary.....	72
5. DISCUSSION AND CONCLUSIONS.....	74
Summary of the Research.....	74
Summary and Discussion of Descriptive Results.....	78
Summary and Discussion of Inferential Results.....	85
Discussion of Narrative Responses.....	87
Conclusions.....	94
Recommendations.....	104
REFERENCES.....	106
APPENDICES.....	116
Appendix A. Adventure Therapy Survey Instrument.....	117
Appendix B. Participant Informed Consent.....	123
Appendix C. Chi-Square Cross-Tabulation Details.....	125
BIOGRAPHY OF THE AUTHOR.....	127

LIST OF TABLES

Table 4.1	Frequency Distributions of Agencies by Type.....	54
Table 4.2	Frequency Distributions by Types of Service.....	55
Table 4.3	Frequencies and Percentages of Clients' Developmental Levels.....	56
Table 4.4	Frequencies and Percentages of Methods of Integration.....	59
Table 4.5	Decisional Factors' Influence Cross-Tabulations.....	63
Table 4.6	Greatest Influence in the Decision to Outsource Cross-Tabulations.....	66
Table C.1	Greatest Influence Cross-Tabulation of Expected and Observed Counts and Percentages.....	125
Table C.2	Referral Out Cross-Tabulation of Expected and Observed Counts and Percentages.....	126

Chapter 1

Security is mostly a superstition. It does not exist in nature, nor do the children of humankind as a whole experience it. Avoiding danger is no safer in the long run than outright exposure. Life is either a daring adventure or it is nothing at all.

Helen Keller (1880-1968)

INTRODUCTION

Statement of the problem

The purpose of this study was to determine the scope and variety of adventure therapy programs that are being offered by licensed mental health facilities in the state of Maine. At the time this study was conducted, there existed no comprehensive listing of facilities offering adventure therapy programs as part of a repertoire of clinical services available to various client populations within the state. A comprehensive review of the literature has disclosed that adventure therapy programs are, in fact, efficacious methods of treatment but a number of problems have perturbed past empirical research efforts (Gillis & Ringer, 1999; Priest, 1999). This study resulted in a proposed definition of adventure therapy that will help make it possible to mitigate some of the problems that have afflicted previous research efforts.

At the outset, the term *adventure therapy* itself appeared to have different meanings depending on the context in which it was used. A number of authors who have conducted research in this area have defined the term *adventure therapy* in different ways. These terms are often used interchangeably when the construct they seem to be describing might more appropriately be subsumed under a more inclusive descriptor. The literature makes reference to a nomenclature containing terms such as adventure-based counseling,

wilderness therapy, and adventure-based therapy (*cf.* Crisp, 1998; Gass, 1993; Raiola & O'Keefe, 1999). The problematic nature of determining an accepted operational definition of *adventure therapy* becomes evident when an investigator endeavors to conduct any type of empirical research on the efficacy of this particular modality of therapy. In this study, a review the literature on the subject of adventure therapy, as well as on the terminology that has been used to describe other closely related treatment approaches, was conducted and a definition was proposed which will help to make operational the term *adventure therapy*. A solution to the need for determining a functional definition of the term *adventure therapy* was necessary in order to facilitate the conduct of more reliable and valid qualitative, as well as quantitative, research into questions related to the comparative effectiveness of all adventure therapy programs.

Because the number of state licensed mental health agencies offering adventure therapy programs was unknown, this work was focused on an effort to determine the scope as well as the variety of programs which are currently being offered. This was accomplished by constructing and implementing a survey instrument which was designed to collect specific data which allowed several important questions to be answered. The relationship between the type of mental health facility offering adventure therapy programs, and the client populations being served was investigated, in order to determine which populations are receiving more of this type of therapy. Finally, the most influential factors that either contributed to or hindered the decision to offer adventure therapy programs in mental health facilities were examined.

Significance of the problem

The first problem which was addressed, with reference to a study of adventure therapy programs being offered within the State of Maine, was to formulate a definition of the term *adventure therapy*. A number of terms have been used to describe the activities associated with a particular theoretical frame of reference involving psychotherapeutic adventure strategies. These strategies typically involve an active, experiential orientation on the part of both the therapist and the client. Structured and non-structured activities that take place in an environment that is unfamiliar to the client are also an essential component of adventure therapy. They also include an element of risk, either real or perceived, on the part of the client and a chance to process the cognitive, affective, and behavioral consequences of the experience in a therapeutic context. In spite of the near universal consensus among adventure therapists regarding the importance of an element of risk in adventure programs, Rohnke (1989) has cautioned practitioners concerning the use of risk in adventure activities:

Much of the outdoor education movement has been based on challenge and stress. The assumption has been that if individuals and groups come up against it in terms of extreme difficulty, change and growth will take place. We need to be careful with this. No matter what we do, we must think about the needs and the potential responses of each group we work with. There are simply many times when a stressful situation is not appropriate. It may take weeks, even months, of lead-up and group development time in order to get to the more challenging and difficult situations (p. 7).

In order for the activities to have a therapeutic impact they should also serve as a metaphoric vehicle for change. There is a focus on the here and now as well as an

expectation that a type of change that Michael Gass (1993) has termed “isomorphic transfer” will occur (p. 248). Gass has cited the work of Hofstadter (1979) to explain that isomorphism occurs when two complex structures are linked together in such a way that similar features can be mapped together. While it is unlikely that identical isomorphic structures will be created, “the closer the adventure experience mirrors the pattern of client treatment, the more isomorphic and therapeutically relevant the adventure experience becomes in reaching treatment objectives” (Gass, 1993, p. 248). The earlier work of the family therapists J. Haley (1973) and S. Minuchin and H. C. Fishman (1981) together with the celebrated hypnotherapist Milton Erickson (1980) inspired the connection between a therapeutic metaphor and the isomorphic transfer as an important component of adventure therapy. These essential features have lead to a confusing nomenclature which has gradually come to be associated with the more generic term; *adventure programming* and these semantic challenges have often made it difficult for researchers to communicate even their most valid empirical findings.

The following is only a partial listing of the terms that have become most commonly associated with the aforementioned type of psychotherapeutic intervention, adventure therapy:

1. adventure based counseling (Shoel, Prouty, & Radcliffe, 1988)
2. wilderness therapy (Crisp, 1998; Gass, 1993; Russell, 2001)
3. expeditioning (Crisp, 1998)
4. wilderness adventure therapy (Crisp, 1998)
5. adventure based therapy (Gass, 1993)
6. long-term residential camping (Gass, 1993)

7. outdoor behavioral healthcare (Outdoor Behavioral Health Care Industry Council, n.d.)
8. outdoor-adventure pursuits (Ewert, 1989)
9. therapeutic recreation (American Therapeutic Recreation Association, 2004)

The solution to the problem of a workable and functional definition of adventure therapy was the first step in conducting quality scholarly research. Gillis and Ringer (1999) have intimated that the common themes of these descriptors might be a reasonable place to begin with a consensual understanding of the meaning of the phrase *adventure therapy*. They conclude their overview of adventure therapy in an article entitled, *Adventure as therapy* by stating, “While there may be subtle differences in how authors describe these various approaches [*sic*] goals appear to be the same to most people who read the literature or listen to therapists describe what they do” (p. 30). In a manner that shares a similarity with the nosology of the criterion based and categorically defined *Diagnostic and Statistical Manual of Mental Disorders IV-TR* (American Psychiatric Association, 2000), the mental health profession could benefit from a functional definition of the term, *adventure therapy*. This definition would help researchers who are interested in the efficacy of adventure therapy approaches to differentiate this approach from other, distinctly different interventions. It would also enable not only researchers, but also clinical practitioners to learn more about the manner in which adventure therapy is integrated with other treatment approaches.

The lack of knowledge with regard to the extent and variety of adventure therapy programs within the state of Maine was also a significant problem. Many social service agency caseworkers might be interested in referring a client to a mental health facility

offering adventure therapy programs but would be unable to do so because of their lack of information regarding the scope and variety of adventure therapy services in Maine. The parent of a child diagnosed with an emotional or behavioral problem might be interested in knowing what licensed facilities providing adventure therapy are available in an area situated more closely to the child's home. This study has provided a way for a parent to know the extent to which mental health facilities are providing adventure therapy services. An example of the types of agencies that might benefit from the knowledge of the scope and variety of existing adventure therapy programs could include all of the Maine State Department of Human Service's regional Child Protective Services offices. In addition, the Office of Juvenile Intake and Probation of the Maine State Department of Corrections frequently seek to make referrals to outside service providers. Many of the licensed alcohol and drug treatment facilities, and any agency providing social services, mental health, or rehabilitation services to children and their families might all be assisted by the knowledge of the types of agencies offering adventure therapy services within the State of Maine.

The knowledge of the scope and variety of adventure therapy services would be of particular importance to anyone who might be interested in conducting scholarly research into the efficacy of this therapeutic modality, especially in comparison to other clinical approaches in the treatment of mental disorders. The paucity of empirical research in the field of adventure therapy appeared to be due, in part, to the prevailing attitudes of some of the practitioners themselves. Dick Prouty, who has served as the Director of Project Adventure, Inc. has written, "we are convinced that the reason for these activities' popularity and effectiveness cannot really be understood by the results of 'valid

evaluation.' The enduring value is in the magic moments of creativity and good feelings that they make possible" (as cited in Rohnke, 1984, p. 6). While the research in this study was designed to be descriptive in nature, some specific procedures from the discipline of inferential statistics were employed in the analysis of the data which examined the nature of the relationships between variables. An important question which relates to the provision of adventure therapy services offered by licensed mental health facilities in the state of Maine pertains to the factors that either encourage or impede the offering of adventure therapy programs. Will White, is a licensed clinical social worker and is a cofounder of Summit Achievement which is a licensed mental health and substance abuse treatment facility offering adventure therapy services in Western Maine. He has identified, among other things, a lack of training in technical skills, together with the need for more training in clinical counseling skills, as primary factors that contribute to difficulties associated with the recruitment, selection, training and supervision of appropriate staff (W. White, personal communication, March 17, 2004). This research represents a methodological contribution to the body of knowledge in the discipline of adventure therapy because it contains a survey instrument which may be used by subsequent researchers.

An examination of the variables that have either contributed to or impeded the proliferation of adventure therapy programs in the treatment of mental disorders was also conducted. The wilderness and semi-wilderness environment in many parts of the state together with the rugged coastline of Maine, when taken in combination, make this an ideal area for the establishment of adventure therapy pursuits. This work also contains an exploration of those factors that influence whether or not a mental health agency either

offered or was likely to offer adventure therapy programming as part of a comprehensive continuum of service. In a chapter on the evaluation and research of adventure therapy programs, Gass (1993) has specified six areas that need further investigation. "These areas were: (1) treatment effectiveness, (2) issues of training and competence of professionals in adventure therapy, (3) integration of adventure therapy with other therapeutic approaches, (4) treatment issues, (5) clearer definitions of programs, and 6) funding issues" (p. 305). The purpose of this study was not to determine the efficacy of adventure therapy as a treatment modality. Rather, it was designed to investigate the availability of appropriately trained professionals in adventure therapy in order to discover whether the availability of staff is related to the program offerings in the state of Maine. Another question was whether or not there existed a relationship between the integration of adventure therapy and other treatment approaches. Finally, the research contains an examination the relationship between funding issues and whether or not a licensed facility was likely to offer adventure therapy services to its clientele. This series of general research questions was used to generate a list of more specific statistical questions. Pryzak and Bruce (2003, pp. 23-28) have emphasized the importance of recognizing the distinction between statistical questions and the general, or substantive, research questions from which the former are derived. The general research questions, which formed the basis for a number of more specific statistical research questions, were explored in the course of this study. A formal discussion of the precise descriptive statistical procedures (Ary, Jacobs, & Razavieh, 1990, p. 45) that were employed has been presented in the Methods chapter of this study. A distinction was drawn between a substantive question, which "is rooted in the substance of the matter under study" and a

statistical question, which “concerns a statistical property of the data” (Minium, Clarke, & Coladarci, 1999, p. 4). This study also contains a proposal for a clearer definition of the term *adventure therapy* in order to facilitate the exploration of these questions.

Researcher reflexivity

Social science research has often tried to dissociate the personal biases and positionality of the researcher from the substantive question in order to objectify the conduct of data collection and analysis and consequently, the conclusions that are derived from the study. Qualitative researchers have taken exception to this directive by asserting that even the most empirical quantitative studies are not free from the subjective influences of the human experimenter. While this study was designed to be quantitative in nature, the criticisms of qualitative researchers have made an important contribution by providing a cautionary statement about empirical research. In their book, *Designing Qualitative Research*, Catherine Marshall, and Gretchen B. Rossman had this to say about quantitative research. “Raw data have no inherent meaning; the interpretive act brings meaning to those data” (Marshall & Rossman, 1999, p. 153). Also, in an effort to reflect empiricism, for example, the tenets of scientific research often mandate that articles for publication are written in a style that avoids the use of first person pronouns (Breuer, Mruck, & Roth, 2002). Qualitative researchers do not subscribe to this professed objectivity in empirical studies and, in fact, do not believe that it is capable of being reified. “Research, like almost everything else in life, has autobiographical roots” (Seidman, 1998, p. 26).

Reflexivity serves as a method which allows for the process of self-examination. This process includes an acknowledgment of the cognitive structures and functions, in addition to the overt behaviors, which influence the biases of the researcher. It encourages a good-faith examination of assumptions. Hatch (2002) has poignantly noted this fact.

“Unpacking assumptions is no simple matter. The very nature of assumptions is that they are unexamined, so it gets intellectually tricky right away” (p. 12). The epistemological implications of this type of examination of the assumptions of the researcher are profound. As Patti Lather (1999) has noted, “In terms of social sciences, the shift is away from cognitive, rule-based, behaviorally focused empirical work and toward more reflexive, language based, interpretive practices” (pp. 101-102). This contention has served to reinforce Lather’s determination that knowledge is subjectively constructed. Creswell (1998) has also agreed that several qualitative research traditions subscribe to the notion that all knowledge is socially constructed and Bloom (2002) has stressed the importance of self-representation in all narrative analysis. Quantitative research still has much to offer and these cautionary statements made by qualitative researchers should serve only to strengthen the findings of empirical efforts and not to undermine them. A disclosure of the positionality of the researcher is intended here to assist with the credibility of the findings and not to imply that this is in any way a qualitative research endeavor.

One of the primary assumptions about human nature held by this researcher is that the human condition is unique. Human beings experience the capability of contemplating their own mortality. This ability gives rise to a type of existential anxiety which, although it may be repressed, is never completely negated. Rollo May, an existential

psychotherapist, has written that anxiety is not something we have, it is something we are. This is not seen as a validation of a nihilistic philosophy of life because it is the capacity for self-awareness, or self-consciousness, which allows human beings a distinctive characteristic, the ability to see one's self as though from the outside (May 1953, p. 74). "This capacity for consciousness of ourselves gives us the ability to see ourselves as others see us and to have empathy with others" (p. 75).

Another important ontological assumption regarding the human condition is the capability of intentional agency (Martin & Sugarman, 1999, p. 65), which implies the ability to make choices, or the condition of free will. These views are consistent with the tenants of counseling that are embodied in the term *humanistic existentialism* which has been suggested by Sydney Thomas, Ph.D. (personal communication, April 3, 2004). The tenants of this view of human nature are embodied in the following assumptions described by Corey (2005, p.137).

1. We are finite and do not have unlimited time to do what we want in life.
2. We have the potential to take action or not to act; inaction is a decision.
3. We choose our actions, and therefore we can partially create our own destiny.
4. Meaning is the product of discovering how we are "thrown" or situated in the world and then, through commitment, living creatively.
5. Existential anxiety, which is basically a consciousness of our own freedom, is an essential part of living; as we increase our awareness of the choices available to us, we also increase our sense of responsibility for the consequences for these choices.
6. We are subject to loneliness, meaninglessness, emptiness, guilt, and isolation.
7. We are basically alone, yet we have an opportunity to relate to others.

This philosophy is compatible with the goals of adventure therapy because it provides a framework for helping to understand universal human concerns. There is a primary emphasis placed on the therapeutic relationship between the client and the counselor. Adventure therapy's experiential components, together with its focus on the here and now, and the use of the therapeutic metaphor to transfer the insights and behaviors from the clinical setting to the client's own world combine to make it particularly appealing to those practitioners who share the aforementioned ontological position.

Summary

This chapter describes an important factor that influences the lack of reliable and valid research on the subject of adventure therapy. The proliferation of a number of terms, ostensibly describing a particular modality of psychotherapeutic intervention, and which share a number of identical or, at least virtually identical, clinical features has created a nomenclature that has had the potential to obfuscate empirical investigation. A comprehensive review of the literature has provided a proposal for an operational definition of the term, *adventure therapy*. A major contribution of this study was to formulate an operational definition and to use that definition to construct a survey instrument which was subsequently used to collect the data necessary to answer a number of specific research questions.

The following is a list of the substantive research questions which were explored in this study:

1. What licensed mental health facilities are offering adventure therapy programs in the state of Maine?

2. What clinical populations are being served by these facilities?
3. What types of services do these facilities provide?
4. What are the factors that either promote or impede the offering of
adventure therapy programs by licensed mental health facilities in Maine?
5. What specific types of problems and disorders are being treated in adventure
therapy programs?
6. How are adventure therapy services integrated with other mental health services?
7. What are the factors that influence the outsourcing of adventure therapy services?

This chapter concluded with a statement of the philosophical assumptions about human nature that frames the theoretical orientation of this researcher. These presuppositions have formed the basis, in the context of counseling theories, for the development of the section which is devoted to theoretical orientations which follows in Chapter 2.

Chapter 2

REVIEW OF RELATED LITERATURE

History of adventure therapy

The provision of mental health services in an outdoor setting began in the United States as early as 1901 when what was then referred to as tent therapy was offered to state psychiatric hospital patients during the summer months. The program was reported to be successful but its discontinuation was necessitated by the seasonal onset of colder winter weather (Davis-Berman & Berman, 1994). The origins of adventure as therapy can be traced back to the seminal work of Dr. Kurt Hahn in the field of experiential education (Schoel, Prouty, & Radcliffe, 1988). Hahn developed a number of curricular changes designed to combine public service and real world experiences with more traditional classroom pedagogy because he wanted to address the psychosocial development of students in a more holistic manner. His ideas were increasingly refined through his work at schools in Germany and later, in Scotland. During World War II a need for high intensity survival training resulted in what later became the Outward Bound course. These courses were focused upon sea training and survival and had a positive influence on the development of practical skills for young British seamen who were struggling to survive the rigors of offshore sailing during the war (Schoel, Prouty, & Radcliffe, 1988). Independent schools emerged to support Hahn's concept of experiential education and the current Outward Bound movement grew from these beginnings (Miner, & Boldt, 1981).

While Kurt Hahn's philosophy of education emphasized the spontaneous development of prosocial values in a learn-by-doing environment, he believed that the mastery of

academic skills or intellectual achievement was only one facet of the educational experience. Hahn believed that students were capable of incorporating the cultivation of civil values as a part of being human and that particular experiential circumstances could call forth those values. As Kimball and Bacon (1993, p. 13) have observed, "Hahn's ideas were perhaps better suited to a psychological model of change than an educational one." In spite of this observation, the earliest Outward Bound programs were decidedly not therapeutic in nature and the leadership positions held by the staff did not include mental health professionals (Davis-Berman & Berman, 1994). In the early 1960s the Outward Bound schools came to the United States from Great Britain where they had demonstrated themselves to be so widely accepted in assisting with the psychosocial development of young people. Five Outward Bound schools were initially established in the United States but by the end of the decade literally hundreds of programs were using some aspect of this approach. By the 1970s, the programs utilizing some replication of the Outward Bound model numbered in the thousands. In the 1980s adventure-based education models had become so prevalent that almost every community had some kind of adventure challenge program. "Increasingly, schools, colleges, youth services, hospitals recreation centers, social service agencies, and vocational programs were making them available" (Kimball & Bacon, 1993, p. 13).

The Outward Bound wilderness challenge model and related programs based on similar models were first applied to clinical populations in the 1960s. Because of the model's orientation to experiential education, and because Outward Bound's primary orientation was devoted to working with adolescents, wilderness therapy was first applied to working with troubled youth or with adjudicated teens (Kimball & Bacon, 1993).

Today, adventure therapy and other wilderness challenge programs are being used with almost every clinical population, including adults, as well as with children and adolescents. A comprehensive review of the related literature has disclosed that adventure and wilderness therapy programs have been used as both a primary treatment regimen or, as an adjunctive modality together with a more traditional form of psychotherapy. Specifically, adventure therapy has been used in the treatment of eating disorders, including anorexia nervosa (Kaye, 1999) and bulimia nervosa (Maguire & Priest, 1994), substance abuse (Bennett, Cardone, & Jarczyk, 1998; Coons, 2004; Gass, 1991; Gass & McPhee, 1990), developmental disabilities (Hebert, 1998), marital discord (Gillis & Gass, 1993), family dysfunction (Burg, 2000; Mulholland & Williams, 1998), schizophrenia (Stich & Senior, 1984), sexual abuse perpetrators (Kjol & Weber, 1993; Rayment, 1998), and other incarcerated convicts (Mossman, 1998).

Even though Kurt Hahn's ideas were alive in the Outward Bound school's model, as well as in other clinical programs in the United States that subscribed to the Hahnian philosophy of human development, when this philosophy was applied in the school settings, it was usually implemented by Outward Bound staff. It was a program that came to be known as Project Adventure that sought to return Hahn's ideas to the setting in which they were first practiced the public school (Schoel, Prouty, & Radcliffe, 1988). Project Adventure was the concept of Jerry Pieh who wanted to return the fundamental concepts of learning by doing, and experiential or active learning processes to the standard high school curriculum (Rohnke & Butler, 1995). In the early 1970's Pieh secured a substantial three-year grant from the Federal Office of Education and hired staff with Outward Bound backgrounds and involved teachers and administrators in

designing and implementing significant curricular changes in a high school located in Massachusetts.

The first director of Project Adventure was Bob Lentz who had been a teacher and school principle and who had also served as the Outward Bounds program's Director of Teacher Training programs from 1969-1971. He was a strong advocate of the experiential learning process (Schoel, Prouty, & Radcliffe, 1988). As a direct result of his efforts, the Project Adventure curriculum began to be successfully institutionalized in a public school system. Miner and Boldt (1981) found that Project Adventure had enjoyed more success in the educational setting than any of the proposals derived from the original Outward Bound model. It was the work of the project adventure staff that led to the origins of Adventure Based Counseling (ABC) as a treatment modality and the first training workshop on ABC was held in May of 1979.

The Adventure Based Counseling model of intervention was a significant influence in the development of adventure therapy. This is because the original Hahnian concepts of experiential learning, the cultivation of prosocial values in young people, and a wilderness-based setting as a backdrop for student-active learning are important components of this model as well. In fact, a retrospective review of the literature reveals that Kurt Hahn's philosophy of experiential education, initially implemented in a school setting, lead to the development of Outward Bound programs and later, to the replication of these approaches in mental health treatment programs. The efforts of Pieh, in the early 1970s, to bring Hahn's philosophy of education back into the school setting, as part of an officially institutionalized curriculum, led to the appointment of Bob Lentz as the first director of Project Adventure, in Massachusetts. The origins of Adventure Based

Counseling can be traced back to two major influences, one associated with Project Adventure in a public school system and the other, affiliated with an outpatient therapy group at a psychiatric hospital in Gloucester, Massachusetts.

A primitive form of Adventure Based Counseling evolved from the work of two Project Adventure staff members, Jim Schoel and Steve Webster, in a program called Action Seminar which was offered in a regional high school in Massachusetts (Schoel, Prouty, & Radcliffe, 1988). Although the students who were referred to the Action Seminar were not formally diagnosed with a specific mental disorder, at least half of these students were considered to be at risk and were deemed appropriate for some form of alternative instruction. This program was later expanded into the Gloucester public school system where it later became known as Project Alliance.

In 1974, at Addison Gilbert Hospital, also in Gloucester, Massachusetts, school psychologist Paul Radcliffe, who had experience with the Project Adventure program, was conducting a therapy group with adolescents which utilized an adventure challenge theme. Radcliffe worked with Mary Smith, who was a Project Adventure staff member, and with a hospital social worker. Together they combined the intake and consultation functions of a hospital therapy group with the essential elements of the Adventure Based Counseling approach (Schoel, Prouty, & Radcliffe, 1988). Radcliffe later worked with others, under a grant from the Massachusetts State Department of Education, that included personnel from the Gloucester and Manchester, Massachusetts school systems, to formalize the process of intake, screening, activities sequencing and staff selection, and training. At the same time, the Project Adventure model curriculum in Massachusetts received a federal grant from the National Diffusion Network of the United States Office

of Education. From 1974-1982 the grant monies were used to subsidize workshops for teachers and administrators nationally in order to replicate the fundamental experiential learning concepts which had become to be associated with the Project Adventure program. Thousands of education professionals received this training and by 1982 over 500 schools or other educational institutions had replicated at least a part of the original Project Adventure model. In 1982 Project Adventure was incorporated as a non-profit corporation. "The main change was the acceleration of the trend to work with institutions other than schools" (Schoel, Prouty, & Radcliffe, 1988, p. 8). Now, it seems, Dr. Kurt Hahn's original school-based experiential learning program had evolved from schools to clinical settings, then back into academic settings and finally, once again, out into the mental health field. More recently, Project Adventure replications were expanded to include, but were by no means limited to, residential treatment centers, substance abuse clinics, state and county youth service rehabilitation programs, school special needs departments, and psychiatric hospitals (Schoel, Prouty, & Radcliffe, 1988).

An examination of the evolution of the adventure therapy movement points to the importance of the contributions to the mental health field made by those in academic institutions who subscribe to the philosophy of experiential education and student-active learning. Adventure-based therapy and experiential learning are inexorably connected. "Experiential learning is also predicated on the belief that change occurs when people are placed outside positions of comfort (e.g. homeostasis, acquiescence) and into states of dissonance. In these states, participants are challenged by the adaptations necessary to reach equilibrium" (Gass, 1993, p. 4). The principles of experiential learning have been adapted and applied to adventure therapy and the importance of learning by doing that

was emphasized by Kurt Hahn has been a consistent theme in the adventure therapy movement. The five Principles of Experiential Learning delineated by Kraft and Sakofs (1985) have been adapted to adventure therapy by Michael Gass (1993, p. 4):

1. The client becomes a participant rather than a spectator in therapy.
2. Therapeutic activities require client motivation in the form of energy, involvement, and responsibility.
3. Therapeutic activities are real and meaningful in terms of natural consequences for the client.
4. Reflection is a critical element of the therapeutic process.
5. Functional change must have present as well as future relevance for clients and their society.

Karl Rohnke (2004) has added a concept that he has termed *Challenge by Choice*, which puts the choice of participating in high risk adventure activities into the hands of the participants themselves (p. ix). These principles have been generally held to be consistent among various experiential learning theorists (Luckner & Nadler, 1992). The connection between education and psychotherapy was perhaps nowhere more evident than in the application of experiential learning principles to the field of adventure therapy.

Theoretical orientations

All efficacious theories of counseling and the techniques of clinical practice that have become associated therewith are inexorably contingent on a credible theory of human nature. In the field of adventure therapy, some of these theories more readily lend themselves to the practical application of the techniques associated with adventure-based

counseling. Many of these theories regarding the very nature of the human condition are based on contradictory assumptions with regard to concepts such as intentional human agency, determinism, freedom of choice, and the etiology of stimulus-response behaviors. At present, there are more than 400 different types of psychotherapy in existence (Seligman, 2001) but fortunately, most of these therapies can be grouped, roughly, into four or five general theoretical orientations that are based on each therapy's view of human nature. Gillis and Ringer (1999) have observed that adventure therapy programs apply principles from four psychological orientations. These are, humanistic or existential, psychodynamic, behavioral, and systemic. Other researchers have suggested groupings that included psychoanalytic or psychodynamic therapies, behavioral or cognitive/behavioral therapies, humanistic as well as existential (or phenomenological) therapies, and the biological therapies (Barlow & Durand, 1995; Coon, 2000; Gray, 2002; Rathus & Nevid, 1999). The biological therapies have been most commonly associated with a medical model of intervention that emphasized somatic therapies such as psychopharmacological treatments, electro-convulsive shock, and even psychosurgery, for use in certain refractory cases. These treatments are not directly related to the methodologies used by adventure therapists and therefore, will not be relevant to the therapeutic principles employed in this modality of treatment. Because the theoretical orientations of the mental health profession have been predicated on the tradition of philosophical views of human nature, it seems reasonable to group these remaining different therapies into categories that share a negative or somewhat pessimistic view of human nature, those therapies that take a predominantly neutral view of the human condition and finally, those categories that share a more positive view of human nature.

The proliferation of different types of therapeutic intervention has led to a substantial number of mental health clinicians adopting what has been termed an eclectic or integrative approach to therapy. Prochaska and Norcross (1994) believe this number may be as high as 50%. Some of the factors contributing to this recent trend are the inadequacy of any one treatment system to demonstrate superiority over the others, the significant commonalities of many treatment approaches, the recent emphasis on brief, solution-based prescriptive treatment planning, and the failure of any one treatment system to satisfy the needs of diverse client populations (Seligman, 2001). The need to demonstrate the empirical effectiveness of different treatment regimens has resulted in the publication of a report by a task force of the American Psychological Association listing those therapies that it viewed as efficacious in the treatment of mental disorders. These treatment protocols, initially referred to as Empirically Validated Treatments, and later, more modestly referred to as Empirically Supported Treatments, are virtually all behaviorally oriented and as Messer in Slife, Williams, and Barlow (2001) has so poignantly noted, "Almost totally absent are the psychodynamic, experiential, client-centered, family and existential therapies" (p. 4). If a substantial number of clinical therapists are now utilizing eclectic, or integrated, approaches to counseling and the American Psychological Association has determined that the behavioral treatments are the most empirically supported form of intervention, the question that logically follows is, what type of therapy are those who practice eclectic or integrative approaches actually practicing? The most common combinations of theories, in ascending order of frequency, are (3) psychoanalytic and cognitive approaches, (2) humanistic and cognitive approaches, and (1) cognitive and behavioral treatment systems (Prochaska & Norcross,

1999). The presence of cognitive therapy in all three combinations is worth noting because it suggests the profound influence of both cognitive and behavioral theoretical orientations on the field of psychotherapy.

The next question that arises in this context is what are the theoretical beliefs about the nature of the human condition that cognitive/behaviorists hold to be true? There is a great amount of diversity and variability among different, specific types of behavioral and cognitive/behavioral therapies. These approaches may not be appropriate for all client populations (Brown & Srebalus, 2003, p. 292). Some general assumptions regarding the view of human nature seem to be common to virtually all of these approaches. First of all, behaviorists tend to believe that human nature can be studied empirically and that the scientific method can be used to learn about human behaviors, cognitions, and emotions. Many of the more modern cognitive and behavioral therapies have revised the earlier Skinnerian belief that human behavior was merely a function of stimulus-response psychology and that human beings were nothing more than a product of their socio-cultural conditioning (Neukrug, 1999). Models of animal behavior were used to make literal inferences about human nature. Most current cognitive/behavioral therapists subscribe to the notion that the person is both the producer and the product of his environment (Corey, 2005). The vestiges of determinism still influence some behavioral approaches, especially with regard to the concept of freedom of choice and human intentional agency. Some critics have described these approaches as being mechanistic and overly prescriptive (Martin & Sugarman, 1999). "In an era when many people suffer from a collapse in a sense of significance, behavior therapy strives only for symptom relief" (Prochaska & Norcross, 1999, p. 314). The cognitive/behavior therapies

too, tend to emphasize therapeutic techniques that lead to conditioning to extinction those cognitions that clients associate with negative emotions such as, anxiety, depression, and negative self-image. It is possible that an increased awareness of these emotions might lead to a reformulation of an individual's prioritization of some of life's most important issues. The importance of having a sense of purpose, a will to meaning, and the ability to live with the existential anxieties of the human condition are questions that are seldom raised in the context of behavioral and cognitive/behavioral therapist's repertoire of psychotherapeutic techniques. Many cognitive therapies appear similar to the more traditional behavioral approaches in that they frequently involve the application of classical and operant conditioning techniques to human thinking, or cognitions, as if the only difference between thoughts and behaviors is that the former are performed covertly and the latter are performed overtly. The social-learning theorists have expanded on the fundamental precepts of classical and operant conditioning but, even this philosophy is prone to the overgeneralizations that plague the more traditional behaviorists.

The existential or phenomenological orientations to the human condition (and the psychotherapeutic approaches that are derived therefrom) have embedded in them some assumptions about human nature that seem more holistic or complete. A comparison between existential therapies and behavioral techniques is difficult because the existential therapies do not focus on specific techniques but rather, endeavor to apply a philosophy of human nature to the psychotherapeutic process. The behaviorists and cognitive/behaviorists emphasize the techniques of therapy more than a philosophy of human nature. Implicit in the behavioral orientations are assumptions about human nature that suggest human beings are simply a more evolutionarily advanced type of mammalian

vertebrate. The existential orientations to psychotherapy view human nature as being unique from that of the animal kingdom and they do not believe that animal models of behavior can be easily generalized to the behavior of human beings. Specifically, humans have the ability to manipulate symbols, which allows the use of true language, to make free choices, and to contemplate their own mortality. These and other differences between humans and animals form the assumptions that existential psychotherapists make about the uniqueness of the human condition. Viktor Frankl, MD, PhD (1963) writes about what he describes as the last of human freedoms. This is the human ability to choose one's own attitudes in any given set of circumstances. This is a precise definition of an existential counselor's belief in the human being's unique condition, existing in space and time. Although human beings are mortal entities, subject to the laws of a temporal universe, they do exclusively possess the ability to act with agentic intentionality and this is a capability which is not shared with their animal brethren. Humans are not compelled by the instinctual drives that seemly regulate the behavior of even the most evolutionarily advanced species of primates. Frankl's theory of human nature appears to be the most credible description of the greatest difference between human beings and animals. His Logotherapy focuses on an individual's search for the meaning of human existence. Humans demonstrate plasticity throughout the continuum of their life-span development. The psychological dynamics of the individual certainly emerge from, and are cultivated by, the sociocultural forms and practices in which one develops but are not reducible to them (Martin & Sugarman, 1999). Existential therapies are not well suited to empirical investigation with regard to validity in a statistical sense. However, absence of evidence is not evidence of absence. The most important questions

are those which surround the individual's search for meaning and finding a sense of purpose, making sense of suffering, and coping with existential anxiety. Adventure therapy offers a credible vehicle for addressing these universal human dilemmas.

Definition of terms

One problem, frequently associated with empirical research into the treatment efficacy of adventure therapy programs, is the degree of misunderstanding and outright disagreement among practitioners relative to a definition of the term *adventure therapy*. The term was operationalized in order to allow researchers to replicate the results of experiments designed to provide evidence of the effectiveness of adventure therapy as a psychotherapeutic treatment intervention. In a review of the literature, different authors have very often used different terms to describe what are essentially very similar methodological approaches to the treatment of mental disorders. This is especially true in the field of adventure therapy where the terms wilderness therapy, wilderness-adventure therapy, adventure-based counseling, and adventure programming all have more in common than they have in contrast. Some researchers have attempted to make distinctions between these terms by defining particular aspects that differentiate one term from another but, because of the relative paucity of generalized agreement among practitioners, there still exists much confusion in the field.

In a recent paper entitled, *International Models of Best Practice in Wilderness and Adventure Therapy*, Crisp (1998) offers definitions of the terms *adventure therapy*, *wilderness therapy*, and *wilderness-adventure therapy*. He notes that the term *adventure therapy* is often used to include the entire field of wilderness, outdoor, and adventure

interventions. Others take the term to mean specific, short-term, non-wilderness based approaches and include activities such as trust exercises, initiative games, and ropes course work. His definition of adventure therapy is “a therapeutic intervention, which uses contrived activities of an experiential, risk taking and challenging nature in the treatment of an individual or group” (Crisp, 1998, p. 58). He further specified that the interventions occur indoors or, within an urban environment and do not involve camping or living within the environment where the interventions are practiced. One delimiting factor that specifically defines this term is that the activities employed in therapy must be contrived and must occur in an artificial environment where the therapist assumes a more direct role in the determination of goals, rules, and the criteria for success or failure. The theoretical influences implicit in this definition and subsequent therapeutic interventions are consistent with the conditions of change as a result of disequilibrium (Luckner & Nadler, 1992) and contain a strong emphasis on constructivism as a learning perspective. This perspective maintains that people do not learn by acquiring new information but rather, by constructing new meanings from new and prior experiences, especially in the context of meaningful social interactions. Adventure therapy typically includes a focus on isomorphic transfer as a paradigm of the experiential learning model and the psychotherapeutic intervention (Gass, 1993).

Wilderness therapy differs from adventure therapy in that wilderness therapy emphasizes the impact of an isolated natural environment combined with the influence of a social community on the human change process. Crisp (1998) has described the concept of environment and community being encapsulated in a kind of therapeutic wilderness milieu. He named two intervention formats: (1) wilderness base camping, and (2)

expeditioning. The former was defined as the establishment of a camp, with a minimal amount of equipment, in an isolated natural environment, while the latter was defined as moving to different places using a self-sufficient means of support and transportation. These activities could entail canoeing or kayaking, sailing, rafting, back-backing, and skiing or snowshoeing. He correctly asserted that while expeditioning is often a component of base camping, expeditioning might be used exclusively as a therapeutic component of many wilderness therapy programs. Besides the wilderness environment and social influences of an isolated community, wilderness therapy typically involves some type of modified group therapy which is designed to encourage personal and interpersonal insight, and to be inextricably linked to the social change process (Crisp, 1998).

Wilderness-adventure therapy is defined as distinctly different from the two previously defined types of therapy in that in wilderness-adventure therapy, a feature of the natural environment may be used for an adventure therapy type of activity but, it is not necessary that the environmental feature be an isolated one. Therapeutic interventions are structured around activities which take place in the natural environment but, the participants do not spend time living together as they do in wilderness base-camping programs or in those programs that utilize an expeditioning component. "For research purposes wilderness-adventure therapy in particular should be differentiated from wilderness therapy and from adventure therapy" (Crisp, 1998, p. 59). This statement provides no rationale for the importance of isolating wilderness-adventure therapy from both adventure therapy and from wilderness therapy for the purpose of conducting research. These definitions make a significant contribution to the efforts in the field which strive to operationalize specific terms and it seems important to differentiate all

three terms, for the purposes of research, since these definitions clearly delineate the boundaries of three different types of therapeutic intervention. Research investigations into the efficacy of wilderness-adventure therapy and wilderness therapy, by definition, must contend with the confounding influence of extraneous variables in a field setting. This fact has more than likely contributed to the lack of empirical results on the efficacy of all three forms of therapy.

The term *therapeutic recreation* is often used to describe a type of clinical intervention, which is similar to adventure therapy. The American Therapeutic Recreation Association (2004) has issued the following definition statement:

Therapeutic Recreation is the provision of treatment services and the provision of recreation services to persons with illnesses or disabling conditions. The primary purposes of treatment services which are often referred to as Recreation Therapy, are to restore, remediate or rehabilitate in order to improve functioning and independence as well as reduce or eliminate the effects of illness or disability. The primary purposes of recreational services are to provide recreation resources and opportunities in order to improve health and well being. Therapeutic Recreation is provided by professionals who are trained and certified, registered and/or licensed to provide Therapeutic Recreation. (ATRA Definition Statement, para. 1).

This kind of recreation therapy is most often associated with use in clinical populations which are made up of individuals with more severe functional impairments, including physical disabilities and illnesses. While this definition does not preclude the provision of therapeutic recreation services to individuals with diagnosed mental illnesses, the therapy is most commonly used with chronically mentally ill populations. This definition does

not require that the recreational activities, which are employed, contain any element risk, either real or perceived.

Other researchers have made similar distinctions between terms most commonly associated with the field of adventure therapy. Gass (1993), for example, stated that the term *adventure therapy* had evolved into three specific types of activities associated with the implementation of adventure challenge work applied to therapeutic settings. He defined the term *wilderness therapy* as a therapeutic experience that occurs in remote wilderness settings and was conducted with a small group of individuals over a period of several days. Gass credited Outward Bound and adapted Outward Bound programs with being the primary innovators of this kind of therapeutic programming. Russell (2001) had also stated that, “Wilderness therapy has been defined and characterized in many ways. Rehabilitative outdoor-based approaches such as challenge courses, adventure-based therapy, or wilderness experience programs (WEPs), are often used interchangeably to describe wilderness therapy.” (p. 70). Russell has also described the difficulties that researchers have faced by these various definitions when they have to conduct empirical studies in the field. These include the problems confronting any methodological approach which seeks to compare one program or setting to another with regard to specific types of activities, processes, or outcomes.

Although Gass saw these terms as being derived from the more generic label, *adventure therapy*, he contrasted *wilderness therapy* with *adventure-based therapy* by noting that the latter type of therapy was usually conducted on the grounds of, or in close physical proximity to, the facility where the client is being served. This could be a residential treatment facility, a psychiatric hospital, or a school. In this type of therapy,

adventure therapy may be only one part of a broader therapeutic regimen. The adventure experiences tended to be artificial, or contrived, in the sense that the physical structures used to facilitate the adventure programming experiences were deliberately constructed for such a purpose. An example of these structures might include be a low ropes course or an indoor rock climbing wall. This meaning of this term is very similar to the *adventure-based counseling* expression that has been previously described with the Project Adventure programs (Schoel, Prouty, & Radcliffe, 1988).

A third term derived from the nomenclature of adventure therapy is *long-term residential camping*. This consists of serving clients in outdoor camps for an extended period of time where residents are expected to prepare their own meals and, sometimes, to assist in the construction of their own living shelters. An alternative form of this type of adventure therapy is often provided on extended sailing voyages or on wagon train expeditions. “Much of the inherent value of such programming in these types of settings is seen to extend from the value of developing a positive peer culture, confronting the problems encountered with day-to-day living, and dealing with existing natural consequences” (Gass, 1993, p. 10). This variant of adventure therapy is most similar to the type described by the term, *expeditioning*, used by Crisp (1998).

The similarity between Crisp’s term, *adventure therapy* and Gass’ term, *adventure-based therapy* is evident in the descriptions given by the authors. Both interventions occur within the context of contrived or artificial adventure challenge environments. Crisp (1998) has qualified this definition with the following disclaimer:

Adventure therapy as a term is frequently used to include, more or less, the entire field of wilderness, outdoor and adventure interventions. Other times it refers to

specifically short-term, non-wilderness based approaches such as ropes course and initiative activities. This becomes confusing, and tends to hide important differences and assumptions about therapy (p. 58).

The confusion could perhaps be minimized by accepting the term Gass has proposed, *adventure-based therapy* which is, again, similar to the term used by Project Adventure, *adventure-based counseling*, with the understanding that these terms more precisely define what Crisp has termed, *adventure therapy*. The term *adventure therapy*, as Gass has proposed, would then be used to encompass all of the more precisely defined types of adventure challenge programs and might then be used as a more generic descriptor of the field, per se. Raiola and O'Keefe (1999) and Gillis and Ringer (1999) appear to be in agreement with regard to the term, *wilderness therapy* and have suggested that this term should now be subsumed under the more overarching term, *adventure therapy*. For the purpose of designing and implementing a survey instrument, the term *adventure therapy* was formally operationalized in the Methods chapter of this document.

The efficacy of adventure therapy

One of the difficulties that have confronted researchers who seek to gather evidence on the effectiveness of adventure therapy is the question of whether or not adventure therapy is a form of psychotherapeutic intervention, in its own right, or whether it is simply another kind of treatment modality used as a means of delivering a particular type of intervention. For the purposes of research, this distinction is important because the modalities of psychotherapeutic intervention are not the same thing as different forms, or types, of psychotherapy therapy. To confuse a treatment modality with a constellation of

techniques which are associated with a particular theoretical orientation to psychotherapy is an inaccuracy that has contributed to inconsistent approaches to the design of empirical research studies. If one research endeavor was engaged in a comparative study of the effects of adventure therapy and Eye Movement Desensitization and Reprocessing (EMDR) in the treatment of post traumatic stress disorder, the validity of the conclusions must be called into question because the study might not have been designed to compare either different modalities or different types of psychotherapy. An example of this conundrum is illustrated by the case of a psychoanalytically oriented therapist who uses play therapy as a modality of service delivery. The psychotherapeutic intervention will be psychodynamically focused but the mode of delivery will include the techniques of play therapy. A practitioner of phenomenologically oriented psychotherapy who uses art therapy with her clients, as a specific treatment modality, would demonstrate another example of the manner in which modalities of treatment constitute more of a vehicle of service delivery than a specific psychotherapeutic orientation.

The literature indicates that adventure therapy is used as both a specific type of psychotherapeutic intervention and as a specialized kind of treatment modality. “It is important to note that in most cases, adventure therapy is not used to replace other therapeutic interventions and practices; instead, it is used to enhance established treatment objectives and to provide a richer therapeutic environment for change so that therapy is more successful” (Gass, 1993, p. 5). Adventure therapy and adventure-based counseling programs readily lend themselves to a clinician’s own theoretical perspective on the helping process. A therapist who practices a psychodynamic, behavioral, cognitive, or existential approach may readily use his or her own theoretical orientation

as a lens through which to interpret the process of change that adventure therapy experiences can generate (Schoel, Prouty, & Radcliffe, 1988). Even the recent emergence of transtheoretical models of psychotherapeutic change has included adventure therapy as a modality of treatment (Porter, 1999).

Extant reviews of the literature on the efficacy of adventure therapy have shown that global measures of self-esteem/self concept are increased significantly as a result of adventure therapy, especially in client populations consisting of children and adolescents (Moote & Wodarski, 1997). However, these same researchers have observed that reviewing the literature on empirical evaluations of adventure-based counseling programs immediately discloses that there have been few comprehensive and methodologically sound studies of this treatment approach. Many of the investigations have been plagued by common methodological problems such as small research samples, the use of different instruments to measure similar outcomes, and a lack of agreement among researchers with regard to the nomenclature that is used to describe adventure therapy programs. Even though self-esteem has been shown to improve following clients' participation in therapeutic adventure experiences, the permanence of these changes and significantly, the isomorphic transfer of these changes to other settings have not been empirically validated (Hattie, Marsh, Neil, & Richards, 1997; Moote & Wodarski, 1997; Cason & Gillis, 1995; Ewert, 1989). As Gillis and Ringer (1999) have stated, "There is still no one clearly defined and researched method of conducting therapy with adventure activities." (p. 34). They have proposed including a common set of information in all research endeavors that specifies the precise type of program being employed, the demographics of the

population being studied including such variables as age, gender, and clinical diagnosis or statement of problem (Gillis & Ringer, 1999).

Stouffer (1999) has integrated adventure therapy with psychodynamic therapy and reports that adventure activity is a powerful influence in bringing unconscious material to light. In a recent study, measures of self-esteem in elementary school children showed significant improvements after a form of Adlerian Adventure Therapy (Wick, Wick, J., & Peterson, 1997) which combined the theory and intervention techniques of Alfred Adler with adventure therapy. The parallels between Gestalt Therapy and adventure therapy were examined by Gilsdorf (1998) and found to include an emphasis on experiential approaches to treatment, a focus on the here and now, and a client centered focus. Other types of spiritual and more existential approaches have been successfully conjoined with adventure therapy (Fox, 1999). A formal model for the implementation of behavior therapies in adventure challenge programs (Kemp & McCarron, 1998) has been proposed and another program which combines wilderness experiences with cognitive-behavioral models of psychology (Haynes & Gallagher, 1998) is being conducted in Western Australia. Even less mainstream forms of counseling and psychotherapy such as Ericksonian hypnotherapy (Itin, 1998) and pastoral counseling (Shackles, 1998) have been successfully combined with adventure therapy programs. Gillis and Ringer (1999) have stated, "The relative youth of the field of adventure therapy offers a rich opportunity for psychotherapists who are attracted to the use of adventure therapy for personal change and to adventure practitioners who wish to develop their expertise in the human change processes" (p. 35).

Summary

This chapter contains a review of related literature on the subject of adventure therapy. An overview of the history of adventure therapy begins with the provision of mental health services in an outdoor setting in 1901 in the United States. The term associated with this modality of therapy was *tent therapy*. Kurt Hahn's philosophy of experiential education which he refined in Germany and later, Scotland is described as a major contribution to the evolution of the modern adventure therapy movement. The development of the Outward Bound program in the United States and the subsequent growth of the Adventure Based Counseling programs in New England were also described. The influence of these programs in schools and in mental health settings was documented with regard to their contributions to experiential education and the field of mental health, respectively.

This chapter also included a section in which the major theoretical orientations associated with psychology and the profession of counseling is explored. Although this review of the literature has demonstrated that practitioners utilize those techniques most clearly allied with psychodynamic, behavioral, cognitive approaches, it was the humanistic approaches, which emphasize the importance of trust-building and a client-centered focus, which among practitioners appeared to be the most crucial element of adventure therapy.

Finally, a discussion of the often confusing nomenclature which had been associated with the field of adventure therapy was presented and the need to develop an operationalized definition of the term, *adventure therapy* was cited as a requirement for the execution of more methodologically sound research efforts into the clinical efficacy

of adventure therapy. The development of this functional definition has represented a preliminary step toward strengthening the methodology of future research endeavors and has helped to facilitate the effort to design and implement the survey instrument which was used to collect the data which was required for the execution of this study.

Chapter 3

METHODS

Adventure therapy defined

Before an effective survey instrument could be designed and administered to all licensed mental health agencies in the state, a functional definition of the term *adventure therapy* had to be constructed. The previous chapter on the Review of the Literature has shown that different authors often use different terms to describe what are, essentially, very similar methodological approaches to the treatment of mental disorders. A number of researchers have attempted to describe specific distinctions between the terms, *adventure-based counseling* (Schoel, Prouty, & Radcliffe, 1988), *wilderness therapy* (Gass, 1993; Crisp, 1998; Russell, 2004), *expeditioning* (Crisp, 1998), *adventure-based therapy* (Gass, 1993), *wilderness adventure therapy* (Crisp, 1998), *long-term residential camping* (Gass, 1993), *outdoor behavioral healthcare* (Outdoor Behavioral Health Care, n.d.), and *outdoor adventure pursuits* (Ewert, 1989). Rather than focusing on the specific distinctions between these terms, the method used for this study included an examination of the elements that these descriptors have in common.

Saso (20004,) has written “that the lack of a proper definition of adventure therapy presents a stumbling block for future development of the field” (p. 1). He has distilled two common themes from a number of proposed definitions and has concluded that all of the definitions contain the following two components.

1. Adventure therapy consists of any intentional, facilitated use of adventure tools and techniques to guide personal change toward desired therapeutic goals.

2. It is a form of therapy that uses the components of adventure: real or perceived risk, uncertainty of outcome, and personal decision-making.

While these two components certainly appear to be critical to the fulfillment of the goals of adventure programming, they seem to encompass other types of activities which are not traditionally thought of as being associated exclusively with the types of activities that are common to adventure therapy. Those programs whose only goal is to control or extinguish undesirable behaviors might use these elements as a part of their treatment regimens but the programs themselves could, in fact, more closely resemble a type of military boot camp or a highly regimented survival experience.

Gillis (1995) has defined adventure therapy by including specific experiences and activities as well as some target population identifiers.

Adventure therapy is an active approach to psychotherapy for people seeking behavioral change, either voluntarily or through some court ordered coercion, that utilizes adventure activities, be they group games and initiatives, or wilderness expeditions (with some form of real or perceived risk) as the primary therapeutic medium to bring about change (para. 4).

By identifying the clients served as being either voluntary or court ordered, this definition seems to exclude the involuntarily committed residents of psychiatric hospitals or, perhaps from a particular child's perspective, residents of children's residential treatment centers. The literature on adventure therapy makes numerous references to members of both of these populations being served by adventure therapy programs. (*cf.* Roland, 1993; Gilliam, 1993). The Gillis definition contains a limitation that restricts the populations served and for this reason it appears to be inadequate.

Itin (2001) has also addressed the debate surrounding the definition of adventure therapy. Rather than formulating an actual definition, he described the basis for three different ways in which the term *adventure therapy* could be defined:

The level of change—Is the change directed at changing behaviors or on the meta-level issues that contribute to the behavior?

The degree of the practitioner—Does the practitioner hold a degree in a specialized academic field [*sic*] is this field considered clinical?

The population worked with—Is the population one traditionally considered in a clinical context? (p. 81).

Itin stressed the distinction between the term *therapeutic adventure* and the term *adventure therapy*. Therapeutic adventure activities tend to focus on concrete behaviors of the client that are causing functional problems while in adventure therapy the focus is on both concrete behaviors and on meta-level processes involving the unconscious influences behind overt behaviors. With regard to the educational degree held by the practitioner, only a graduate degree in a human service field such as psychology, counseling, or social work would qualify one to practice as an adventure therapist. The true adventure therapist would also require skills training in adventure activities. The third approach to defining adventure therapy considered only the population being served. Itin believes that this definition is perhaps the least restrictive of the three and that the one that is the most restrictive is an integration of all of these definitions. This is because the latter definition requires only that the practitioner is working with a population that is typically considered clinical, for example individuals with a DSM-IV-TR diagnosis, and that adventure pursuits are being utilized in treatment. Itin

acknowledges that this definition is closely related to other forms of experiential therapy such as, art, animal assisted, dance, music, psychodrama, and horticultural therapy (Itin, 2001, p. 82). Itin did not propose a formal definition of the term *adventure therapy*, but rather, offered three basic areas which should be considered in the defining process.

Perhaps the most significant obstacle to the formulation of an operationalized definition of the term *adventure therapy* is the question of whether adventure therapy is a distinct type of therapy, in much the same way that Glasser's Reality Therapy, Perls' Gestalt Therapy, and Ellis' Rational Emotive Behavior Therapy are considered to be, or whether adventure therapy is, in fact, a specific modality of psychotherapeutic service delivery. Modalities of therapy include, as Nugent (2000) has observed, expressive arts therapies such as music therapy, art therapy, and dance therapy (p. 397). Other examples of modes of therapy include play therapy, which may include art therapy (Klespich & Logie, 1982), equine therapy, and biblio-therapy. The reason that this distinction is important is because *modes* of therapy are not usually aligned with one particular *type* of psychotherapeutic intervention. Many researchers in the field have taken the view that adventure therapy is more closely associated with a modality of treatment than with a specific type of psychotherapy (Gass, 1993; Porter, 1999; Schoel, Prouty, & Radcliffe, 1988). This is not, however, a position that is universally agreed upon. Gillen (2003) has asserted that cognitive behavior therapy forms the underlying basis of adventure therapy and this contention leads one to the conclusion that adventure therapy might be more appropriately considered a type of cognitive behavior therapy. This view represents only a small minority of practitioners and the scholarly body of literature on this subject seems to be in agreement with the assertion that adventure therapy can best be defined as a

specific mode of mental health service delivery. For this reason, the method which was used to arrive at an operationalized of adventure therapy included the decision to consider adventure therapy to be most accurately described as a modality of treatment.

Defining adventure therapy as a modality of treatment and not as a specific type of therapy obviates to need to describe a more rigid regimen of treatment protocols. This has allowed the term *adventure therapy* to become a more generic descriptor of the field and to subsume all of the other, more precisely defined, types of adventure challenge programs which were discussed in Chapter One. After a careful review of the most salient factors to be considered in proposing an operationalized definition of the term *adventure therapy*, the following definition of adventure therapy was designed to be used in the survey instrument:

Adventure therapy is defined here as a modality of psychotherapeutic intervention which is used to treat clients who are experiencing clinically significant cognitive, affective, or behavioral dysfunctions and is provided by, or under the supervision of, a licensed, certified, or otherwise qualified mental health professional. Adventure therapy activities may occur in either a natural or contrived environment, are experiential in nature, involve elements of real or perceived risk, and consist of a facilitated integration of adventure challenges and therapeutic counseling strategies. This definition identifies adventure therapy as modality of service delivery and not as a specific type of psychotherapy. Operationalizing this term as a mode of therapy will allow any practicing mental health professional to incorporate adventure-programming techniques, and to be considered an adventure therapist, regardless of her or his theoretical orientation to psychotherapeutic intervention.

The definition has further defined adventure therapy as a psychotherapeutic intervention, which will help to differentiate the therapeutic component from adventure education programming and wilderness experiences which do not contain elements of mental health therapy. The client population being served must be composed of individuals who have been clinically diagnosed with either affective, cognitive, or behavioral difficulties which are significant enough to have resulted in some degree of impairment in social, occupational (including academic), or recreational activities. This definition has also specified that adventure therapy must be provided by a licensed, certified, or otherwise qualified mental health professional. The state of Maine requires that mental health professionals hold an appropriate licensing credential issued by the board which oversees the practice of a number of mental health disciplines. Included among these are the fields of psychiatry, psychology, social work, clinical counseling, and marriage and family therapy. Other qualified mental health certifications include the Mental Health Rehabilitation Technician-Community (MHRT/C), and the Other Qualified Mental Health Professional (OQMHP) credential which allows workers to provide services to children. In an effort to keep the definition of an adventure therapist less restrictive, these services may be provided under the supervision of an appropriately licensed mental health professional.

This proposed definition also states that adventure therapy activities might be performed in either a natural or contrived environment. This will permit the adventure activities to be provided in either an outdoors or wilderness setting, or in an indoor setting such as a gymnasium containing an artificial climbing wall. The definition also requires that all participants become involved in an active, experiential manner and that there

exists an element of real or perceived risk that is incorporated in the therapeutic regimen. The facilitated integration of adventure challenge experiences and therapeutic counseling strategies includes both the interpersonal and intrapersonal processing of the experiences, the debriefing activities, and the opportunity for the metamorphic transfer of the adventure experience to the clients' real-world environments. This facilitation may be accomplished regardless of the therapist's theoretical orientation or the practical applications and techniques associated with any particular type of psychotherapy.

Statistical questions

The substantive research questions which were posed in the introduction to this thesis have led to the formulation of a series of statistical questions. In order to gather the data that related to the research questions, a survey was conducted with a sample of all licensed mental health facilities operating within the state of Maine. Though this study was designed to be non-experimental in nature the methods utilized to analyze the data involved both descriptive and inferential statistics. The use of descriptive statistical procedures (Ary, D., Jacobs, L., & Razavieh, 1990; Patten, M., 2002) allowed the data to be organized and summarized in frequency distributions and the observations were described in the *Data analysis and results* section of this study.

The statistical questions, which were derived from the substantive questions which were introduced in the first chapter of this document, involved the use of descriptive statistics and consisted of the plotting of frequency distributions for the following questions:

1. What licensed mental health facilities in the state of Maine are offering adventure therapy services?
2. What clinical populations are being served by adventure therapy programs?
3. What types of services do these licensed facilities provide?
4. What types of problems and disorders are being treated with adventure therapy?
5. How are adventure therapy services integrated with other mental health services?

In order to determine the answers to the two other substantive questions, both a null hypothesis and an alternative hypothesis were formulated. The use the chi-square test of independence was selected as the most appropriate statistic because this is an inferential statistic which is appropriate for the analysis of bivariate frequency distributions (Minium, Clarke, & Coladarci, 1999, p.391). The research question dealing with the factors that either encourage or discourage the offering of adventure therapy services was answered by a significance test of the null hypothesis of independence. Contingency tables were constructed of the observed and expected frequencies of the data from two variables. The null hypothesis stated independence in the population of row and column variables:

H_0 : there is independence between those mental health facilities which do and those that do not offer adventure therapy services and the decisional factors variable. The alternative hypothesis stated that there was dependence between the row and column variables:

H_1 : any state of affairs other than that specified in H_0 .

The level of significance was specified at .05. A chi-square test of independence was performed on the null hypothesis which was derived from the second inferential analysis question that was formulated from the research question that pertained to the decisional factors that influenced the outsourcing of adventure therapy services. Another contingency table was constructed from the expected frequencies of those mental health facilities that outsource adventure therapy services and those that do not and the frequencies of the reasons that were given for the decision of whether or not to outsource those particular services.

This null hypothesis stated again, independence in the population of row and column variables:

H_0 : there is independence between the mental health facilities that outsource adventure therapy services and those that do not and the factors thought to influence outsourcing.

The alternative hypothesis stated that some factors do influence the outsourcing of adventure therapy services:

H_1 : any state of affairs other than that specified in H_0 .

The level of significance was again specified at .05.

The survey instrument

The survey instrument was constructed in a manner that allowed for the collection of the data necessary to answer the research questions. The instrument was first pilot tested on a group of experts which included three practicing adventure therapists, two college professors who are teaching in the discipline of adventure therapy, one college professor who is teaching statistics. Also included in the test group were two licensed mental health

clinicians who were also serving as directors of adventure therapy programs. These group members provided a great deal of valuable feedback. Before being administered to the sample, the survey was revised based on the information provided by this panel of experts in order to help increase the content validity of the instrument. The survey was constructed in a manner that helped to ensure reliability with regard to the internal consistency of the instrument (Ary, Jacobs, & Razavieh, 1990, p. 434-435).

Following the revisions associated with the panel of experts' advice, the survey was then mailed to all mental health facilities licensed to operate within the state of Maine. A list of these facilities was obtained from the appropriate licensing offices of the Maine State Department of Health and Human Services. The current name of this department was recently changed in the state of Maine when the Department of Human Services and the Department of Behavioral and Developmental Services were combined administratively. These two offices grant licenses to all agencies providing mental health services to adults and mental health services to children and adolescents, respectively.

The survey procedure

The instrument was mailed to the directors of clinical services of all agencies and a letter of introduction was also enclosed. The letter of introduction described the purpose of the study and contained information which identified the principal investigator as a doctoral student enrolled in the University of Maine's College of Education and Human Development. A written statement of the proposed definition of adventure therapy was also included in order to maximize the number of responses to the questionnaire. An explanation of the manner in which the data collected is to be used also stated that this

project was being conducted in partial fulfillment of the requirements for a doctoral thesis on adventure therapy. The name and title of the principal investigator's academic advisor were disclosed, as well. The respondents were given the information necessary to contact either of these individuals in the event that any of the participants had either general or specific questions or comments regarding the proposed study.

Postage paid and self-addressed return envelope was provided to all potential respondents in order to facilitate the most favorable rate of return of the survey data. A copy of the survey instrument, in addition to the letter accompanying the survey, is exhibited in Appendix A and in Appendix B of this manuscript, respectively.

Institutional Review Board approval

Because the data for this study were collected from human subjects, the approval of the Institution Review Board (I.R.B.) of the University of Maine was required before the survey could be administered. A formal application was made to the appropriate Unit Review Board according to the University's guidelines which have been specified for protecting human subjects from harm. A description of the participants' right to informed consent was included in the mailing containing the survey and it also included a statement that potential respondents were being asked to participate in a research project. Specific information, which was described in the previous section, accompanied the instrument and included the name of the doctoral student conducting the research and the name of the university affiliated with the study. The name of the student's doctoral committee advisor was disclosed, together with her faculty rank. A description of the purpose of the research and an estimation of the amount of time it will take to complete

the survey was given. A statement of any reasonably foreseeable risks as well as any potential benefits was also provided. Finally, a description of the protections and limitations of confidentiality was provided to all of the potential respondents. The respondents' actual return of the survey instrument itself satisfied the requirement of the human subjects' right to informed consent. The study was not conducted until the approval of the Institutional Review Board (IRB) was obtained. Because of the nature of the data being collected, the Office of Institutional Research and Sponsored Programs of the University of Maine determined that the application for human subject experimentation was eligible for a hearing by the Unit Review committee of the College of Education and Human Development. It was further decided that, contingent upon this committee's approval, the proposal would be exempt from further review by the IRB.

The application proposal was submitted to the Unit Review committee and after several minor revisions were made, the approval to proceed with the data collection was granted. The survey was mailed to the directors of clinical services of all licensed mental health facilities in the state of Maine during the first week of October, 2004.

Limitations

This study was designed to identify the number of state licensed mental health facilities that are providing adventure therapy services. It is also concerned with the identification of those clinically diagnosed populations that are being served by adventure therapy programs. The data which were collected gave an indication of the factors that influenced the decision to offer adventure therapy services as well as of the factors that influenced the outsourcing of adventure therapy services. The study was not designed to

collect empirical evidence of the efficacy of those adventure therapy programs in treating specific client populations. This limitation can perhaps be overcome by the subsequent efforts of researchers who will be able to use the findings of this study and to use the definition which was proposed herein as a basis for even more empirical investigations on the treatment outcomes of the adventure therapy programs operating within the state of Maine.

Because this study has relied on data which were collected through the use of a survey instrument, there exists the possibility that the phenomenon of volunteer-bias may have influenced the rates of return in favor of the agencies that were more likely to be offering adventure therapy programs. Several researchers have discussed the effects of volunteer-bias, or self-selection, on the part of survey respondents (Plaud, Gaither, Hegstad, & Rowan, 1999; Wiederman, 1999). In this example, the agencies that were already offering adventure therapy services might have been more likely to hold positive attitudes toward this modality of intervention and therefore, may have been more likely to complete and return the instrument than those agencies that did not offer adventure therapy programs. If volunteer-bias did influence the results of the survey, the data may have been skewed more favorably in the direction of a higher level of adventure therapy offerings. Because the responses to the survey included almost twice as many agencies that did not provide adventure therapy, the possibility of this effect may have been mitigated to some degree. Additional measures, which included contacting a number of the non-respondents, were also taken to help ensure that the sample was representative of the population.

Delimitations

This study was delimited to a survey of mental health facilities currently providing adventure therapy services only within the state of Maine. This was not a limitation because one objective of this research was to provide a means for referral agents within the state to gain knowledge of the scope and variety of those agencies which either provide or outsource adventure therapy services. Because this study was delimited to a population which consisted of all of the mental health facilities that were licensed to operate within the state of Maine, the extent to which these findings may be generalized to a larger population is unknown. It will also be possible to make available a deidentified listing of the clinical populations which were being served but again, this information represents only the client populations being served within the state of Maine. Because the survey respondents were informed that their participation was confidential, the availability of this information will require further approval from the University of Maine's College of Education and Human Development Unit Review committee.

Summary

This chapter included a proposed definition of adventure therapy which operationalized the term and which was used on a survey instrument designed to collect data from all mental health facilities on the extent and variety of adventure therapy services currently being provided within the state of Maine. This chapter also discussed the methods that were used in conducting the study. The substantive, or research, questions were delineated as well as the statistical questions which followed therefrom. The study was conducted using both descriptive and inferential statistics. Since the

hypotheses which were formulated were bivariate and nominal data were gathered, the chi-square test of independence was selected as the inferential statistic of choice.

A survey instrument was designed, presented to a group of experts for their feedback and revised before being administered to the total population of all mental health facilities in the state of Maine. The procedures that were employed in conducting the survey were described, as well as the provisions for a follow-up mailing to those agencies that did not respond to the initial request for a reply. An overview of the informed consent process and the Institutional Review Board approval requirement for human subjects testing was discussed. Finally, the limitations and delimitations of the research methods were explored. The possible effects of the survey respondents' self-selection and the influences of volunteer-bias on non-experimental research were also analyzed.

Chapter 4

ANALYSIS AND RESULTS

Descriptive statistics

One hundred and ninety-one surveys were mailed to the entire population of licensed mental health facilities in the state of Maine. Sixty-three surveys were returned. This number represents a rate of response of nearly 33%. Six unopened surveys were also returned and marked as undeliverable by postal authorities either because the site of the facility had no mail receptacle or because the agency had moved and left no forwarding address. Of the 63 returned surveys, seven were found to be unusable and were not included in the analyses because they were filled out either erroneously or incompletely. All of the data contained in the remaining 56 surveys were entered into the computer software program SPSS 11.0 and the database that was created was used for all of the subsequent statistical analyses. The descriptive statistics have been presented as frequency distributions and these distributions have provided the answers to five of the seven research questions that were posed in the introduction to this thesis. The frequency distributions also provided information about the sample which was derived from all of those mental health agencies that responded to the survey.

With regard to the types of agencies that provided responses, approximately 18% were from private, for-profit facilities and approximately 9% were from state or government agencies. The majority of the responses, over 73%, were from private, non-profit agencies. The exact frequencies and percentages are shown in table 4.1.

Table 4.1 *Frequency Distributions of Agencies by Type*

		Frequency	Percent	Cumulative Percent
Valid	Private	10	17.9	17.9
	State or	5	8.9	26.8
	Government			
	Private, Non-profit	41	73.2	100.0
	Total	56	100.0	

The types of services provided by these facilities included inpatient services, outpatient services, residential treatment services, and comprehensive services. Several agencies also indicated that they provided other types of services. These other services were described as activities that included home-based family interventions and direct and indirect community support services. The actual frequencies and percentages are shown in table 4.2 that follows:

Table 4.2 *Frequency Distributions by Types of Service*

		Frequency	Percent	Cumulative Percent
Valid	Inpatient	1	1.8	1.8
	Outpatient	10	17.9	19.6
	Residential Treatment	26	46.4	66.1
	Comprehensive	8	14.3	80.4
	Other	11	19.6	100.0
Total		56	100.0	

The developmental levels of the clients served by the agencies that comprised the sample were found to include all age groups. Services were being delivered to a clientele that was made up of over 14% children, nearly 20% adolescents, over 14% adults, with more than half of the agencies providing services to consumers of all ages. The exact frequencies and percentages are included in table 4.3 that follows:

Table 4.3 *Frequencies and Percentages of Clients' Developmental Levels*

		Frequency	Percent	Cumulative Percent
Valid	Children	8	14.3	14.3
	Adolescents	11	19.6	33.9
	Adults	8	14.3	48.2
	All ages	29	51.8	100.0
	Total	56	100.0	

Of particular interest are the characteristics of the agencies that are providing adventure therapy services in the state of Maine. The results of the survey showed that 33.9% of the agencies that responded were, in fact, providing adventure therapy services. The remaining 66.1% of the agencies reported that they did not offer any type of adventure therapy services directly to their clients. It is noteworthy however, that over half of these agencies, 51.8%, did refer their clients to programs that offer adventure activities as an ongoing part of the referring agency's adjunctive, or supplemental service offerings. These agencies indicated that the programs to which they were outsourcing the adventure component of their service continuum included such programs as Outward Bound which is located in Rockland, Maine, Camp Kieve for Affective Education which is located in Damariscotta, Maine, and Teen Adventure, which is located in Portland, Maine.

Question number 7 on the survey was also posed in the introduction to this study and it asked what clinical populations were being served. The data analysis revealed that adolescents were the most likely clients to be receiving adventure therapy services. Of the

agencies that responded affirmatively to the question pertaining to whether or not they provided adventure therapy services, 52.6% indicated that they provided these services to adolescents. Only one agency indicated that they provided adventure therapy exclusively to children and none of the agencies said that they provided adventure therapy only to adults. The remaining 42.1% of the agencies stated that they provided this service to clients of all ages. The data which were obtained from this question were also consistent with the responses to question number 14 which asked respondents providing adventure therapy to indicate the chronological age groupings of their clients.

Question number 10 concerned the types of psychiatric disorders that had been diagnosed in the clinical populations which were being served by adventure therapy. The survey instrument was designed so that the accepted convention of grouping all of the mental disorders that are listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR)* into three general categories was observed (American Psychiatric Association, 2000; Maddux & Winstead, 2005; Whiston, 2000). These categories consisted of the cognitive disorders and included mental retardation, specific or pervasive developmental disabilities, dementia, amnesic, and other cognitive disorders. Another category was comprised of the affective disorders and this included the anxiety disorders, the depressive disorders, and the bi-polar disorders. The final category of disorders was reserved for the behavioral disorders and this category included, as examples, all of the eating disorders, all of the substance use disorders, and the disruptive behavior disorders of childhood and adolescence. The survey also allowed respondents to indicate whether their agencies provided treatment services to clients diagnosed in all of the above categories. The results showed that only one agency

provided adventure therapy to clients with mental retardation or other cognitive disorder. None of the respondents indicated that they provided adventure therapy services to a clientele diagnosed exclusively with affective disorders. Slightly over 10% of the agencies stated that they provided services only to clients with behavioral disorders. The majority of the agencies providing adventure therapy services (84.2%) were providing them to clients who were diagnosed with a mental disorder that could be classified in any of the aforementioned categories. None of the respondents selected the diagnostic category of *other*.

Question number 11, which was answered by the survey data, was formulated to determine how adventure therapy services were integrated with any other mental health services that were being provided to clients by the responding agency. The possible responses to this question included the statement that adventure therapy services were not integrated with any other agency services and none of the respondents chose this answer. Another response option was that integration was provided by individual clinical consultation with other service providers of the agency. Slightly more than 42% of the respondents whose agencies offered adventure therapy selected this response. Another response was that adventure therapy services were integrated with other services in conjunction with an assigned case manager. Nearly 16% of the agencies responding selected this option. The final possible response to this question included the category of *other* and slightly more than 40% of the responses were registered in this category. For a discussion of the narrative responses which were included with this question, please refer to the section of this chapter entitled, *Analysis of narrative comments*. A breakdown of

the exact frequencies and percentages of the responses to this question may be observed in table 4.4 that follows:

Table 4.4 *Frequencies and Percentages of Methods of Integration*

		Frequency	Percent	Cumulative Percent
Valid	No adventure program	37	66.1	66.1
	Individual consultation	8	14.3	80.4
	In conjunction w/case mgr.	3	5.4	85.7
	Other	8	14.3	100.0

Note. Table shows percentages for all agencies reporting

Although it was not listed as an original research question, one of the scholarly experts who was a higher education faculty member teaching in the discipline of adventure therapy and who also reviewed and pilot tested an earlier draft of the survey instrument made the suggestion that a question should be included that would determine the time of the year that adventure therapy programs were being offered. This individual indicated that since the time and effort were being devoted to the design and administration of survey, an answer to this question might contribute to the body of research in a helpful manner. This question was subsequently included on the survey and the options for the respondents to select for this item were listed as year round, school year, summer, or

other. None of the respondents selected the choices, school year or other. The overwhelming majority of the agencies (89.5%) that provided adventure therapy services stated that they provided them all year round. The remainder of these agencies (10.5%) provided adventure therapy programs only during the summer months.

Question number 14 relates to the demographic characteristics of the clinical populations which are being served by adventure therapy and asked respondents to indicate the sex of these populations. Respondents were asked to indicate whether they served either females only, males only, both males and females in separate groups, or whether clients were provided with adventure therapy services in coed groups. Only one of these agencies affirmed that they provided services to females only. One other agency reported that they served only males in their adventure therapy groups. Three agencies stated that they provided adventure therapy to both males and females but only within the context of separate groupings. The majority of the agencies reporting (73.7%) indicated that they provide these services to both males and females simultaneously in coed groups. The survey instrument made no provisions for the inclusion of individuals for whom the biological sex categories of female and male were not appropriate.

All of the survey respondents were asked to select the single most important type of assistance that would be required if they were interested in either offering a new adventure therapy program or in expanding an existing adventure therapy program. The largest percentage of the agencies (41.1%) cited financial resources as their most important consideration. Slightly over 14% indicated that staff training was their most significant concern and 5.4% selected the availability of technical assistance and support in response to this item. A commitment of administrative support for the benefits of

adventure therapy was cited as the most important factor by 3.6% of the agencies responding. The second largest response selection was in the category of *other* at 35.7% and the narrative responses to this question are described in the *Analysis of Narrative Responses* section of this document.

Inferential statistics

Two of the research questions associated with this study required an analysis involving the use of non-parametric, inferential statistics. All of the information collected from the survey consisted exclusively of nominal data and these two research questions were designed to examine the factors that influence the offering of adventure therapy services and to examine the decisional factors that influence whether or not a mental health agency would be likely to outsource adventure therapy services, respectively. For both of these questions, each of the agencies was classified in terms of two other variables in order to examine the relationships among them. Specifically, this analysis sought to find significant differences among the proportions of agencies that fell into different categories. This procedure required the use of the chi-square test of independence in order to perform a bivariate analysis. Even though the entire population of mental health agencies in the state of Maine was surveyed, the data that were collected from the actual returns represented only a sample of all of these agencies and therefore, it was important to assess whether the observed results reflected the true results which would have been obtained if the entire population had responded to the survey.

In order to determine whether there existed significant decisional factors which influenced an agency's decision of whether or not to offer adventure therapy services, all of the agencies that responded were categorized according to whether or not they offered

adventure therapy programs. The agencies in these two categories were compared according to their responses to survey question number 15 which included the following five response options: (a) Expenses including supplies and equipment, (b) Liability insurance, (c) The availability of qualified and appropriately trained staff, (d) A belief in the efficacy of adventure therapy, and (e) Other. A frequency table of the distributions of proportions was constructed and this was analyzed using the chi-square test of independence. The following assumptions were also met: all of the observed results were independent, each of the response categories was mutually exclusive, and the observed results were measured as frequencies. The recommended sample sizes for the two chi-square tests were determined by consulting the guidelines described in the statistical tables found in the authoritative work by Cohen (1988, p. 259) and these were found to be 44 and 48 in his sample size tables for chi-square tests. These were the sample sizes that were suggested for three and four degrees of freedom, respectively, when a statistical power of .80 and an effect size of .50 are selected. An effect size of .50 has been described by Cohen as moderate and he has proposed the convention of selecting a statistical power of .80 in order to strengthen the probability of detecting the aforementioned effect size. An Alpha (the probability of rejecting a null hypothesis when it is actually true) of .05 was selected because the resulting 95% confidence level ($100 [1 - \text{Alpha}]$) is traditionally used for non-critical tests in the behavioral sciences. Since the number of the sample size that resulted from the survey was 56 and this number so closely approximated the numbers that were obtained from the tables, the decision was made to include the data from all of the useable surveys which had been returned.

The null hypothesis which was given in the previous chapter stated that there was independence in the population of row and column variables:

H_0 : there is independence between those mental health facilities which do and those that do not offer adventure therapy services and the decisional factors variable.

The alternative hypothesis stated that there was dependence between the row and column variables:

H_1 : any state of affairs other than that specified in H_0 .

Table 4.5 shows the data from the preliminary cross-tabulations of the variables.

Additional data on the cross-tabulations of the proportions of expected frequencies with the proportions of observed frequencies are exhibited in Appendix C.

Table 4.5 *Decisional Factors' Influence Cross-Tabulation*

Count		Greatest Influence					Total
		Expenses	Liability	Staff availability	Belief in efficacy	Other	
Adventure Therapy	Yes	2	1	7	4	9	19
	No	12	1	8	3	13	37
Total		14	2	15	7	18	56

$\alpha = .05$

The results of this analysis showed: $\chi^2 = 5.71$, $df = 4$, $p = .222$, and this finding shows that the results were not statistically significant. This meant that the null hypothesis, which was formulated in the previous chapter, could not be rejected because it stated that there existed no significant relationship between those agencies that had decided to offer adventure therapy services and those that did not when compared with the factors that were hypothesized to have influenced those decisions. The table above showed that five of the cells had an expected frequency of less than 5 and Kirkpatrick and Feeney (2003)

have reported that, in the past, some statisticians have recommended that all of the expected frequencies needed to be at least 5 in order for the chi-square test results to be considered significant. Cochran has recommended that for chi-square tests with degrees of freedom larger than 1, fewer than 20% of the cells should have an expected frequency of less than 5 (as cited in Seigel, 1956, p. 178). More recent research has determined that this advice may have been unnecessarily conservative. Glass and Hopkins (1996) have stated that a chi-square test can be assumed to give accurate results when the average expected frequency is as low as 2 (p. 335). These more recent findings gave support to the statistical validity of this test.

The question of whether or not the survey results were representative of the population was dealt with by contacting the clinical directors of eleven of the agencies that did not respond to the survey and asking them to indicate any factors that might have contributed to the reason for their non-response. This was done in an effort to determine whether or not the agencies which were already offering adventure therapy services would have been more likely to submit responses than the agencies that were not because of an assumption of differing levels of interest in the subject. The effects of volunteer-bias were mitigated somewhat by the fact that, of the agencies which were contacted, all eleven of their clinical directors indicated that the reason for their non-response was because of the time constraints which had been imposed by either their regularly scheduled client caseloads or their administrative responsibilities. This information, when taken together with the fact that most of the survey responses were from agencies that did not offer adventure therapy programs, has lead to the conclusion that the survey results were more representative of the population.

The final inferential statistic to be interpreted was the results of the chi-square analysis of the data that addressed the research question that pertained to the decisional factors that influenced whether or not an agency would be likely to outsource, or refer to outside agencies, adventure therapy services for their clients. This research question was addressed by the item listed as number 17 on the survey instrument. The question asked all respondents to select the most appropriate response to the following statement. The single greatest influence in the determination of whether or not to make referrals to outside agencies offering adventure programming is: (a) The client or families' ability to afford the services, (b) A belief in the efficacy of adventure therapy services as an adjunctive therapeutic service, (c) The physical proximity of appropriate facilities, or (d) Other. The null hypothesis, which was stated in the previous chapter, was written as follows:

H_0 : there is independence between the agencies that outsource adventure therapy services and those that do not and the decisional factors variable.

The alternative hypothesis stated that there was dependence between the row and column variable.

H_1 : any state of affairs other than that specified in H_0 .

The results of the cross-tabulations are shown in table 4.6 and additional data on the cross-tabulations of the observed frequencies with the expected frequencies are exhibited in Appendix C.

Table 4.6 *Greatest Influence in the Decision to Outsource Cross-Tabulations*

Count		Referral Influence				Total
		Ability to afford	Belief in efficacy	Facility proximity	Other	
Refer out	Yes	18	8	1	2	29
	No	7	4	3	13	27
Total		25	12	4	15	56

$\alpha = .05$

The results of this analysis showed: $\chi^2 = 15.19$, $df = 3$, $p = .002$. Since the p -value of .002 is less than the .05 level of significance which was chosen for this test, the null hypothesis is rejected. In other words, the test provides evidence that there is a statistically significant relationship between the variable indicating whether or not an agency outsources their adventure therapy services and the variable indicating the reasons given for making that particular that decision. The agencies which reported that they outsourced adventure therapy services cited their clients' ability to afford the services as the most influential factor in making their decision. Those agencies that did not refer their clients to other agencies for adventure therapy services cited other reasons as the factors which most strongly influenced their decision. An analysis of the narrative responses to the survey items that permitted this option may be found in the section that follows.

Analysis of narrative responses

The survey instrument contained seven items that allowed the respondents to select the category of *other* and a provision was made for the entry of their narrative comments to be included with these items. The analysis of these data involved the identification of the common themes that represented the most significant impressions of the respondents. Item number 5 asked about the types of services that a particular agency provided.

Eleven of the respondents choose to add a number of various types of services that were not listed as choices on the survey. The following is a list of the types of service and their frequencies as they were provided by the agencies:

1. Day treatment services (3)
2. Home-based services (2)
3. Case management services (2)
4. Crisis intervention or shelter services (2)
5. Group home living services (1)
6. Substance abuse services (1)

Questions number 10 through 12, inclusively, asked only those agencies that were providing adventure therapy services to their clients for a response. Question number 10 asked those responding to indicate the types of clinical diagnoses that were being treated with adventure therapy. None of these agencies indicated any other type of diagnosis other than the ones which were listed among the survey instrument's responses. This list of responses divided the diagnostic groupings into cognitive disorders, affective disorders and behavioral disorders, as well as a category for all of the above. Each of the diagnostic categories provided examples of specific disorders which are currently listed in the DSM IV-TR. None of the survey results showed an agency that provided adventure therapy exclusively to individuals with affective disturbances. Only one agency reported providing services to clients diagnosed exclusively with cognitive disorders and two other agencies reported that they offered adventure therapy services only to a clientele with a diagnosis of behavioral disorders. As was reported earlier, the remainder of these agencies (84.2%) indicated that they served clients with diagnoses in every category.

Because none of the respondents on this item selected the category of *other*, there were no narrative responses to report.

Question number 11 was concerned with the ways in which adventure therapy services were integrated with other services provided by the agencies. The narrative responses, as well as their frequencies, are described in the following list:

1. In consultation with academic staff (2)
2. As indicated by hospital's rehabilitative or psychological assessment (2)
3. Coordinated by the program's clinician (3)
4. Provided as group recreational activities. (1)

Question number 12 inquired about the time of year that adventure therapy services were offered and none of the respondents provided a narrative response for this item.

Question number 15 asked all respondents to select the single greatest influence on the decision of whether or not to offer adventure therapy services. Among those agencies indicating that they were currently offering adventure therapy services the five following narrative responses were included in the category of *other*:

1. Scheduling or providing time for the activities (2)
2. Client interest (3)

Thirteen of the agencies that were not offering adventure therapy activities provided the following responses in the *other* category of the same question:

1. Have not investigated this modality of treatment (1)
2. Adventure programs are not a focus for us at the present time (2)
3. All of the above (2)
4. Lack of interest on the part of clients (1)

5. Lack of interest on the part of agency administration (2)
6. Efficacy for a particular client population questioned (1)
7. Services would not be reimbursable under rates set by the state (3)
8. Prefer to outsource these services (1)

Question number 17 asked survey participants to name the single greatest influence on the determination of whether or not to make referrals to outside agencies offering adventure programming activities. The options given for selection on this item were the client or families' ability to afford the service, a belief in the efficacy of adventure programs as an adjunctive therapeutic service, the physical proximity of appropriate facilities, and again, *other*. The 18 narrative responses and their associated frequencies are listed below:

1. We are already providing similar services (4)
2. All of the above (3)
3. Not aware of adventure therapy services (3)
4. Not a priority for most of our residents (1)
5. Clients' ability to participate because the moms have young kids (1)
6. Third party payees being willing/able to afford services (1)
7. None of these items are barriers (2)
8. The availability of services (1)
9. Client needs/interest (2)

Question number 18 on the survey asked respondents to indicate the single most important type of assistance that would be necessary in order to either offer an adventure therapy program or to expand an existing program. Twenty of the agency representatives

elected to submit a narrative response with this item. The following is a list of the narrative responses which were given in the category of *other* on this question:

1. Not interested at this time (2)
2. All of the above (9)
3. Availability of clinical staff (1)
4. More information and data needed to support the efficacy (4)
5. Client interest (3)
6. Reinstatement of Medicaid cuts at the state level (1)

The final item on the survey was suggested as an addition to the instrument by the chairperson of the Unit Review Committee on the Protection of Human Subjects in Research. The suggestion was to provide an opportunity at the end of the survey for additional comments from the respondents and this suggestion was subsequently implemented as a part of the final approval process. The following is a list of general comments taken from this section of the survey that most typifies the impressions of clinical staff members affiliated both with agencies that provided adventure therapy services and with those that did not:

1. If adventure therapy was tailored to the unique needs of the individual, then some clients could possibly benefit. Many of our clients are elderly and are not comfortable in new situations. Some of the younger people could possibly be encouraged to participate (difficult to assess). This is not an issue because there is no funding.
2. We serve an older population.

3. While our agency does not provide adventure therapy, we do collaborate with a local agency to provide some services, e. g. a three day winter trip/hike, kayaking/canoeing trips.
4. Recreational/play therapy is a very effective strategy to encourage children and adolescents to express their thoughts and feelings in their “real world” [*sic*] with their peers.
5. It is not difficult to conceive adventure therapy as beneficial or as “adjunctive therapy” but can it be appropriately used to solve life’s problems or to change one’s life, as in psychotherapy? If not, does it then become recreational therapy?
6. Although I am an avid believer that adventure therapy is one of the most effective ways for a client to gain mental health and emotional growth, I am currently employed at an agency that is not supportive, nor willing to take the risk, to offer adventure therapy.
7. We used it primarily for the 30 adolescent inpatients as well as for the 30 adult inpatients admitted to the 28 day stay chemical dependency program. It was awesome, beneficial, and an integral component of the patient’s clinical program...(we used to do outcome studies... however, I no longer have any of the data...cleaned house so to speak when we moved into a new facility this past spring). Decreasing lengths of stay, liability issues, severity of illness, and safety concerns were cited as reasons for the diminished use of adventure programming.

In addition to the descriptive and inferential statistics, these anecdotal comments have provided a valuable source of information regarding the extent to which adventure

therapy programs are available within the state of Maine. This information has also been helpful in trying to make a determination regarding the most significant factors influencing the development or the mitigation of new adventure therapy offerings.

Summary

This chapter has described the survey response rate of the population of all licensed mental health facilities in the state of Maine. The number of the sample that made up the viable responses was 56. The results of the descriptive statistics associated with this sample have been reported as frequency distributions and percentages and a number of relevant tables have been inserted in order to make clear the comparisons which highlight the differences among agencies that reported adventure therapy offerings and those that did not. The information described in this chapter has sequentially addressed the substantive research questions that were posed in the introduction to this thesis.

Following the reporting of the descriptive statistics, the results of the inferential statistics were reported and these have provided answers to the two research questions that concerned both the decisional factors that influenced the offering of adventure therapy programs and the factors that influenced the outsourcing of adventure therapy services. The measures which were taken to address the problem of the representativeness of the sample to the entire population were also discussed. References to research supporting the statistical validity of the results of this analysis have also been included. The results of the chi-square tests were provided in the text and the results of the cross-tabulations of the observed frequencies with the expected frequencies have been shown in the appendices.

Following the analysis of the inferential statistics, a section which reported the results of the narrative data which took the form of anecdotal responses to several survey items was described. These data were grouped according to thematic similarities and they were reported as frequencies whenever it was most appropriate.

Chapter Five

DISCUSSION AND CONCLUSIONS

Summary of the research

The purpose of this study was to determine the scope and variety of adventure therapy services which were being offered by licensed mental health facilities within the state of Maine. This was accomplished by identifying a list of substantive research questions from which a number of specific research questions subsequently were derived. A comprehensive review of the literature revealed a paucity of empirical research studies on the subject of adventure therapy and a major contributing factor to this exigency appeared to be the lack of a functional definition of the term *adventure therapy* itself. Although the literature review disclosed a number of published academic articles on the relatively recent history of adventure therapy programs in industrialized nations, this study did not seek evidence for the efficacy of adventure therapy as a therapeutic intervention. In order to determine the scope and variety of adventure therapy programs in the state of Maine, a survey instrument needed to be constructed and administered to the clinical directors of all of the mental health facilities operating within the state. Before the survey instrument could be designed and constructed, an operationalized definition of the term *adventure therapy* needed to be formulated. This study explored a number of the definitions which have been suggested for this term and it also discussed many of the specific problems that have become associated with each of them. In addition to a lack of agreement on the part of practitioners in the field regarding the definition of adventure therapy, the literature review showed that a number of closely related terms have come to be confused with the term *adventure therapy* and also disclosed that several of these authors have

recommended that many of these terms be subsumed under the more inclusive descriptor, *adventure therapy*. There was still much disagreement in the field with regard to a universally accepted definition of this term and before more valid research studies could be conducted, this condition needed to be remediated. The definition which was proposed in this thesis will provide an opportunity for academicians and practitioners to evaluate its potential for acceptance as the standard for use in the field of adventure therapy.

This study has made a theoretical and a methodological contribution by developing an operationalized definition of the term *adventure therapy* and this definition has incorporated many of the suggestions which have been offered by the authors of a number of academic texts and journal articles in this field. This definition describes adventure therapy as follows:

Adventure therapy is defined here as a modality of psychotherapeutic intervention which is used to treat clients who are experiencing clinically significant cognitive, affective, or behavioral dysfunctions and is provided by, or under the supervision of a licensed, certified, or otherwise qualified mental health professional. Adventure therapy activities may occur in either a natural or contrived environment, are experiential in nature, involve elements of real or perceived risk, and consist of a facilitated integration of adventure challenges and therapeutic counseling strategies.

The rationale for each component that was included in the construction of this definition was based upon the concept of inclusivity and it is described in Chapter Four of this thesis. The acceptance of this operationalized definition of the term *adventure therapy* will help to facilitate the conduct of more empirical research into the efficacy of this modality of intervention and will also allow it to be compared with many other types of

psychotherapy which themselves have a long-established and agreed upon consensus among practitioners with regard to an operational definition of the terms that define their respective approaches. This proposed definition has also made it possible to construct and administer the survey instrument which was used to gather the data for this investigation into the scope and variety of adventure therapy services which are being provided by licensed mental health agencies within the state of Maine.

This research began with a review of the literature that has traced the history of the development of adventure therapy from its beginnings with the work of Kurt Hahn, first in Germany in the school systems, and later in Scotland when it was used to train soldiers in the skills of rescue at sea. The development of the adventure therapy movement in the United States was traced from the adaptation of Kurt Hahn's model to the Outward Bound schools and later to the beginnings of Project Adventure in the early seventies and to the advent of Adventure Based Counseling. The use of adventure therapy in the mental health professions has evolved from the use of adventure activities which were initially based in the public schools and, from there, moved to the use of adventure experiences as a type of therapeutic modality in psychiatric hospital-based settings. Adventure therapy, although often referred to by different names, later came to be incorporated into the community mental health movement as a widely accepted regimen of psychotherapeutic intervention. Today, adventure therapy programs are in existence throughout the United States. This modality of therapy is ideally adapted for use in a state like Maine because Maine contains geographic areas which readily allow the utilization of the types of wilderness environments that are necessary for the inclusion of adventure pursuits within the field of mental health. The extent to which adventure therapy was used by the mental

health facilities which are licensed to operate within the state was unknown. This has made it difficult for families and referring agents to find appropriate programs that are in close enough physical proximity to allow a family member or clinical caseworker to help a client obtain access to adventure therapy services. This examination of the scope and variety of adventure therapy services within the state has constituted a necessary first step in the process of helping mental health consumers to gain access to a potentially valuable resource in the repertoire of mental health treatment services.

The lack of consensus among members of the mental health profession with regard to a single accepted definition of the term *adventure therapy* has also resulted in confusion for both consumers and practitioners alike. One clinical staff member might recommend a program that offers Adventure Based Counseling services while another might recommend a program that offers Wilderness Therapy as a treatment option. While there are several relatively minor distinctions between these two terms, which have more to do with the types of adventure activities that are employed, the treatment goals for the client might be just as effectively met by either of these modalities. Without a clear understanding of the nomenclature which is used to describe many adventure therapy pursuits, which share more similarities than differences, a state of misunderstanding has resulted in confusion for both clinicians and their clients. By operationalizing the definition of adventure therapy, it was possible to develop a survey instrument and to pilot test it with a group of academic and clinical experts in the field before the revised survey was mailed to the clinical directors of all of the licensed mental health facilities in the state of Maine. The data that were gathered from the responses were entered into a computer database and from there a number of analyses were performed which utilized

both descriptive and inferential statistics in order to answer the specific research questions which were posed at the beginning of this project. The favorable response rate which was returned from the survey included a significant number of agencies that reported adventure therapy offerings. This was discussed as a potential limitation to this research because of a phenomenon known in the field of survey research as volunteer-bias. The agencies that were offering adventure therapy programs might have been more likely to complete and return a survey on adventure therapy because of their predisposed interest in this topic. On the other hand, an agency that did not offer adventure therapy, or for that matter, did not know what adventure therapy was, might have been less likely to complete and return the instrument. An agency that did not subscribe to the definition of adventure therapy that was proposed in the survey might not respond and this might have adversely affected the representativeness of the sample. Another limitation of this study was that it was not designed to determine the efficacy of adventure therapy as a treatment modality. A delimitation of this study was that it was confined to geographic limitations of the state of Maine and no inferences were able to be drawn on the prevalence of adventure therapy programs in other states or countries. The limitations and delimitations were more fully discussed in Chapter Four. The results of the analyses of the data were also presented in Chapter Four of this document, together with the most relevant statistical tables, and a discussion of these results follows.

Discussion of descriptive results

From the entire population of all mental health agencies which were licensed to operate within the state of Maine, a survey response rate of approximately 1/3 was

obtained. This number was encouraging because it provided enough information to enable the use of the inferential statistics that were necessary for the analysis of the data. The representativeness of the sample may have been restricted by the constraints which were imposed by the definition of adventure therapy that was used in this study. An example might be an agency that did not subscribe to the proposed definition as a descriptor of its therapeutic outdoor activities. However, because the definition was deliberately configured to allow for the broadest degree of inclusivity, the possibility of a higher rate of non-response was intentionally minimized. Fifty-six of these responses were appropriate for use in this study and the database that was constructed provided valuable information about the types of agencies as well as the types of services that they provided. The majority of the agencies, over 73%, were incorporated as private, non-profit facilities. The remainder of the agencies that responded was made up of either for-profit corporations or they were licensed as state or government entities. The types of services provided by these agencies represented a cross-section of the mental health services spectrum. The makeup of the agencies that responded included psychiatric inpatient or hospital-based providers, outpatient mental health clinics, children's residential treatment centers, home-based or community support service providers, and comprehensively licensed community mental health centers. Eleven of the agencies that responded also provided narrative comments which explained other services which were not listed as response options on the survey instrument. Three of these agencies listed day-treatment services as their primary service delivery function. Two other agencies indicated that their primary service offerings were either crisis intervention or emergency shelter options. One of these agencies stated that they provided only substance abuse

services to their clients. The sample which was generated by the survey appears to consist of a representative grouping of the types of mental health services that are provided throughout the state of Maine.

Another one of the initial research questions which was asked at the outset of this investigation was concerned with the clinical populations that were being served by adventure therapy services. A review of the analysis of the data has shown that the developmental levels of the clients served by all of the agencies that responded to the survey represented all chronological age groupings. Over one half of all of these agencies reported that they served clients of all ages. Almost 20% of the agencies indicated that they served adolescents exclusively. The remainder of the agencies reported that they served only children or only adults. These data are of interest especially when they are compared to the chronological age groupings of the clients served by the agencies which were providing adventure therapy services. Among this group of respondents, more than half of the agencies were providing adventure therapy services solely to adolescents. This datum is not surprising since the preponderance of the journal articles which were examined in the literature review for this study cited adolescence as the most common stage of development for the recipients of adventure programming activities in the mental health field. A sizable proportion, over 40%, of the agencies which were providing adventure therapy services to their clients stated that they offered this service to clients of all ages. Surprisingly, only slightly over 5% of the agencies offered adventure therapy to young children exclusively. It is possible that the monetary expenses concomitant with establishment of a fully functional adventure therapy program would be a powerful

enough influence to affect the decision to offer these programs to as many chronologically diverse groups as possible.

The results of this study also determined the different types of specific psychiatric problems or disorders that adventure therapy was being used to treat, either alone, or as part of a treatment regimen. There was one agency which indicated that it was using adventure therapy to treat clients whose only diagnosis was a cognitive disorder an example of which is mental retardation. None of the agencies reported that they were using adventure therapy to treat affective disturbances exclusively. Two of the agencies reported that they were using adventure therapy to treat only behavior disorders. This finding might be best accounted for by the likelihood that these agencies specialize in the treatment these particular disorders. Almost 85% of the agencies replied that they used adventure therapy to treat cognitive, affective, and behavioral disorders inclusively. Again, this finding is not surprising since the literature review on this subject has shown that adventure therapy is continuing to be used by a growing number of clinicians in the mental health profession and this study has shown, at least in the state of Maine, that it has come to be increasingly utilized as an alternative to the more traditional therapies in the treatment of a variety of psychiatric disorders.

The research question that was designed to determine whether or not adventure therapy services were integrated with any other mental health services which were being offered was answered by the agencies that were also offering adventure therapy programs. In the event that any other services were being integrated, this same survey question provided the respondents an opportunity to indicate the manner in which the process of integration was facilitated. A review of the data analysis has shown that more

than 42% of the agencies reported that adventure therapy services were integrated with other services by individual consultation with other service providers. Almost 16% of the respondents indicated that they accomplished the integration of services in conjunction with an assigned case manager. The remainder of the answers was comprised of various narrative responses which were written in the category of *other*. Two agencies that had maintained a close working relationship with the local school systems stated that their adventure therapy services were coordinated by conducting ongoing consultations with members of the academic staff who were working at the schools where their clients were attending classes. Another two of the respondents replied that these services were integrated as they were indicated by a hospital's rehabilitative treatment plan or as they had been prescribed as part of a psychological assessment. Three of the agencies stated that the integration of services was coordinated by their program's clinician. Finally, one agency reported that the integration was provided as a regular part of their group's recreational programming. It is encouraging to note that all of the respondents indicated that adventure therapy services were integrated with the other services that were being provided because this suggests that adventure therapy is a modality of treatment that may be seamlessly integrated into a broad continuum of mental health service offerings.

The responses to the survey question which sought to determine the time of year that adventure therapy services were being offered revealed that nearly 90% of the agencies offered these services throughout the calendar year. There were only two of the agencies that had restricted their offerings of adventure therapy programs to the summer months. Even though the majority of adventure therapy programs are designed so that the experiential activities can take place outdoors, it was also encouraging to discover that, in

spite of the harsh winter seasons that are so common in the higher northern latitudes of New England, adventure therapy is seen as a viable mental health treatment option throughout the year.

The addition of the survey question which was suggested by one of the adventure therapy experts, in advance of the IRB approval process, was designed to determine the sex of the clients who were receiving adventure therapy services. There was only one agency that reported providing adventure therapy services exclusively to females. There was one other agency that reported providing adventure therapy services only to a clinical population of males. Almost 3/4 of the agencies reported that they provided adventure therapy services to both females and males in sexually integrated groups. Three of the agencies responded that they provided adventure programs to both males and females but in separate groups. It would be of interest to understand the rationale for the choice to segregate the groups based on an individual's sex. Some scholars have speculated that adventure therapy activities have historically been designed by males and because of this fact, there has been a lack of awareness regarding the distinct needs of the female participants who have been involved in these programs (Warren, 1999, p. 393). This is an area of investigation that certainly deserves more attention; however, it is beyond the scope of the present study. With regard to the reports from two of the respondents who were affiliated with agencies that offered adventure programs to only one sex, there is a distinct possibility that these agencies were restricted in all of their service offerings to only one sex. An example of this type of segregation might occur deliberately in a group home for adolescents or an outpatient mental health program for victims of sexual assault. Unfortunately, this particular survey item made no accommodation for the

respondents to select an option other than the categories of *male* and *female* and consequently this limitation precluded all of the individuals for whom neither of these categories could be appropriately applied.

All of the agencies that responded to the survey were asked to indicate the type of assistance that would be required if they were to consider either offering a new adventure therapy program or if they were to consider the expansion of an adventure therapy program that was already in existence. The single most influential factor which influenced the decision of whether or not to offer or to expand adventure programs was reported as being the need for adequate financial resources. The other factors, in descending order, which influenced the decisions were (a) the need for appropriate staff training, (b) the need for technical assistance and equipment, and (c) a commitment of administrative support for the use of adventure therapy. This particular question also allowed respondents to state any other considerations in the form of narrative comments. Of the 20 comments that were submitted, 9 of them reported that all of the multiple choice items were equally important. These comments were submitted in spite of the survey item's instructions to select only the single most important type of assistance that would be necessary to make these decisions. Three of the responses cited the importance of an adequate level of interest on the part of their clientele. One of these agencies reported that they provided services exclusively to a population of more elderly clients. Four of the respondents indicated that they would require more information and data on the efficacy of adventure therapy. These responses support the need for the publication of more empirical research on the effectiveness of adventure therapy and the need for more effort, perhaps at professional conferences and in graduate training programs, to raise the

consciousness of mental health practitioners regarding the potential clinical merits of this type of intervention. Finally, two agencies simply stated that they were not interested in establishing a new program at this time.

Discussion of inferential results

Two of the research questions that were formulated for this study required the use of an inferential test statistic. The first question was concerned with identifying the decisional factors that either encouraged or mitigated against the offering of adventure therapy services. This question was specifically designed to determine if there existed any significant differences between the factors that influenced the decision of whether or not to offer adventure therapy services among the agencies that did, in fact, offer them and those agencies that did not. Since all of the data which were collected on this question were nominal, the chi-square test of independence was performed. The results of this analysis are shown in the previous chapter of this document. This analysis revealed that there were no statistically significant differences between the agencies that offered adventure therapy programs and those that did not when compared across the reasons that were identified as contributing the most influence on those decisions. A cursory examination of the cross-tabulation data disclosed that there were no apparent differences between the agencies that offered adventure therapy and those that did not when compared to a number of the decisional factors. These factors included the cost of liability insurance, the availability of qualified and appropriately trained staff, and a belief in the efficacy of adventure therapy. There were numerical differences among choices selected by the agencies on the survey. The largest differences were accounted

for by the agencies that did not offer adventure programs and their concerns regarding the financial expenses, including supplies and equipment, when these agencies were compared on this item to the agencies that did offer adventure therapy. Another numerical difference was accounted for by the influence of other factors which were described by many of the agencies that did not offer adventure therapy in their narrative comments which accompanied this question. Notwithstanding the fact that the results of the chi-square test of independence were not statistically significant in this case, the information which is contained in the discussion of the qualitative data might lend itself to some useful possibilities with regard to potential areas for future research into the factors that actually do either promote or discourage the offering of adventure therapy.

The other research question that required the use of an inferential test was the question that was concerned with identifying the decisional factors that influenced the outsourcing of adventure therapy programs. Again, because the survey data were entirely nominal, the chi-square test of independence was chosen as the appropriate test statistic. The results of this analysis are shown in the previous chapter and they demonstrate that the differences among the decisional factors between the agencies that outsourced adventure therapy services and those that did not were, in this case, statistically significant. The cross-tabulation data show that the agencies which reported that they regularly outsourced adventure therapy activities also indicated that their clients' ability to afford the service was the factor that most strongly influenced their decision. This finding suggests that these agencies did not believe that the expenses associated with adventure therapy services were cost-prohibitive. Among the agencies that reported that they did not refer their clients to other agencies for adventure therapy services, other reasons were cited as

factors which influenced their decision. The most frequently cited reason was the lack of awareness on the part of the clients or the administration regarding the utility of adventure therapy programs. This lack of awareness could be due to the relatively recent history that adventure therapy has had within the mental health profession (Raiola & O'Keffe, 1999, p.51). The other, less frequently cited, decisional factors are reported in the narrative responses that were submitted in response to this item. An analysis of these responses is included in the discussion of the qualitative data section which follows.

Discussion of narrative data

The survey instrument contained several questions that allowed the respondents to include narrative comments in order to more fully describe the services performed by their agencies as well as to provide an opportunity to share their views on adventure therapy services. These comments contained information that was useful in the examination of the scope and variety of adventure therapy services which were being offered by the licensed mental health facilities within the state of Maine.

Question number 5 on the survey concerned the types of services that all of the agencies primarily provided. Three of the agencies reported in the narrative comments that they offered day-treatment services to their clients. One of the response selections for this question was partial hospitalization and this term has often been used in the mental health profession as a synonym for day-treatment services. It is possible that the agencies that included day-treatment services as a narrative response to this question did not consider their day-treatment programs to be a type of partial hospitalization and it was possibly for this reason that these responses were included in their narrative comments.

Four other comments included either case management and crisis intervention or emergency shelter services. Although the question was designed to accommodate these services within the listed response categories, these narrative comments were included in order to further illustrate the wide range and variety of mental health services that were being provided by the survey respondents. For this reason, because there was one agency that reported offering primarily group home living services and another agency that reported offering primarily substance abuse services, their narrative responses were included here as well. All of these responses indicate that these agencies were providing a continuum of mental health services which included a range from the least restrictive to the most restrictive alternatives.

Four of the questions on the survey instrument were designed specifically to collect information from only the mental health facilities which were offering adventure therapy services to their clientele. From among these questions, 3 of them made provisions for the participants to include a narrative response option.

One of these questions asked how adventure therapy services were integrated with the other services that were being provided by the agency. Two of the 19 respondents that were offering adventure therapy indicated that their adventure therapy services were integrated through consultation with their academic staff members. These were probably comments from agencies that provided some type of educational component as an adjunct to their mental health service offerings. This fact supports the contention that adventure therapy's experiential emphasis is suited for use in educational settings (Wurdinger & Priest, 1999). Two other inpatient agencies stated that they integrated adventure therapy services as a part of the hospital's rehabilitative or psychological assessment. It was

encouraging to discover that patients who had been admitted to psychiatric inpatient facilities were able to also benefit from the use of adventure therapy programs. Three of the agencies that provided adventure therapy services reported that the integration of these services was coordinated by the program's clinician. These data suggest that there appear to be an emphasis on the importance of integrating adventure therapy with other clinical services that a client might be receiving and they also suggest support for a philosophy of a more holistic approach to the provision of mental health services. This finding is also consistent with the review of the literature (Davis-Berman & Berman, 1999, p. 367). Another agency indicated that adventure therapy services were provided as a part of a group's recreational activities. It seems reasonable, since this response was reported in relation to the survey question that pertained to service integration, to assume that the intention of this respondent was to indicate that adventure therapy services were integrated with other types of recreational activities.

The respondents were asked to indicate the single greatest influence on the decision of whether or not to offer adventure therapy services. This question provided the basis for one of the chi-square analyses which were described in the previously. Although the results of the chi-square test were not found to be statistically significant, the observed frequencies table showed that the response option of *other* was the most common selection among those agencies that had decided not to offer adventure therapy services. This was surprising because it had been assumed that the factors which were hypothesized to have influenced this decision would have revealed differences. Three of the agencies indicated that they did not believe that adventure therapy services would be reimbursable under the rates that are presently fixed by the state. These responses clearly

indicate that the financial expenses associated with offering an adventure therapy program were dissuading factors in making this decision. Even though one of the response items on the survey instrument would have perhaps been more appropriate, the narrative responses also suggest the respondents' belief that adventure therapy services would not be legitimate expenses for third party reimbursement. The operationalized definition of adventure therapy that was provided to all of the respondents as part of this study included the stipulation that adventure therapy services must be provided by, or under the supervision of an appropriately licensed, certified, or otherwise qualified mental health professional. This contingency alone would render the assumption of non-reimbursement to be erroneous. It is possible that not all of the respondents answered from the context or the perspective of the operationalized definition of adventure therapy which was included at the beginning of the survey instrument.

Three of the narrative responses stated that a lack of interest on the part of either the clients or on the part of the agency's administration was the most influential factor resulting in the decision not to offer adventure therapy. The efficacy of adventure therapy for use with a particular client population was questioned by one of the respondents. Another reported that they were unaware of this modality of mental health treatment. Two other agencies reported that adventure therapy programs were not a focus for them at the present time. The majority of all of the narrative comments contained themes that seem to indicate a lack of awareness on the part of either the clients or the agency's professional staff about adventure therapy as an appropriate modality of intervention. This finding points to the need for more education and awareness among mental health professionals with regard to a functional definition as well as expanded studies into the

clinical efficacy of adventure therapy programs. Since all licensed or certified mental health professionals are required to receive continuing education as part of their license renewal processes, the advocates for the use of adventure therapy programs might consider using this as a way to raise the levels of awareness within the mental health community. The remainder of the written responses to this question contained a variety of miscellaneous themes and included the statement from one agency that their preference was to outsource adventure therapy services and two other agencies reported that they believed that every one of the response options was appropriate to cite as the single greatest influence on the decision of whether or not to offer adventure therapy services.

A chi-square test of independence was performed in order to determine the single greatest influence on the agency's decision of whether or not to make referrals to outside agencies which were offering adventure programming activities. The results of this test were shown to be statistically significant and these were statistically dependent on the decisional factors variable which was whether or not an agency outsourced adventure therapy services. Eighteen of the respondents who were outsourcing adventure therapy programs said that the ability of their clients to afford the services was the greatest decisional factor. Among the agencies that chose not to outsource these services, other reasons were cited as having the most influence on their decision. Here again, the qualitative data that was contained in the survey respondents' narrative responses provided some valuable insights into the factors that influenced this decision. Several of the agencies stated that they would not refer their clients out for adventure therapy services for the obvious reason that they were already providing these services. A lack of interest on the part of clients and a lack of awareness of adventure therapy services were

cited by many of the respondents as a reason not to outsource adventure therapy programs. This finding, once again, supports the need for more education and awareness on the part of the mental health community regarding the use of this treatment modality. The clients' levels of awareness might also be increased by availability of more research studies that could document the effectiveness of adventure therapy. The availability of appropriate adventure activity referral sources was cited on this question by one respondent. A number of miscellaneous narrative comments included, as influences that impeded the outsourcing of adventure therapy offerings, third party payees' willingness or ability to afford the services and the demands of custodial care for their children on their clients who were parents. These data seem to indicate that while the agencies that outsource adventure therapy services do so because of their belief in their clients' ability to afford them, the agencies that do not outsource these services have different reasons that influence their decision. Increasing the awareness on the part of the public and the mental health profession about the uses of adventure therapy and about the physical proximity of the agencies that offer it would help to remediate several of these decisional impediments.

All of the agencies surveyed were asked to name the single most important type of assistance that would be required in order to offer either a new adventure therapy program or to expand an existing one. The comments that follow were submitted in response to this question and have revealed more insights into factors that have contributed to either the commencement or to the expansion of adventure therapy programs. Four of the respondents indicated that more information was required in order to support the utilization of this type of therapy. There were three agencies indicated that

the need for an increased level of interest on the part of their clients was an important decisional factor. These comments reflect the importance of any efforts to make the potential advantages of adventure therapy more widely known. The remainder of the responses could not be grouped according to any thematic similarities and they included a comment concerning the need to reinstate the state's federal funding cuts and a comment concerning the availability of adequate clinical staff. Interestingly, nine of the agencies that responded with a narrative comment to this item cited all of the response options as the single most important type of assistance that would be required in order to offer either an adventure therapy program or to expand an existing one. These responses might have suggested that there was a sense of discouragement on the part of the respondents at the perception of what seemed like overwhelmingly complex logistical considerations which they associated the development or the expansion an adventure therapy program. It is also possible that these respondents believed that the lack of published research supporting the efficacy of adventure therapy was an impediment to this type of therapeutic alternative.

The final item on the survey invited all of the respondents to include any additional narrative comments on the subject of adventure therapy. The responses to this item came both from agencies that were providing adventure therapy and from those that were not. Contained within these data were some enlightening disclosures regarding the attitudes that were held by clinical staff members of a variety of mental health facilities toward adventure therapy services. All of the narrative comments were grouped according to a number of thematic similarities. The first grouping included all of the comments that stated the belief that adventure therapy was not appropriate for a particular type of client. The majority of these referred to a client population that the respondents believed was

either too elderly or too young to benefit from adventure therapy. Another concern was expressed as a significant degree of uncertainty with regard to the clinical efficacy of adventure therapy as a treatment modality. A lack of administrative support for any adventure therapy services was voiced by one clinician even though she expresses wholehearted support for this mode of intervention. The remainder of the comments expressed a most favorable impression of adventure therapy, the liability issues and financial expense concerns notwithstanding. Because adventure therapy has a relatively short history in the field of mental health and because of the dearth of scholarly research and publications which could provide stronger empirical evidence for its clinical efficacy, a common attitude among many professionals appears to be one of trepidation or uncertainty regarding the appropriateness of its use. This might be best addressed by conducting and making available more scholarly research that supports the clinical efficacy of adventure therapy programs.

Conclusions

The purpose of this study was to determine the scope and variety of adventure therapy programs which were being offered by licensed mental health facilities within the state of Maine. This study was designed to be nonexperimental in nature. Nonexperimental studies have taken many forms because they serve a variety of purposes (Patten, 2002, p. 9). In order to examine the attitudes, beliefs, and behaviors of the clinicians who were responsible for the provision of adventure therapy services, a survey method of collecting data was chosen. Before an appropriate survey instrument could be constructed, the problem of defining an operationalized definition of the term *adventure therapy* needed

to be overcome. An exhaustive review of the literature revealed that there were many different terms that were used by practitioners and researchers alike to describe adventure therapy. These myriad terms often seemed to be used interchangeably in order to describe a single construct. The lack of an accepted definition of adventure therapy has hindered the conduct of earlier empirical research efforts into the efficacy of adventure therapy as a modern type of psychotherapeutic intervention. The first step in the implementation of this study was to produce a list of substantive research questions that would assist with the examination of the extent of adventure therapy programs in Maine. The following is a list of the questions which were explored in this study.

1. What licensed mental health facilities are offering adventure therapy services within the state of Maine?
2. What clinical populations are being served by these facilities?
3. What types of services do these facilities provide?
4. What are the factors that either encourage or impede the offering of adventure therapy programs by mental health facilities within the state of Maine?
5. What specific types of problems and disorders are being treated in adventure therapy programs?
6. How are adventure therapy services integrated with other mental health services?
7. What are the factors that influence the outsourcing of adventure therapy services?

In order to discover the answers to these questions, it was necessary to produce a functional definition of the term *adventure therapy* and to then use this definition for the purpose of constructing a survey instrument which was subsequently administered to the

clinical directors of the agencies that made up the entire population of all of the mental health facilities that were licensed to operate within the state of Maine.

A critical analysis of the adventure therapy definitions that existed in the literature was performed and the suggestions which had been provided by scholars (Gillis, 1995; Itin, 2001) concerning the factors to be considered in the formulation of a more adequate and functional definition were finally incorporated into the definition that was used for the survey. The proposed definition is described here again as:

Adventure therapy is defined here as a modality of psychotherapeutic intervention which is used to treat clients who are experiencing clinically significant cognitive, affective, or behavioral dysfunctions and is provided by, or under the supervision of, a licensed, certified, or otherwise qualified mental health professional. Adventure therapy activities may occur in either a natural or contrived environment, are experiential in nature, and involve elements of real or perceived risk, and consist of a facilitated integration of adventure challenges and therapeutic counseling strategies.

A rationale for each component is discussed in the Methods chapter of this document.

This definition represents a potentially valuable methodological contribution to the ongoing study of the subject of adventure therapy and it has also permitted the preliminary intentions of this study to be carried out. These intentions were to construct a survey instrument in order to collect the data and to perform the statistical analyses that were necessary in order to answer the substantive research questions.

The survey instrument contained a number of questions which were designed to explore the extent of the adventure therapy programs which were being offered by mental health facilities in the state of Maine. The instrument was pilot tested on a group

of experts in order to strengthen its content validity. These experts were working in the field of adventure therapy either as practitioners or as academicians. The revised instrument was approved by the Unit Review Committee for the Protection of Human Subjects in Research at The University of Maine. The instrument was then administered to the clinical directors of all of the mental health facilities which were licensed to operate within the state of Maine. The survey instrument itself represents a valuable contribution to the body of research on the subject of adventure therapy because it can be used in future efforts within the state of Maine in order to examine the growth or abatement of trends in the adventure therapy movement. This instrument could also serve as a template for the survey research endeavors that are taking place in other states or countries and it could also be used as a standardized instrument of measure which might be used as a comparative indicator for the study of prevalence rates of other adventure therapy programs. The instrument could be easily adapted to collect data on other subjects such as the types of training that adventure therapists receive or the length of clients' participation in adventure therapy programs.

The number of agencies that responded to the survey very closely approximated a return rate of 1/3 of all of the licensed mental health agencies operating in the state. The number of surveys which were used in the analysis of the data was 56 and this number constituted nearly 30% of all licensed mental health agencies. This rate of response was robust enough to allow for the minimum sample sizes which were required to complete the chi-square tests that were used for the inferential statistics' analyses. Measures to help ensure the representativeness of the sample included asking a number of non-respondents to disclose their reasons for not participating in the survey. These surveys

were then used to compile the data which were used in the analysis of the descriptive statistics. The types of agencies that participated in this study represented a reasonable cross-section of all of the mental health agencies operating in the state and the types of services provided by these agencies were reported to cover the entire continuum of service delivery and ranged from outpatient and home-based family services to residential treatment and inpatient hospitalization. The chronological ages of the clients served, which were reported as developmental levels ranging from children to adults, also indicated that there was a continuum service provision with most of the agencies reporting that they served clients of all ages. A conclusion based on the results of this study is that adventure therapy programs are commonly being used in the state of Maine to treat a diverse population of mental health clients who are exhibiting cognitive, affective, and behavioral psychiatric disorders.

A large proportion, more than 1/3, of the mental health agencies that responded to the survey stated that they were providing adventure therapy services. While the actual number of agencies providing adventure therapy services was unknown at the outset of this study, a proportion this large was not anticipated. Perhaps even more surprising was the fact that the majority of the agencies that did not offer adventure therapy services of any kind did however, refer their clients to other programs that offered adventure activities. This is powerful evidence of the support being accorded to adventure therapy by the mental health community for the use of the type of psychotherapeutic intervention that adventure therapy has to offer.

The survey results showed that adolescents were the most frequent client population to be receiving adventure therapy services. This result is in accordance with the

information which was contained in the review of the literature on adventure therapy because the preponderance of this body of literature has shown that these services were being provided most frequently to adolescents (Davis-Berman & Berman, 1999, p. 365). The remainder of the agencies reported that they were providing adventure therapy services to clients of all ages. This is consistent with the philosophical tenets of adventure therapy because there is no reason why any particular age group should be excluded from the experiences of adventure programming. Physically or psychiatrically challenged populations notwithstanding, adventure therapy programs have been proven to be used with varied and diverse groups of clients. This is also true of the types of mental health diagnoses that client populations present with in community mental health settings. The data which were collected from the survey instrument showed that a large majority of the agencies reporting used adventure therapy as a therapeutic regimen in the treatment of cognitive, affective, and behavioral disorders. Future researchers might want to use surveys to seek the answers to additional questions which might pertain to the types of training that would best prepare adventure therapy practitioners and length of time that clients are actually spending in adventure therapy programs. The findings reported in this study have demonstrated that, in the state of Maine at least, adventure therapy is accepted as appropriate psychotherapeutic intervention for virtually any type of psychiatric diagnoses. While it is true that there may be some mental disorders that are more refractory to adventure therapy strategies, this is certainly true of all mental health therapies and further research into the comparative benefits of adventure programming is warranted.

Among the agencies that offered adventure therapy services, these services were integrated with the other mental health services that were also offered by the agency as a part of a client's regular treatment plan. While there appeared to exist number of different options which were in place in order to facilitate the service integration, none of the agencies reported that adventure therapy services were not integrated. This finding is evidence that adventure therapy can be integrated with a broad mental health service delivery continuum. Even the agencies that offered adventure therapy as their sole treatment option valued the need to integrate these services with other providers, such as academic or rehabilitative services, and this observation attests to the importance of the value that these agencies placed on a more holistic approach to treatment.

Almost 90% of the agencies responding reported that adventure therapy services were being provided throughout the calendar year. The remainder of the agencies stated that they offered adventure therapy services only during the summer months. This region of the Northeast is vulnerable to climate extremes and below-zero temperature fluctuations so it was interesting to note that the activities which are often frequently associated with the execution of adventure therapy programs were not being limited by the restrictions of weather.

Besides the question which concerned the time of year that adventure therapy programs were being offered, this study also sought to determine the sex of the clients who were being served by adventure therapy. It was shown in the analysis chapter of this document that only one agency had reported that adventure therapy services were being provided exclusively to female clients. One other agency reported that they were providing adventure therapy services only to a clinical population of males. Almost 3/4

of the agencies indicated that they were providing adventure therapy to both males and females together in coed groups. While the review of the literature has clearly indicated numerous examples of adventure therapy programs that were being provided to females and males together (Gass, 1993; Gillis & Ringer, 1999), the results of this survey analysis revealed that there were several agencies which were providing these services to both females but in separate groups. No reasons were given for segregating the groups but it is possible that these agencies administered separate residential treatment facilities for male and females. It seems reasonable to conclude that there is no valid evidence to support a general prohibition of coed groupings of clients but there are clinical considerations that would make the utilization of adventure therapy services more appropriate for delivery to single sex populations (Warren, 1999). Some examples of the types of situations where clinicians might reasonably contemplate segregating clients based solely on the consideration of their biological sex might include an adventure therapy group for survivors of sexual assault or for combat veterans who were experiencing the anxiety symptoms of post traumatic stress disorder. The survey instrument was constructed in such a manner that the response options for any of the biological sex categories other than the ones for male and female were precluded. In the future, surveys that are modeled after this one should be designed to be more inclusive of other sex categories.

The responses to the survey question that was designed to determine the single most important type of assistance that would be required if an agency was interested in either offering a new adventure therapy program or in expanding an existing one were perhaps not surprising in that the most frequently cited reason was the need for adequate

financial resources. The lack of funding for social service programs, including mental health services, seems to be a perennial concern among program administrators and adventure therapy activities must compete with a variety of other essential services which all require access to a finite amount of financial resources. The second most frequent response to this question was provided in the form of the anecdotal comments which accompanied the response category of Other. These comments included many of the respondent's concerns regarding the level of interest on the part of their clients and their need to learn more about the efficacy of adventure therapy. The lack of financial resources could be mitigated by more empirical studies which demonstrate the clinical effectiveness of adventure therapy because the funding sources of mental health services are interested in the results of cost/benefit analyses.

Another of the substantive research questions asked about the factors that influenced the decision to offer adventure therapy services. Since the statistical results of the chi-square analysis were not significant, there was not sufficient evidence to conclude that there was a relationship between the decision of whether or not to offer adventure therapy and the factors which were hypothesized to have influenced that decision. The narrative comments that accompanied this question have suggested some speculative conclusions even though they are not supported by any statistical outcome. Once again, the themes that have appeared among the agencies that did not offer adventure therapy programs were focused upon financial considerations and their questions about the treatment efficacy of adventure therapy. The respondents' concerns about the level of their clients' interest were also cited as factors which influenced their decision not to

offer adventure therapy services. These latter two factors emphasize the need for more awareness about the potential clinical benefits of adventure therapy programs.

The research question that was designed to determine whether or not there were any important decisional factors which influenced the outsourcing of adventure therapy services was answered by the utilization of another chi-square test of independence. Again, the results of this analysis were found to be statistically significant. The results also revealed an inconsistency between the agencies that outsourced adventure therapy services and those that did not. While the agencies that outsourced these services cited the ability of their clients to afford them as reasons for this decision, the agencies that did not outsource these services cited other reasons as one of their most important decisional factors. There apparently exists a great deal of confusion in the mental health profession about the actual cost/benefit ratio of adventure therapy services. Having access to this information could make an important contribution to the efforts of those who would advocate for the use of adventure therapy programs in the field of mental health. A necessary research endeavor for future investigations into the discipline of adventure therapy would be an exploration into the actual financial expenses which are associated with the costs to mental health facilities of providing adventure therapy services. The source of this information could be from the agencies that are administering successful programs and this knowledge could then be made available to the administrators who might be the most favorably disposed to the consideration of adding an adventure therapy program to their agency's repertoire of mental health service offerings. This information would be helpful to agencies that did not offer adventure therapy services because it would provide them with financial data on the cost to their clients of

outsourcing these services. These agencies are in need of an increased level of awareness on the part of their staff and their clients about the use of adventure therapy in the mental health field.

Recommendations

The following is a list of recommendations which resulted from the conclusions of this study:

1. The operationalized definition of the term *adventure therapy* which has been proposed in this thesis should be subjected to a critical analysis by both scholars and practitioners in the field of adventure therapy. If this definition successfully satisfies the criteria for acceptance by the peer review of members of the adventure therapy community, it should then be adopted as the definitive standard for all future research endeavors.
2. The survey instrument which was designed and approved for use in this study should be administered to the clinical directors of mental health agencies in other states and countries in order to determine the extent of adventure therapy programs offered by mental health facilities in places other than the state of Maine.
3. Once an operationalized definition of adventure therapy has been accepted, more research must be conducted into the clinical efficacy of this psychotherapeutic modality when it is used with client populations that are composed of a diverse cross section of psychiatric diagnoses.

4. In order to raise the level of awareness, the skills and protocols of successful adventure therapy programs must be communicated to the members of the mental health profession through the expansion of scholarly publications in the relevant literature and through the presentation of adventure therapy workshops and seminars at professional conferences and conventions.

In this study, a list of specific recommendations was presented. They have been predicated upon the outcomes of the survey research which were discussed in the previous section. These recommendations are intended to promote the efforts of future research into the clinical efficacy of adventure therapy and to provide support for the increased use of this modality of treatment if its effectiveness can be empirically demonstrated. The initial objective of exploring the scope and variety of adventure therapy programs which are currently being offered in the state of Maine has been met. The recommendations are not all inclusive with regard to the work that has yet to be accomplished but rather, they represent an apposite beginning to the advancement of future research in the field. In spite of its relatively recent history, adventure therapy has been shown to be a more frequently chosen alternative to many of the more traditional mental health service delivery mechanisms. The climate and geography of the state of Maine, with its tracts of northern wilderness and its rugged coastline, are ideally suited as a preferred location for of all types of adventure therapy pursuits and it was encouraging to learn that so many of the mental health agencies that are licensed to operate here are taking full advantage of this exciting and promising opportunity.

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APPENDICES

APPENDIX A

Adventure therapy survey instrument

A SURVEY TO DETERMINE THE SCOPE AND VARIETY OF ADVENTURE THERAPY SERVICES OFFERED BY LICENSED MENTAL HEALTH FACILITIES WITHIN THE STATE OF MAINE

Donald Lynch, who is a doctoral student in the Counselor Education Program at the University of Maine, is conducting this survey. The survey is being used to collect data for a thesis to be completed in partial fulfillment of the requirements for a doctoral degree in the College of Education and Human Development. Any questions regarding the survey or its use may be directed to the principal investigator, Donald Lynch at 234-2194 or to his thesis advisor, Sydney Thomas, Ph.D., Associate Professor of Education at 581-2490 in the College of Education and Human Development located in Shibles Hall at the University of Maine in Orono, ME 04473.

Definition: Adventure Therapy is defined here as a modality of psychotherapeutic intervention which is used to treat clients who are experiencing clinically significant cognitive, affective, or behavioral dysfunctions and is provided by, or under the supervision of a licensed, certified, or otherwise qualified mental health professional. Adventure therapy activities may occur in either a natural or contrived environment, are experiential in nature, involve elements of real or perceived risk, and consist of a facilitated integration of adventure challenges and therapeutic counseling strategies.

Please take a few moments to respond to the following questions by circling the letter in front of the item that best reflects your opinion and return this survey in the enclosed return postage envelope. Please select only one response to each question unless otherwise indicated. Thank you for your time and assistance in helping to make a valuable contribution to the body of research on adventure therapy.

1. Name of agency: _____
2. Address: _____
3. Telephone: _____
4. If you are interested in receiving a copy of the results, please provide your email address: _____

5. What types of services does your agency primarily provide?
- A. Inpatient
 - B. Outpatient
 - C. Partial hospitalization
 - D. Residential treatment services
 - E. Comprehensive
 - F. Other: _____
6. This agency is licensed as a:
- A. Private for profit
 - B. State or government
 - C. Private non-profit
7. What clinical populations are being served? (Check all that apply.)
- A. Children
 - B. Adolescents
 - C. Adults
 - D. All age groups
8. Does your agency provide adventure therapy services? (If you answered no, please skip to question number 15.)
- A. Yes
 - B. No

9. What clinical populations are being served by adventure therapy? (Check all that apply.)
- A. Children
 - B. Adolescents
 - C. Adults
 - D. All age groups
10. What types of diagnoses are being treated with adventure therapy?
- A. Cognitive, e.g. MR, specific or pervasive developmental disabilities, dementia
 - B. Affective, e.g. anxiety, depression, bi-polar
 - C. Behavioral, e.g. substance use, conduct disorder, eating disorders
 - D. All of the above
 - E. Other: _____
11. How are adventure therapy services integrated with other services provided by your agency?
- A. By individual clinical consultation with other service providers
 - B. In conjunction with an assigned case manager
 - C. Adventure therapy services are not integrated w/ other services
 - D. Other: _____
12. At what time of year are adventure therapy services offered?
- A. Year round
 - B. School year
 - C. Summer
 - D. Other: _____

13. Adventure therapy services are provided to:
- A. Females only
 - B. Males only
 - C. Females and males separately
 - D. Coed groups
14. What is the age of clients most likely to receive adventure therapy services?
- A. birth-5
 - B. 6-12
 - C. 13-18
 - D. 19-25
 - E. 26-55
 - F. Over 55
15. The single greatest influence in the determination of whether or not to offer adventure therapy services is:
- A. Expenses including supplies and equipment
 - B. Liability insurance
 - C. The availability of qualified and appropriately trained adventure staff
 - D. A belief in the efficacy of adventure therapy
 - E. Other: _____

16. If your agency does not offer adventure therapy services, do you or your staff make referrals to agencies that offer adventure programming (such as Camp Kieve, Outward Bound, or Summit Achievement) as an adjunctive therapeutic service to your clients?
- A. Yes
 - B. No
17. The single greatest influence in the determination of whether or not to make referrals to outside agencies offering adventure programming is:
- A. Client or families' ability to afford the services
 - B. A belief in the efficacy of adventure programs as an adjunctive therapeutic service
 - C. The physical proximity of appropriate facilities
 - D. Other: _____
18. If your agency was interested in either offering adventure therapy services or in expanding an existing adventure therapy program, what is the single most important type of assistance that would be required?
- A. Financial resources
 - B. Staff training
 - C. Technical assistance and equipment
 - D. A commitment of administrative support for the benefits of adventure therapy
 - E. Other: _____

Thank you for taking the time to complete and return this survey. Your kind consideration is greatly appreciated! Please feel free to add any additional comments in the space provided below:

.Comments:

APPENDIX B

Participant informed consent

An Examination of the Scope and Variety of Adventure Therapy Services within the State of Maine

Dear Participant:

I am writing to ask for your participation in a research project which is being conducted by Don Lynch, a doctoral student in the College of Education and Human Development at the University of Maine at Orono. I am interested in collecting information, through the use of the enclosed survey, on the types of adventure therapy services that are being offered by licensed mental health agencies within the state of Maine. The purpose of this research is to learn more about the use of adventure programming as a treatment modality, the populations being served, and the types of agencies currently offering adventure therapy. I am also planning to use the data collected for a doctoral thesis on the subject of adventure therapy.

I am requesting that you take a few minutes to complete the survey and return it to me in the enclosed, postage paid envelope. Your participation in this project is voluntary. Except for your time and inconvenience, there are no foreseeable risks to your participating in this study. While this study may have no direct benefit to you, your assistance in completing the survey will help to make a valuable contribution to the body of research on the subject of adventure therapy as a treatment modality.

The survey responses will be kept confidential. Other than to the principal investigator and to his thesis advisor, the name of the agency and the name of the survey respondent will not be disclosed. This information is being requested in order to keep track of those agencies which have not responded, and to permit the mailing of one follow-up reminder in an effort to improve the survey response rate. Participants who are interested in receiving the results of this study are asked to disclose their email address so that their requests can be accommodated. The data collected in this study may also later be used to write journal articles and for presentations at professional conferences. The survey data will be kept in the investigator's locked office and will be destroyed when it is no longer necessary.

If you have any questions about this research, I can be reached by telephone at 234-2194 or by email at dlynch@unity.edu. Sydney Thomas, Ph.D. is my thesis advisor and she may be contacted in Shibles Hall at the University of Maine at Orono. Her telephone number is 581-2490 and her email address is sydney_thomas@umit.maine.edu. If you have any questions about your rights as a research participant, they may be directed to Gayle Anderson at the University of Maine's Office of Research and Sponsored Programs, 581-1498.

Your return of this questionnaire will imply an indication of your consent to participate in this study. I would like to express my sincere appreciation for your time and assistance in helping to make a valuable contribution to research necessary for completion of this study. THANK YOU!

APPENDIX C

Chi-square cross-tabulation details**Table C.1** *Greatest Influence Cross-Tabulation of Expected and Observed Counts and**Percentages*

Greatest Influence in the Decision to Offer Adventure Therapy								
			expenses	liability	staff availability	belief in efficacy	other	total
Adventure Therapy	yes	Count	2	1	7	4	5	19
		Expected Count	4.8	.7	5.1	2.4	6.1	19.0
		% within Adventure Therapy	10.5%	5.3%	36.8%	21.1%	26.3%	100.0%
		% within Greatest Influence	14.3%	50.0%	46.7%	57.1%	27.8%	33.9%
		% of Total	3.6%	1.8%	12.5%	7.1%	8.9%	33.9%
	no	Count	12	1	8	3	13	37
		Expected Count	9.3	1.3	9.9	4.6	11.9	37.0
		% within Adventure Therapy	32.4%	2.7%	21.6%	8.1%	35.1%	100.0%
		% within Greatest Influence	85.7%	50.0%	53.3%	42.9%	72.2%	66.1%
		% of Total	21.4%	1.8%	14.3%	5.4%	23.2%	66.1%
Total		Count	14	2	15	7	18	56
		Expected Count	14.0	2.0	15.0	7.0	18.0	56.0
		% within Adventure Therapy	25.0%	3.6%	26.8%	12.5%	32.1%	100.0%
		% within Greatest Influence	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	25.0%	3.6%	26.8%	12.5%	32.1%	100.0%

Table C.2 *Referral Out Cross-Tabulation of Expected and Observed Counts and**Percentages*

Greatest Influence in the Decision to Refer Out							
			ability to afford	belief in efficacy	facility proximity	other	total
Refer to Others	yes	Count	18	8	1	2	29
		Expected Count	12.9	6.2	2.1	7.8	29.0
		% within Refer Out	62.1%	27.6%	3.4%	6.9%	100.0%
		% within Referral Influence	72.0%	66.7%	25.0%	13.3%	51.8%
		% of Total	32.1%	14.3%	1.8%	3.6%	51.8%
	no	Count	7	4	3	13	27
		Expected Count	12.1	5.8	1.9	7.2	27.0
		% within Refer Out	25.9%	14.8%	11.1%	48.1%	100.0%
		% within Referral Influence	28.0%	33.3%	75.0%	86.7%	48.2%
		% of Total	12.5%	7.1%	5.4%	23.2%	48.2%
Total		Count	25	12	4	15	56
		Expected Count	25.0	12.0	4.0	15.0	56.0
		% within Refer Out	44.6%	21.4%	7.1%	26.8%	100.0%
		% within Referral Influence	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	44.6%	21.4%	7.1%	26.8%	100.0%

BIOGRAPHY OF THE AUTHOR

Donald Lynch was born in Augusta, Maine on December 31, 1950. He was raised in Augusta and graduated from Cony High School in 1969. He attended The University of Maine at Orono and graduated in 1973 with a Bachelor's degree in Sociology with an emphasis in Social Work. He continued on to earn a Master's degree in Counselor Education from the University of Maine in 1974. He was employed as the Clinical Director of Outpatient Mental Health Services at Community Health and Counseling Services in Bangor before accepting a faculty position in Psychology at Unity College in 1986. In the state of Maine, Don holds an LCPC counseling license and a CSW-IP license in social work. He entered the Counselor Education doctoral program at the University of Maine in 2000.

After receiving his degree, Don will continue to serve as an Associate Professor of Psychology at Unity College-in-Maine. He is a candidate for the Doctor of Education degree in Counselor Education from The University of Maine in May, 2005.