Experiences of Adventure Therapy: A Narrative Inquiry

By Will Dobud

A thesis submitted in fulfilment of
the requirements for the degree of
Doctor of Philosophy

CANDIDATE

Name: Will Dobud

Principal Supervisor: John Paul Healy PhD

Co-Supervisor: Susan Mlcek PhD

COURSE & CODE

School: School of Humanities and Social Sciences

Code: OAZZ

CONTACT INFORMATION

Email: wdobud@csu.edu.au
Certificate of Authorship

I hereby declare that this submission is my own work and to the best of my knowledge and belief, understand that it contains no material previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgement is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of thesis, subject to confidentiality provisions as approved by the University.

Name: Will Dobud
Date: 14 November 2019
Acknowledgments

I would like to thank my principal supervisor Dr. John Paul Healy for his guidance, support, and relationship. In 2014, I spoke to John on the phone about supervising an evaluation of my program. John dropped his banjo, sparking a new conversation about bluegrass and old time music for more than an hour. In 2018, I met with John in West Virginia and was able to share the special place where my adventure therapy journey began. His ability to balance leadership and direction with compassion and humour was so important.

No one completes a doctorate on their own. There are so many people who put in the hard yards. My co-supervisor Dr. Susan Mlcek has been such a great support. I appreciate all of your feedback and guidance throughout this project. At the start of my young academic career, I feel fortunate to continue learning from you!

My family have been invaluable support. From travelling with me to conferences, putting up with 3.00 a.m. alarms to interview folks in different time zones, to long discussions of research methods and pragmatic philosophy, they sacrificed a lot. Everyone who has met my wife Renee knows she is one of the most caring and loving persons they will encounter. Although she will be excited to see this project go to bed, she has stood by my side and supported me throughout. To the children Isabella and Lucas, thanks for putting up with all of those dinner time discussions. I appreciate that you have all decided to call me doctor from here on out. My mother Holly and brother George, I love you both. We sure did some great adventures over the past few years and will continue to do so!

There is not enough space to thank everyone from the international adventure therapy community. Dr. Nevin Harper, Dr. Stephan Natynczuk, future Dr Daniel Cavanaugh, Dr. Leiv Einar Gabrielsen, Dr. Carina Fernee, future Dr Graham Pringle, Lynette Nikkel, Nicky Treadway, Christopher Russo, Ricky Santiago, Kat Sharp, Andrew Bach, Mark Cartner, Noel
Pompa, Fred Borroel, and Andy Hamilton, thank you for putting up with my ramblings and passionate debates on how we can improve our awesome field. I will always value your contribution to this field, your feedback, and, most importantly, your friendship. Thank you!

If you find any typos while reading this thesis, please do not blame me. I have read and reread this document more than you know. Analysis paralysis is real. This brings me to the Detail Devil, Pam Firth. Thank you Pam for your professional copyediting services. You were so thorough and patient as we prepared this dissertation for submission.

Jokes aside, there were 56 people who trusted me to share their stories. While I made epistemological and methodological commitments to avoid researching the person out of the person, their willingness to be vulnerable, sharing their adventure therapy experiences with me, is what made this a story worth sharing. Those who made me wake up in the middle the night, I acknowledge you, too.
Ethics Approval

In accordance with the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research (National Statement)*, the Charles Sturt University Human Research Ethics Committee approved this research on the 28th of February in 2017. The protocol number for this research is H17019.
Professional Editorial Assistance

Paid editorial assistance was obtained, with written permission from my supervisor, by Pam Firth who is a professionally trained copyeditor and proofreader who specialises in the humanities and social sciences. Pam’s work was limited to formatting, grammar, and style, as per the Australian Standard for Editing Practice (ASEP) Standard D – Language and Illustrations and ASEP Standard E – Completeness and Consistency. Pam did not alter or improve the substantive content or conceptual organisation of the thesis.
Abstract

The purpose of my qualitative inquiry was to explore people’s experiences in adventure therapy. The methodology of narrative inquiry, a method of studying people’s lived experiences, was preferred in order to build knowledge about the storied lives of adventure therapy practitioners and program participants. I conducted semi-structured interviews with an international group of 30 former adventure therapy participants, aged 18 to 30, and 26 adventure therapy practitioners. Participant observation was conducted on adventure therapy programs in Norway, the United States, and Australia to explore the diversity of adventure therapy practice.

Data were organised into patterns of experience, called narrative threads, serving as plot marks to provide comparing and contrasting experiences in adventure therapy. Analysis and interpretation led to resonant threads, or the echoes of meaning emerging from my interpretation of the narratives are presented in the discussion of findings.

Commonalities of adventure therapy practice can include the intentional use of outdoor settings, experiential therapy, and active bodily engagement. My thesis explored how program participants and practitioners perceive psychotherapy interactions in outdoor settings. The time outdoors provided a novel environment for some participants to experience success and mastery, but was one that could also leave them feeling disenchanted.

The varieties of adventure therapy practice forms a discussion about unethical treatment of vulnerable youth and potentially demoralising approaches. For example, participant narratives of wilderness therapy programs in the United States require re-evaluation and a considering of ethical practice. For example, coercion, the use of secure transport services and the common involuntary referral to ongoing residential treatment were common experiences of participants in United States, yet these core ingredients are described little in the available literature.
Given the contribution of therapeutic relationships to psychotherapy outcomes, the literature provides only a general overview of those effects. My inquiry provided opportunities for a thorough examination of these types of engagements in adventure therapy settings, with the findings having the potential to address any gaps in knowledge, and to build better understanding of the links between therapeutic relationships and adventure therapy. For example, not present in the current literature, my findings indicate that positive relationships included authenticity, democracy, and collaboration.

Implications from my inquiry are made for practitioners to privilege the participants’ experiences of the therapeutic relationship, no matter the mode of adventure therapy provided. Adventure therapy literature does not do justice in representing the experiences of participants and level of coercion and inequality they can experience. As practitioners, we should focus on how participants construct meaning throughout an adventure therapy experience and taking their self-determination seriously. My thesis concludes with implications for a research agenda focusing on improved outcomes and a revisiting of ethical practice.
Table of Contents

Certificate of Authorship.................................................................ii

Acknowledgments ........................................................................... iii

Ethics Approval ................................................................................. v

Professional Editorial Assistance ......................................................... vi

Abstract ........................................................................................ vii

Table of Figures ............................................................................... xiv

Chapter 1: Introduction .....................................................................1
  Narrative Beginnings & Positionality .................................................. 5
  Adventure Therapy: The Name Game ................................................. 10
  Research Questions .......................................................................... 15
  Short History of Adventure Therapy .................................................... 17
    Adolescents and Adventure Therapy ............................................... 17
    Origins of Adventure Therapy ........................................................ 19
    Adventure Therapy and Ethics ......................................................... 26
  Outline of My Inquiry ....................................................................... 30
  Conclusion ....................................................................................... 33

Chapter 2: Review of Literature ....................................................... 35
  Search Methods ............................................................................... 35
  Efficacy of Adventure Therapy ........................................................ 37
  Qualitative Research in Adventure Therapy ....................................... 41
  Quality and Rigour of Adventure Therapy Research ........................... 48
  Discussion and Implications ............................................................. 51

Chapter 3: Theoretical Framework ................................................... 54
  When, Where, and Why of Pragmatism ............................................ 54
## Table of Contents

**Ontological Commitment to Experience** ................................................................. 59  
**Narrative Ways of Knowing** .................................................................................. 62  
**Humanism, Social Construction, and Solution-Focused Assumptions** ................. 66  
**Criticisms and Final Thoughts** ................................................................................ 69  
**Conclusion** ................................................................................................................. 70  

### Chapter 4: Methodology ......................................................................................... 72  
**Significance** .............................................................................................................. 72  
**Aims and Objectives** ................................................................................................. 74  
**Research Questions** ................................................................................................. 74  
**Methodology** ............................................................................................................. 75  
  - Narrative Inquiry ........................................................................................................ 77  
**Methods** .................................................................................................................... 81  
  - Research Participants ................................................................................................. 81  
  - Interviews ................................................................................................................... 85  
  - Journal Records ........................................................................................................ 88  
  - Participant Observation: Field Notes of Shared Experience .................................. 88  
  - Analysis ...................................................................................................................... 90  
**Ethical Considerations** ............................................................................................. 94  
**Trustworthiness and Credibility** ............................................................................. 96  
**Conclusion** ................................................................................................................ 100  

### Chapter 5: The Beginnings .................................................................................. 101  
**Diversity of Adventure Therapy’s Participants** ..................................................... 101  
  - Adoption and Identity ............................................................................................... 117  
  - Exhausting Local Resources: Previous Experiences in Therapy ...................... 120  
**Varieties of Adventure Therapy Practitioners** ....................................................... 125  
  - Personal Experiences in the Outdoors .................................................................. 133  
  - Diversity of Adventure Therapy Practice .............................................................. 137  
**Resonant Threads** .................................................................................................... 143
Who Conducts Adventure Therapy? ................................................................. 143
Who Receives Adventure Therapy? .............................................................. 147

Conclusion ........................................................................................................ 156

Chapter 6: Varieties of Adventure Therapy Experiences ....................... 157

The Call to Adventure ...................................................................................... 160
  Education Consultants: She Never Met Me .................................................. 160
  Secure Transport Services ........................................................................... 165
  Parent Deception: Almost Like a Summer Camp ........................................... 170

Continuous-Flow Wilderness Therapy Programs ........................................ 174
  Strip Search .................................................................................................. 176
  Cleansing Phase .......................................................................................... 181
  Impact Letter ................................................................................................ 186
  Social Responsibility Phase ......................................................................... 189
  Family Involvement ...................................................................................... 196

Contained Expeditions .................................................................................... 202
  Arrival ........................................................................................................... 205
  Expedition .................................................................................................... 212
  Program’s End ............................................................................................... 215

Community-Based Adventure Therapy Practice ....................................... 219
  Community-Based Programming ................................................................. 222

Wilderness-Based Therapeutic Boarding Schools ..................................... 227

Resonant Threads ............................................................................................ 233
  Gooning ....................................................................................................... 234
  They’re Trying to Break Me ........................................................................ 237
  Similarities in Wilderness Therapy Programming ....................................... 240
  Shared Experience versus Forced Experience ............................................. 243

Conclusion ........................................................................................................ 245

Chapter 7: Therapeutic Relationships in Adventure Therapy Settings ........ 246

Real Relationships ........................................................................................... 250
  You Felt Like a Person ................................................................................ 250
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stereotypical Therapist</td>
<td>259</td>
</tr>
<tr>
<td>Shared Experience</td>
<td>263</td>
</tr>
<tr>
<td>Feeding Valued</td>
<td>268</td>
</tr>
<tr>
<td>Parental Feel</td>
<td>272</td>
</tr>
<tr>
<td>Positive Use of Confrontation</td>
<td>275</td>
</tr>
<tr>
<td>Therapeutic Community</td>
<td>278</td>
</tr>
<tr>
<td>Once in a Blue Moon</td>
<td>285</td>
</tr>
<tr>
<td>Inequality and Force</td>
<td>292</td>
</tr>
<tr>
<td>Resonant Threads</td>
<td>295</td>
</tr>
<tr>
<td>Efforts to Remoralise</td>
<td>295</td>
</tr>
<tr>
<td>Democracy and Collaboration</td>
<td>299</td>
</tr>
<tr>
<td>Solution-Forced Therapy</td>
<td>302</td>
</tr>
<tr>
<td>Conclusion</td>
<td>303</td>
</tr>
</tbody>
</table>

**Chapter 8: The Adventure Therapy Setting** ........................................... 304

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novel Environment</td>
<td>305</td>
</tr>
<tr>
<td>Success and Mastery</td>
<td>312</td>
</tr>
<tr>
<td>Solo</td>
<td>318</td>
</tr>
<tr>
<td>Disenchanted</td>
<td>323</td>
</tr>
<tr>
<td>Resonant Threads</td>
<td>329</td>
</tr>
<tr>
<td>Taking Therapy to the Outdoors</td>
<td>329</td>
</tr>
<tr>
<td>Conclusion</td>
<td>334</td>
</tr>
</tbody>
</table>

**Chapter 9: The Road Back** ................................................................. 335

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare: You’re Sending Me Away Again</td>
<td>335</td>
</tr>
<tr>
<td>Trials and Tribulations</td>
<td>346</td>
</tr>
<tr>
<td>Becoming a Wounded Healer</td>
<td>356</td>
</tr>
<tr>
<td>Reflections on Adventure Therapy Experiences</td>
<td>360</td>
</tr>
<tr>
<td>Strong Opinion</td>
<td>362</td>
</tr>
<tr>
<td>Cost/Benefit of Adventure Therapy</td>
<td>365</td>
</tr>
</tbody>
</table>
Resonant Threads .......................................................................................................................... 368
Back to Square One ....................................................................................................................... 369

Conclusion .................................................................................................................................. 373

Chapter 10: Contextual Understanding of Adventure Therapy ............................ 374

Revisiting the Research Process .................................................................................................. 374
Summary of Findings .................................................................................................................... 375
  Who Conducts Adventure Therapy? .......................................................................................... 376
  Who Receives Adventure Therapy? ......................................................................................... 378
  Varieties of Adventure Therapy Experiences ........................................................................... 381
  Therapeutic Relationship in Adventure Therapy Settings ....................................................... 389
  Success and Mastery ................................................................................................................ 391
  Re-Entry .................................................................................................................................... 394
  Adventure Therapy: A Reflection .............................................................................................. 397

Implications for Helping Professionals in the Field ................................................................. 397

Limitations ................................................................................................................................... 400

Implications for Future Research .............................................................................................. 403

My Reflections on the Study ....................................................................................................... 404

Conclusion .................................................................................................................................. 405

References .................................................................................................................................... 408

Appendices .................................................................................................................................. 435

Appendix A: Example of Journal Records ................................................................................. 437
Appendix B: Ethics Approval ......................................................................................................... 438
Appendix C: Information Sheet ..................................................................................................... 440
Appendix D: Consent Form ............................................................................................................ 442
Appendix E: Fieldwork Information Sheet .................................................................................... 443
Table of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Search Methods</td>
<td>36</td>
</tr>
<tr>
<td>2</td>
<td>Elements informing my methodological decisions</td>
<td>71</td>
</tr>
<tr>
<td>3</td>
<td>Participant Struggles</td>
<td>113</td>
</tr>
<tr>
<td>4</td>
<td>Exhausting the Local Resources</td>
<td>121</td>
</tr>
<tr>
<td>5</td>
<td>Practitioner Characteristics</td>
<td>132</td>
</tr>
<tr>
<td>6</td>
<td>The Call to Adventure</td>
<td>161</td>
</tr>
<tr>
<td>7</td>
<td>Continuous-Flow Wilderness Therapy Programs</td>
<td>175</td>
</tr>
<tr>
<td>8</td>
<td>Contained Expeditions</td>
<td>204</td>
</tr>
<tr>
<td>9</td>
<td>Community-Based Organisations</td>
<td>220</td>
</tr>
<tr>
<td>10</td>
<td>Wilderness-Based Therapeutic Boarding School</td>
<td>228</td>
</tr>
<tr>
<td>11</td>
<td>The Therapeutic Relationship</td>
<td>251</td>
</tr>
<tr>
<td>12</td>
<td>Real Relationships</td>
<td>252</td>
</tr>
<tr>
<td>13</td>
<td>Therapeutic Community</td>
<td>280</td>
</tr>
<tr>
<td>14</td>
<td>The Adventure Therapy Setting</td>
<td>307</td>
</tr>
<tr>
<td>15</td>
<td>The Road Back</td>
<td>337</td>
</tr>
<tr>
<td>16</td>
<td>Adventure Therapy: A Reflection</td>
<td>361</td>
</tr>
</tbody>
</table>
Chapter 1: Introduction

When stuck along the way, we join clients in looking for and exploring alternate routes on their own maps. In the process clients uncover trails we never dreamed existed.
—Duncan, Miller, & Sparks (2004, p. 136)

“Okay, show of hands. Who would like to go for a hike?” “Surely none of these kids are going to hike,” I thought. Three female participants raised their hands. The last strands of Norwegian snow held tight from last winter along the mountain peaks, and they wanted to see it. So did I. Along with another social worker, we set off.

It was a dense and difficult climb. Large boulders and thick, wet bush reminded me of the temperate rainforests I grew accustomed to having worked in Alaska and West Virginia. Although we carried the usual map, compass, GPS, and satellite phone, we could see the plume of smoke from camp as we ascended the steep mountain so we kept those tucked away in our pack. As we ducked and dodged tree limbs, I bumped my head. The participants laughed.

We held interesting conversations. Participants shared the little hope they held in the effectiveness of therapy and described their previous therapy experiences. I asked why they had then chosen to participate in this program. They wanted to be outside and felt uncomfortable sharing their story to another stranger while sitting on the couch. Most of these young women spent their days locked away in their bedrooms, having struggled with social anxiety, family conflict, and trauma. They were seasoned therapy goers.

After two hours, we stopped for lunch. I had brought an extra chocolate bar, which we shared. Me being an American current living in Australia, I accepted the usual battery of questions: “Does everyone really have guns?” “Why don’t you provide your citizens with healthcare?” “Are there bears on your programs?” “Can you ride a kangaroo?” “Does everything there really kill you?” To be fair, I queried the Norwegian adolescents about Vikings and trolls. We laughed through our break and threw snowballs at each other.
We pushed on for another hour, emerging from the tree line. We began scaling large sheets of snow, which required us digging our toes deeply to avoid slipping. One of the participants, less fit than the others, said she was done climbing. The others wanted to continue to the summit, though we had achieved our initial goal of reaching the snow. I offered to accompany her back to camp. The group split.

The young woman looked up the mountain, then down towards the lake where camp remained. I could sense some hesitation. “What’s up?” I asked. “Are you sure you want to go back?” She continued to look back and forth. “I don’t know,” she said. “I’m tired and don’t want to slow down the group. They’re faster than me. I’d be a burden.” I said we could go up or down at any pace she wanted. It was her journey. “Why don’t we climb for 10 more minutes and then we’ll gauge what to do next?” She thought this was a good idea, so we started walking. I set a timer.

As we slowly climbed one foot in front of another, I took out my phone, placed it in my enamel mug to create a makeshift speaker, and started listening to The Flatliners, a Canadian punk band. “What is this?” she asked. “Everyone needs punk rock motivation,” I replied. The timer went off, interrupting the music. “Ten more minutes,” she said.

False peak after false peak, we kept going. Our 10-minute timer became our hiking snooze button. It went off six times and we kept walking. Finally, we sat in a snowbank with our backs towards the mountain. We looked over the valley below as a crystal clear rainbow appeared beneath us. We were speechless. She took my phone out of the mug. She reached into her jacket, pulled out hers, and picked a song of her own.

“Is this Christian music?” I asked. I was quite surprised. She did not seem like a religious person, especially after making the devil horns with her hands and shouting, “The devil!” regularly during the first few days of the expedition. She nodded. It was in fact a religious hymn. My interest was piqued. I shared my surprise and asked her to say more.
“Look at this, Will,” she said, pointing to the rainbow and valley below. “This is my church. I love this country. I am so lucky to live here and this is just a few hours from my home. I’ll remember this day forever. Thank you for not giving up on me.”

We made it back to camp before dinner. The clouds opened during our descent, and we were soaked. I was thinking about the experience, and some of my assumptions about adventure therapy were challenged. I wrote these questions in my journal. Would this experience have been as beneficial for the other program participants had the leaders pressured everyone to hike? A lot of us adventure therapy folk think mobile phones and social media are a nuisance, but I just witnessed a young adolescent post a picture of herself and the rainbow with a comment about the healing moment she had while listening to music. Her phone may have helped her to consolidate the positive experience. Maybe this was the accidental learning John Dewey (1938) had described in his early philosophies of experiential education.

I felt stuck thinking about how to interpret the experience we shared. Therapeutically, what happened? While some practitioners may wish to explore the participant’s comments, such as “I’d be a burden,” my training in solution-focused brief therapy urges me to remain on the surface, focused on constructing a hopeful future for the participant, rather than exploring a participant’s problem history (Ratner, George, & Iveson, 2012). I bring to my work and inquiry some drastically different experiences in adventure therapy from a range of theoretical orientations. Rich experiences, such as these, motivated me towards conducting my inquiry: an exploration of people’s experiences in adventure therapy. I have engaged in adventure therapy as a social worker in private practice, residential, intensive outpatient, and community-based settings in the United States and Australia. At present, I run a small practice in South Australia providing short-term adventure therapy expeditions and individual
social work services for children, adolescents, and families. I love this field and the unexpected rich moments I get to experience with young people.

For my inquiry, I used the methodology of narrative inquiry, a qualitative method for exploring people’s experiences (Clandinin & Huber, 2010). The choice to undertake a narrative inquiry was made to provide a thorough exploration of adventure therapy experiences, specifically adolescents. I conducted participant observation and interviewed adventure therapy practitioners and past participants to build knowledge and interpret these experiences with a theoretical perspective underutilised in the adventure therapy literature.

My inquiry was informed by pragmatic philosophy, a lens useful for bridging different paradigms of research. Based on the contributions, among others, of William James and John Dewey, pragmatism is a tool for moving through various ways of knowing and incorporating them towards building new knowledge, bridging theory and practice, and understanding of phenomena (Morgan, 2007). This is not to discount the contributions of so-called “neo-pragmatists” (McDermid, 2006), such as Rorty, Habermas, Putman, Holmes, or West. I, instead, returned to James and Dewey’s commitment to experience, which felt necessary given Dewey’s contribution to experiential learning and its implications for adventure therapy (Walsh & Golins, 1976). For Quay (2016), this focus on experience “affords intimate connection between theory (reason) and practice” (p. 1015). Pragmatism offers a departure from traditional philosophical arguments about epistemology and ontology, which can occur in the humanities. Knowledge is built as the result of certain actions and the dichotomies of qualitative or quantitative methods may be unhelpful for bridging the various forms of knowledge unearthed in the field of adventure therapy. Both can explore what helped or hindered progress. They are opposite sides of the same coin of inquiry (Morgan, 2014). Using pragmatism as a theoretical underpinning raises unique opportunities to not
only interpret findings from the social sciences, but also to explore the human endeavour, with beliefs and actions, all knowledge stems from. This discussion is continued in Chapter 3.

In this Chapter, I present the *narrative beginnings*, discuss some of my experiences in adventure therapy, and my positionality in regards to my inquiry. I discuss some of the issues with defining what is or is not adventure therapy and present the research questions informing my inquiry. Taking into account different cultural contexts, a brief history of adventure therapy is explored. This chapter concludes with an outline of the thesis.

**Narrative Beginnings & Positionality**

Clandinin, Pushor, and Orr (2007) recommended inquirers speak to their relationship with and interest in pursuing a certain topic. This they called the *narrative beginnings* of an inquiry. Exploring my positionality, as described by Temple and Young (2004), is important as “one’s position within the social world influences the way in which you see you” (p. 164). Informed by feminist and standpoint theories, my positionality can affect the outcomes and interpretations made throughout the course of a study. As a feminist theoretical perspective, standpoint theory, in particular, is a perspective that denies objectivism in research, instead suggesting that knowledge is influenced by social position. Providing my personal justifications can show how conducting my inquiry has changed my understanding of people’s experiences in adventure therapy.

Though I have lived in Australia for the past decade, travelling back and forth from the United States for work and family visits, I see myself as an American, white male. I am 32 years old, married, an older brother, son, and step-parent to two teenagers aged 16 and 17. As a “troubled teen” myself, I do have a passion for working with adolescents, which cannot be ignored as my personal experiences have influenced me. I grew up with father who struggled with alcohol and substance use. He moved out of my home when I was 10 years
old. He and my mother would fight when I was growing up and at times he would become aggressive and violent, not towards any person but towards our property. On one occasion, he ripped the railing off of our staircase and threw it through the front door.

During my younger years, I struggled in school. I am a slow reader and was diagnosed with attention-deficit hyperactivity disorder (ADHD) and prescribed stimulants to help improve my focus. In year 9, I learned about a boarding school and thought this was a good idea to leave home. I went to summer camp interstate for seven weeks a year and enjoyed those experiences away from home.

I started smoking marijuana in boarding school. By year 11, I was smoking marijuana every day and eventually was asked to leave the school for failing a drug test. After a discussion with my mother, I enrolled in a boarding school, which focused on helping young people with substance abuse issues. The school went through three head principals during my two-month stay and I was able to re-enrol in my previous boarding school. I lasted only two months before being asked to leave the school again after getting caught with alcohol.

I moved home and enrolled in the local public school. I quickly became involved with the drug crowd and I returned to daily marijuana use. I dropped out of school after a few weeks. One month before my 17th birthday, I was in a car with friends driving overnight from the beach. Though I was asleep and do not remember what happened, I woke up on the side of the road in a terrible accident. The driver was helicoptered to the hospital with multiple broken bones in his legs, another friend required over 500 stitches, and I was treated for a skull fracture and was given over 20 staples to the back of my head.

While in recovery, I managed to enrol in a rural and remote boarding school where I was able to receive therapy and work through my high school credits at my own pace. I thrived in this environment, which was less restrictive, and quickly graduated. I returned home and began working as a firefighter and took courses at a local community college.
I started in the field of wilderness therapy as a field staff in 2006 in the United States. My first thought was that I loved the outdoors and could help adolescents who had similar experiences to me. Not making enough money to study and work, I left the program and moved back to Washington DC after a year to study full time. One of the program’s therapists contacted me. He was starting a relapse prevention program for adolescents returning home from residential treatment centres, including wilderness therapy programs. The program would be just a 10-minute drive from the community college where I was studying. I went along to be a mentor for the program’s first group therapy session with just two participants.

Within six months of working for him, I changed my degree focus so that I could quickly transfer to the University of Maryland, Baltimore County’s social work program. As our program grew, we visited wilderness therapy programs across the United States, and he urged me to work with as many as I could, to learn from as many people as possible, not just him. Along with working at six different adventure therapy programs, we continued to lead weekly group therapy sessions, and I co-facilitated a biweekly weekend outdoor adventure. We took groups to Hawaii and the Grand Canyon, incorporating various outdoor activities such as caving, canoeing, white-water rafting, and mountain biking.

I feel fortunate to have worked in wilderness therapy and in aftercare, as I witnessed how difficult it was for participants to return to their community. I was gaining experience with groups of adolescents in long term outdoor residential settings and as they returned to their community. I did not find working in the outdoors that difficult. Growing up with my own experience of family conflict, it was my time in the outdoors, especially so at summer camp, when I felt my best. I enjoyed getting to know different people and seemed to handle challenging situations naturally. I felt I could relate to the participants coming from similar
circumstances as I had. I also know how to have fun in the outdoors and it seemed the participants felt comfortable and excited about our time together.

Although I was confident in my ability to engage young people, I never felt like a confident therapist. I am still a slow reader and did not understand the latest neuroscience or which evidence-based practice was the latest and greatest to hit the mainstream. At a social work conference in 2009, I attended my first training in solution-focused brief therapy delivered by Matthew Selekman (2005). This changed my view of therapeutic interactions, and I began seeing participants as experts in their own life, already having the necessary resources for change. I grew critical of therapy practice and started asking questions like “How long should participants be in residential treatment?” and “How do we actually know if we are helping or getting in the way?” Solution-focused brief therapy argues therapy should be kept as brief as necessary (Ratner et al., 2012). This does not mean that therapy should have time-constraints, but its brevity should be defined by when the problem that brought the person to therapy is solved. Training in solution-focused brief therapy kick started me to think more critically about the core ingredients required for me to be more effective at my job.

During my initial write up of my thesis I intended to pocket my solution-focused values and approaches, and it was during my analysis and discussion that I saw these perspectives come through. The importance of positioning my inquiry from my standpoint is that when examining therapeutic interactions, I often do so from a solution-focused stance. I will present how this position has informed my inquiry and perceptions of therapeutic experiences, but will present some of these criticisms here.

Critics have argued that solution-focused therapists do not attend to emotions, compared to what a psychodynamic practitioner would do; often raising a surface versus depth argument (Ratner, George, & Iveson, 2012). Proponents of solution-focused brief
therapy do not separate emotions from action, and I do not throughout my inquiry. Miller and de Shazer (2000) wrote, in response to such critique, that therapists have needlessly constructed a field that “treats emotions as abstract entities about which some therapists are uniquely knowledgeable” (p. 70). As I present in Chapter 3, inner experiences, such as the participant describing feeling like a burden in the introduction of the chapter, should not be explored in isolation to social context and action. Miller and de Shazer (2000) used the example of someone crying, to illustrate this point. One can cry tears of joy or sadness. Likewise, chopping an onion can also lead to crying. Throughout my analysis and interpretation, I attended to the participants based solely on the data they provided me, and avoided dichotomies such as surface versus depth. Emotions are not separated from their social context and action, and because my training in human behaviour, trauma, and assessment strategies, I do not approach these participants as an expert in their lived experience.

I moved to Australia in 2009 when I met my wife and began working in different practice settings. I was first hired as a social worker in a community-based agency working with disadvantaged youth and refugees arriving from Syria and Sudan. I saved money and eventually made the leap into private practice. I created a program and had three participants attend my first 14-day expedition in March 2013. Since then, I have run over 20 expeditions and have worked with hundreds of young people in various contexts.

I bring to my study a unique standpoint and positionality. My previous experiences as a young person, a therapy participant, and a social worker trained in specific modalities have all impacted my analysis and interpretation. In the following section, I present a discussion about the adventure therapy ‘name game’ (Harper, Siegal, & Rose, 2019) and provide a brief introduction to the inclusion criteria I used for determining what is, and what is not, an
adventure therapy experience. I then present the research questions I explored and a brief history of adventure therapy.

**Adventure Therapy: The Name Game**

Despite several definitions used throughout the literature, adventure therapy is best understood as an umbrella term encompassing myriad therapeutic approaches, such as wilderness therapy, adventure-based counselling, or outdoor behavioural healthcare (OBH), to name a few (Harper, Peeters, & Carpenter, 2014). Often taking place in outdoor settings, adventure therapy practice can incorporate the likes of outdoor expeditions, ropes or challenge courses, experiential learning activities, and adventure-based activities. Adventure therapy programming can vary, from outpatient to residential, with some programs providing weekly individual therapy to other running for 90 or more days in remote, outdoor settings (Gass et al., 2019; Gillis & Speelman, 2008; Russell, 2001).

Although debating whether a definition was possible, Gass, Gillis, and Russell (2012) defined adventure therapy as “the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels” (p. 1). Despite this definition, adventure therapy practice differs in theory, structure, and programming. Most referenced in the adventure therapy literature is wilderness therapy in the United States, in particular OBH. Wilderness therapy programs can involve travelling, by either foot or boat, from camp to camp in a small group. Some expedition-based programs can run from three to 21 days, while Gass et al. (2019) described residential OBH programs to last an average of 90 days. Groups may also live at a base camp while going on shorter 10- to 14-day expeditions. Nine to 24 months is common for long-term residential programs and might not necessarily include
backpacking expeditions but use the outdoors as part of their everyday living, such as in a wilderness-based therapeutic boarding school (Mooney & Leighton, 2019).

With each of adventure therapy’s subdivisions, unique definitions emerge. OBH, for example, a branch of wilderness therapy in the United States, is defined as “the prescriptive use of wilderness experiences by licensed mental health professionals to meet the therapeutic needs of clients” (Gass et al., 2014, p. 1). DeMille et al. (2018) explained that OBH programs typically include extended outdoor living experiences, active client participation, formal individual and group therapy sessions, group living environments to improve social interactions, and the use of nature to integrate the positive use of stress, linking with Kimball and Bacon’s (1993) controversial article about the intentional use of stress as a core component of wilderness therapy practice. This use of stress emerged throughout my inquiry of participant narratives.

Adventure therapy is also practised in private practice settings (Tucker & Norton, 2013) and community-based organisations (Tucker, Javorski, Tracy, & Beale, 2013). The differences in practice are necessary to discuss, as participants can have remarkably different experiences depending on the program they attend or practitioner they work with, all under the guise of adventure therapy. Boot camps have also included in the umbrella of adventure therapy (Anderson, 2014), though adventure therapy scholars have worked to distance themselves from such programs (Norton et al., 2014). That said, a reader of my thesis may consider whether it is appropriate to describe the programs included in my thesis as ‘therapy’. For this reason, I have included this discussion of how we define adventure therapy and psychotherapy in general.

It is relevant to address Gass et al.’s (2012) definition of adventure therapy, as it cannot be applied in all international contexts (Adventure Therapy International Committee [ATIC], 2016; Bowen & Neill, 2013; Harper et al., 2014). For example, the Australian
Association for Bush Adventure Therapy, Inc. (AABAT, 2013) defined bush adventure therapy as “a diverse field of practice combining adventure and outdoor environments with the intention to achieve therapeutic outcomes for those involved” (para. 1). Nowhere in this Australian definition is the required presence of mental health professionals whereas the United States mandates the presence of such helping professionals. That said, the ATIC (2016) maintained,

Although it is tempting to offer a single definition of international adventure therapy, an implication of any definition is that there will be clarity about what lies inside and what lies outside the definition—and there is no hard boundary around adventure therapy in a global context. (para. 1)

Definitions of what is or is not adventure therapy are important for inclusion criteria, which I present in Chapter 4. Attending to these considerations was necessary due to adventure therapy’s challenging and disorganised history and lack of consensus about what it is and how it works (Bowen & Neill, 2013; Dobud & Harper, 2018; Norton, Tucker, et al., 2014). As I illustrate throughout this thesis, there are many modes of adventure therapy, and an all-encompassing definition may isolate certain factions of practice and exclude the diversity of this broad field.

Given this discussion, it may be important to ask whether adventure therapy is the right term. Harper, Rose, and Segal (2019) provided cause for pausing the “adventure therapy name game” (p. 29), in which practitioners argue about what is or is not adventure therapy. Scholars instead should clearly state what they are doing in practice and support this with literature from the field. The past few decades have shown publications where, for example, outcomes from long-term residential wilderness therapy programs are used to discuss the effects of adventure therapy in short-term outpatient settings (Koperski, et al., 2015). While
there are many specific terms and definitions, the name adventure therapy has been adopted internationally “for its simplicity and utility” (Harper et al., 2019, p. 30). I make specific distinctions between different types of practice defined in the literature, such as wilderness therapy or therapeutic boarding schools.

Along with the debates about what is adventure therapy, there have been recent efforts for adventure therapy to gain evidence-based recognition (DeMille et al., 2018, Gass et al., 2019) on some of the many lists of empirically supported therapies, such as the Substance Abuse and Mental Health Services Administration’s (SAMHSA, 2012) National Registry of Evidence-based Programs and Practices. For example, Norton et al. (2014) presented a future research agenda with aims to position adventure therapy within the evidence-based realm of healthcare. While helpful for seeking funding and third-party payments for adventure therapy services, scholars advocating for the field have raised concerns regarding unjustified claims of superiority and a proposed research agenda guided by economic and political forces (Baldwin, Persing, & Magnuson, 2004; Fernee et al., 2015; Gabrielsen et al., 2015). Specifically, Harper (2010) challenged the “evidence-based practice paradigm and its relationship to adventure education and therapy” (p. 38), referring to evidence-based practice provokingly as a “false idol.” For positioning my inquiry, I provide a review of literature in Chapter 2 and explore where adventure therapy fits with regard to the paradigm of evidence-based practice and our current understanding of what works in therapy (Wampold & Imel, 2015).

Determining whether an adventurous or outdoor experience is (or is not) a psychotherapy is important. Recreation and outdoor education programs can, of course, elicit therapeutic outcomes (Kelly & Baer, 1971; Loynes, 2010; Mutz & Müller, 2016) and may be grouped with adventure therapy though may not be considered a psychotherapy given the
intended and prescribed role of the helping professional. For this reason, I use Wampold and Imel’s (2015) definition of psychotherapy, which states,

> Psychotherapy is a primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client disorder, problem, or complaint; and d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint. (p. 37)

I adapted aspects of this definition and terminology to best suit the realm of adventure therapy. First, I modified trained therapists to practitioners. There are many types of professionals providing adventure therapy services. In Australia, youth workers, social workers, and other professions can provide adventure therapy services and may not identify as therapists. In the United States, unqualified but trained field staff may spend the majority of the time with young participants under clinical supervision. Important to Wampold and Imel’s (2015) definition is the presence of a helping professional modifying a therapeutic service with a psychological rationale for why it will be remedial for a particular person or group. Though U.S. wilderness therapy programs have been rightfully criticised as militaristic boot camps (Anderson, 2014), these programs are delivered by licensed mental health professionals and contain a psychological rationale which meets the criteria of a psychotherapy based on the definition I have utilised. Since there is a diversity of professions and qualifications present in adventure therapy practice, I have made distinctions about specific qualifications or professions when relevant, throughout my thesis.

Wampold and Imel (2015) preferred the term client or patient, though I refer to those who engage in adventure therapy services as participants. This decision reflects my ontological commitments and stresses the sometimes disregarded role therapy goers play in
our current understanding of the services. Bohart and Tallman (2010), for instance, referred to therapy consumers as ‘the neglected factor,’ since researchers continue to focus on programs and specific treatments (Wampold & Bhati, 2004). Instead, I perceive the helper and the helped as active participants, or co-adventurers, in the therapy experience.

I paid particular attention to the therapeutic alliance, which was originally defined by Bordin (1979) to consist of (a) a relational bond, (b) agreement on the goals or purpose of therapy, and (c) agreement on the means and methods of the therapy. When past therapy participants are asked what contributed to their progress in therapy, 90% suggest it was due to the relationship (Norcross, 2010). Empirical evidence and meta-analytic data from over 1,000 studies have confirmed the impact of the therapeutic alliance to outcome (Miller et al., 2013; Norcross & Lambert, 2011). Because of its importance in psychotherapy, I have chosen to explore how participants and practitioners perceive their therapeutic relationships in adventure therapy settings. This understanding and definition of psychotherapy informs the research questions used for my inquiry.

**Research Questions**

My inquiry explores participants’ and practitioners’ adventure therapy experiences by addressing the following research question and sub questions:

1) What are people’s experiences in adventure therapy?

   i. What were past participants’ adolescent experiences in adventure therapy?

   ii. What are practitioners’ experiences in adventure therapy?

   iii. What is a therapeutic relationship in adventure therapy?

   iv. What would program participants and practitioners change about their adventure therapy experiences?
To address these research questions, I used narrative inquiry, a unique method for exploring lived experience. Riley and Hawe (2005) found narrative approaches helpful for gaining “insight into the factors that have helped or hindered program development or might explain why programs appear to work in some contexts, but not in others” (p. 237). Using semistructured interviews and participant observation to explore participants’ experiences through the lens of pragmatism helped bridge the available knowledge from the literature with firsthand experience (Tilsen & McNamee, 2015; Yang, 2011). Due to the sustained influence of the evidence-based paradigm across different schools of therapy, adventure therapy included (DeMille et al., 2018; Gass et al., 2019; Norton et al., 2014), it feels timely and appropriate for an alternative exploration, one with a commitment to the experiences of program participants, practitioners, and researchers (Dewey, 1938).

Although I have elected to conduct a qualitative study, I have not disregarded positivist approaches to the social sciences. The ability to count, measure, predict, and control is a human triumph and a stance that has validated the effectiveness of psychotherapy across different models (Miller, Hubble, Chow, & Seidel, 2013; Wampold, 2015a). However, this stance has struggled to explain how and why change does or does not occur for particular people. While my inquiry is informed by the outcome data, I challenge the validity of viewing change as a linear and quantifiable process where specific, causal, active ingredients act on a particular mental disorder.

That said, my personal reflections are noted throughout the thesis, and I have written from the first person. Writing in the first person allows for clear acknowledgement of my contribution in co-constructing meaning throughout the course of my inquiry. My inquiry provided a space for past program participants of adventure therapy to author their own
stories. The focus on experience is presented to bridge the gap between theory, research, and practice (Quay, 2016), the methodology of which is presented in Chapter 4.

In the section that follows, I present a short history of adventure therapy in a global context. Due to the dominance of literature from the United States, the history of adventure therapy from European and Australian backgrounds has been more difficult to consolidate until recently (Harper, Gabrielsen, & Carpenter, 2017). Thus, the narrative around adventure therapy has been subjugated to a focus on wilderness therapy in the United States

**Short History of Adventure Therapy**

This section begins with a look at the specific populations receiving adventure therapy services, followed by the history of placing adolescents in out-of-home programs. I then present how adventure therapy has developed over the years across North America, Europe, and Australia. This section, along with the following chapter, provide a brief history of scholarship and research in adventure therapy.

**Adolescents and Adventure Therapy**

Although adventure therapy has been delivered to a range of clinical populations, from war veterans to adults in residential treatment to children with disabilities (Dobud & Harper, 2018), my focus is on adolescents. I present, in this section, some of the literature about the commonalities and characteristics of adolescents receiving adventure therapy around the world. As will emerge throughout my inquiry, there are many types of adventure therapy. Russell (2001), for example, labelled some of the different models of wilderness therapy:

1) continuous flow programs, where leaders rotate in and out of the field, and new clients join existing groups, and which a therapist supervises groups and visits them
on a weekly basis; and 2) contained programs, where the therapist and wilderness guide comprise a treatment team which remain with the group the duration of the program. (pp. 74–75)

OBH, often synonymous with continuous-flow wilderness therapy programs the United States (Mooney & Leighton, 2019) are unique forms of involuntary, private pay programs common to wilderness therapy practice only in the United States. Bettmann et al. (2014) examined the histories and demographics of 401 participants who attended these different private-pay wilderness therapy programs. The review found a participant’s average age was 16.1, with 62.6% male, and 16.8% adopted. Hoag, Massey, and Roberts (2014) presented the clinical trends of wilderness therapy participants, comparing young adults to adolescents. The authors found adult participants to have “significantly greater rates of Substance-Related Disorders and Pervasive Developmental Disorders; while adolescents had significantly greater rates of Behavior Disorders, Attachment Disorders, and V Codes” (p. 388), which are not specific diagnoses but codes used for insurance billing in the United States. Issues of noncompliance with treatment, parent–child relational problems, child neglect, academic problems, or bereavement can be listed as V codes.

Norwegian researchers Gabrielsen et al. (2015) offered their wilderness therapy program to “adolescents aged 16 to 18 years that have been referred to mental health services due to challenges such as depression, self-harming behavior, anxiety, and adjustment disorders” (p. 7). Loynes (2004) described a project involving outdoor retreats in the United Kingdom for marginalised young people who identified as drug users, gang members, and school drop outs. In Israel, Margalit and Ben-Ari (2014) worked with adolescents coming from a “low socio-economic background, [who] have been identified as experiencing social or educational difficulties and as being at risk of maldevelopment and delinquency by Social
These brief representations indicate adventure therapy has been delivered for a diverse range of adolescents across different cultures in various social and economic contexts.

**Origins of Adventure Therapy**

On the timeline of adventure therapy, the single biggest influence was the emergence of Outward Bound in 1941 (Gass et al., 2012). Walsh and Golins (1976) further conceptualised Outward Bound’s programming as linked closely with the work of John Dewey and other psychological theories. Though Outward Bound predated these following philosophical stances, the authors linked Outward Bound processes with self-determination theory, humanism, and Rogerian core conditions of change. Founded by experiential educator Kurt Hahn, the first Outward Bound program in Wales provided a “rigorous month long course of small boat training, athletic experiences, map and compass skills, rescue training, an expedition at sea, a land expedition across three mountain ranges, and service to local people” (Gass et al., 2012, p. 27). Although his philosophies were not well documented, Hahn (1960) suggested physical training, adventure-based expeditions, and rescue service were key components to helping at-risk youth. The cost, however, was prohibitive for many families and youth wishing to participate, and remains so today (Gass et al., 2019).

**Theoretical Origins of Adventure Therapy**

The origins of adolescents being sent away to adventure-based programs can be traced back as far as the 1800s (Tucker et al., 2016). At the turn of the century, a hospital opened in Philadelphia that viewed natural environments as crucial for healing mentally ill patients (Davis-Berman & Berman, 1994). In New York, hospitals began using tent therapy
to treat patients with tuberculosis, while summer camps using therapeutic approaches, such as Camp Ahmek, surfaced after World War I.

Nevertheless, Outward Bound caught the eye of the Massachusetts Department of Youth Services who provided Outward Bound experience to 60 adjudicated young people to study if participation on the program would lead to reduced recidivism rates, defined by a new offence or violation of parole versus a training school control group (Kelly & Baer, 1968). The study found 20% of Outward Bound participants reoffended compared to the training school control group’s rate of 37%. Although cited frequently as one of the first comprehensive adventure therapy studies with a comparison group, the findings should be interpreted with caution. Three U.S. Outward Bound schools were used in this study and produced significantly varied results. The Colorado School reported a recidivism rate of 0% and Hurricane Island at 11%. The Minnesota School’s recidivism rate of 42%, however, demonstrated significantly worse recidivism than the training school (37%). This leaves readers wondering what factors differentiated these programs all operating under the same organisation and theoretical perspective.

Outward Bound’s experiential model, presented by Walsh and Golins (1976), is not the only approach used in adventure therapy, but it has been recognised as a cornerstone of practice (Gass, Gillis, & Russell, 2012). It would be a challenge to find wilderness therapy literature excluding a Walsh and Golins (1976) reference. The model described

a motivated learner or program participant being placed into a prescribed physical and social/group environment where specific problem-solving tasks are presented to the learner. Problem-solving tasks, experiences, and learning are presented, sequenced, and facilitated by the leader in such a way that the participant experiences success or mastery, which leads to intra- and interpersonal growth. (Gass et al., 2012, p. 70, emphasis in original)
The model also highlighted a focus on facilitating experiences that increase intrinsic motivation for change through appropriate problem-solving tasks that elicit a sense of mastery. The natural environment is also theorised to play a role in inviting participants to adapt to specific challenges. For example, natural consequences, which are the natural outcomes of a certain behaviour, and without contribution from the practitioner, are suggested to facilitate much of the experiential learning (Russell, 2001). Tucker et al. (2016) acknowledged, “Early programs were founded on the premise that the primitive wilderness experience is a powerful mechanism for therapeutic change” (p. 33). If a participant does not set up an adequate shelter, there is the possibility they could get wet, cold, or woken up throughout the night when the wind blows down their shelter. If challenged by constructing their shelter, participants can use appropriate problem-solving skills such as asking for help. As participants continue to overcome specific obstacles, they can experience a sense of success and mastery.

Kimball and Bacon (1993) presented a wilderness challenge model as a framework for theorising what factors contribute to change in outdoor settings. Their contributions built on the idea of natural consequences and the use of stress as a therapeutic factor:

The intentional use of stress is central to the change process of wilderness therapy. Stress is often magnified by the students’ tendencies to exaggerate the level of risk inherent in adventurous activities. Certainly rock climbing, rappelling on vertical cliffs, exploring deep caves, and traversing steep snowfields entail some genuine danger; however, these potential risks can be managed more simply than the novice imagines. Regardless, students often feel as if they are in a genuinely life-threatening situation. (p. 21)
This challenge model has raised concerns, especially from feminist scholar Mitten (1994) who argued that intentionally creating stress does not create a therapeutic community or help a client to “feel like a hero” (p. 64). Still, this notion of using stress as a therapeutic tool continued in the history of adventure therapy. It is worth noting that others, such as Harper et al. (2019) and Hinds (2011), have criticised the notion of using nature as something to conquer. They instead suggest that interventions in the outdoors are not designed for solely climbing a mountain or paddling the most difficult river, but immersing oneself in these natural environments. Since the early days of Outward Bound and the focus on the intentional use of stress, there have been many significant developments in adventure therapy research and practice, which are presented below.

**Significant Developments**

Over time, Outward Bound’s approach to helping at-risk youth highlighted a demand for alternative approaches to mental health in the United States (Gass et al., 2012). At Brigham Young University, the Youth Leadership Through Outdoor Survival course launched in 1968 to support struggling first-year university students. Project Adventure designed the Behavior Management Through Adventure program in 1971 using adventure experiences to facilitate outpatient therapy groups, which became one of two adventure therapy model to be listed on SAMHSA’s (2012) National Registry of Evidence-based Programs and Practices. Born out of the Brigham Young University program, the School of Urban and Wilderness Survival (SUWS) was founded in Idaho as a private, for-profit program providing residential wilderness therapy reimbursable through private health insurance in 1981. More followed suit throughout the 1980s as more psychiatric hospitals closed and stakeholders saw the financial benefits in setting up adventure-based programs for
private-pay families. These events sparked controversy and calls for stricter regulations and disputes over the empirical grounding of adventure therapy (Behrens, Santa, & Gass, 2010).

Programs in Europe also referenced Outward Bound’s influence in the 1960s and 1970s, but less literature is published from European contexts. It was this influence from the United States in the 1980s that led many practitioners in Europe to begin working with young people in the outdoors. Still, boundaries can blur between outdoor education and therapy, increasing the difficulty in differentiating between a psychotherapy program and outdoor pursuit with intended therapeutic benefits. Still, the use and scholarship in adventure therapy has increased in contexts outside of the United States in recent decades.

Van Hoof and Vossen (2017) and Wijnands and Janssen (2017) found adventure therapy in Belgium and the Netherlands borrowed from experiential and Gestalt therapies to inform their practice. The first adventure therapy program in Spain was introduced in 2015, which facilitated indoor rock-climbing activities for participants presenting with schizophrenia and histories of substance abuse (Rose & Garcia, 2017). Other Spanish programs focused on working with adolescents affected by HIV/AIDS, attention deficit hyperactivity disorder, and those in foster care. Fleischer (2017) pointed out that Germany differentiates itself from North American models by placing more emphasis on social interactions than adventurous experiences.

In Hungary, one of the most successful endeavour has been the nonprofit organisation *Bator Tabor*, or Brave Camp in English, which provides “therapeutic recreation camps for seriously ill children and their families, as well as for families who lost their child due to a severe illness” (Rakar-Szabo & Szabo, 2017, p. 40). Hungary’s first program was founded in 2004 and worked with psychiatric outpatients. The program, led by a team of psychologists and social workers, provided group and individual therapy sessions, low ropes courses, and rock-climbing activities. Raimondi and D’Agostino (2017) described adventure therapy as
young but emerging in Italy. Although there are programs taking troubled adolescents on mountain treks, Italy also held the first conference dedicated to scuba diving psychology in 2000. Pressley Ridge in Portugal has been using adventure for at-risk youth since the 1990s (Almeida, 2017), and in 2013, developed the Surf ART program to foster improved social skills and wellbeing through “surfing and contact with nature” (p. 51).

In New Zealand, Eggleston (2000) observed and interviewed adolescent participants attending a month-long, wilderness-based rehabilitation program. The participants were drug and alcohol users, survivors of abuse and neglect, and deemed unmanageable by institutional settings. During the program, participants worked together in fishing and cooking, collecting firewood, and playing organised sport. The program incorporated Mauri traditions and language, such as the haka (chants) or waiata (songs).

A cross-cultural examination by Harper et al. (2017) explored the perceptions of the wild in wilderness therapy from Canada, Norway, and Australia, respectively. Although like Europe, wilderness therapy in Canada is not well represented in the literature, the authors found “wild places . . . central to practice yet do not have theoretical or empirical support for their use in therapy beyond research support from allied fields, the anecdotal and the decisions of practitioners over the years” (p. 6). In Norway, despite a public health focus on the impacts of nature immersion for health and wellbeing, wilderness therapy has only recently been introduced to the mental healthcare system. The authors also referenced the term friluftsli, which refers to the culture’s open-air lifestyle, a tradition with aims not to conquer or overcome the challenges of nature but to live in harmony with it (Fernee et al., 2015). In Australia, there has been exploration to distinguish what separates Australia’s bush adventure therapy from North American and European practice (Harper et al., 2017). In their overview, Harper et al. (2017) stressed the intentional use of natural places while acknowledging that Australians “are still seeking to understand exactly how interactions or
immersion in natural bush locations can contribute to human health and yet not compromise the essence of wild places that is integral to their attraction” (p. 9). The authors further raised points about how different cultures, including Indigenous populations, might interpret certain outdoor settings.

Although I refer to wilderness therapy as a specific type of adventure therapy programming, I made a conscious decision to not refer to the outdoor environments in which these programs take place as a wilderness. Cronon (1996) argued that it is time to revisit our understanding of wilderness, as it is a term coming from colonial, Western cultures. Using the example of early naturalists, such as John Muir and Henry David Thoreau, who wrote about actively ‘preserving the wilderness,’ Cronon (1996) asked what preserving was needed before colonialists arrived and Indigenous cultures were “forcibly removed from an ancient home” (p. 18). It was the removal of people that created the ‘uninhabited’ wilderness in the first place. Although these programs take place in outdoor environments, I avoid the term nature as this may imply that humans are separate from nature (Harper et al., 2019).

Throughout my inquiry, I chose to describe specific settings in which different adventure therapy experiences took place as the outdoors or the field. The field is typically how the outdoor environment is described in adventure therapy and outdoor education (Russell, Gillis, & Lewis, 2008; Taniguchi et al., 2009).

It is also worth noting the possible misrepresentations of Indigenous cultures occurring in the adventure therapy and outdoor education literature. The use of the term ‘primitive’ throughout wilderness therapy literature is problematic. For Skidmore (2017), the framing Indigenous cultures as ‘primitive’ or ‘barbaric’ is misleading. These ideas and terminologies are referenced throughout this thesis and will be noted when necessary.

Advocating for wilderness therapy, Gabrielsen and Harper (2017) discussed the rise of urbanisation and use of technology and increased rates of diagnoses for major depressive
disorder, among others. Despite decreases in infant mortality rates and increases in life expectancy, the authors noted a shift towards “chronic lifestyle diseases, such as obesity and diabetes” (p. 3). Accordingly, wilderness therapy could serve as an antidote for a lack of human connection with the natural world. Along with the rise in popularity of mindfulness, time spent in natural environments could improve connectedness, allow for reflection, and increase self-efficacy through overcoming obstacles, such as climbing a tree, hiking a mountain, or successfully abseiling from a cliff or building.

This section explored some of the influences that have led to the development of adventure therapy programs around the world while discussing some of the debates around terminology and practice. In the following section, I present some of the ethical dilemmas which have affected adventure therapy, specifically in the U.S. context.

**Adventure Therapy and Ethics**

A common theme emerging from adventure therapy’s history in Europe and Australia is the influence of experiential learning and outdoor education. Because qualified mental health practitioners are tied to a code of ethics informing their practice, it is difficult to know where adventure therapy fits in, and who is competent to provide it (Natynczuk, 2016). Becker (2010) recommended taking special consideration when labelling a program as therapy or therapeutic. Scott and Duerson (2010) had similar considerations. Accordingly, U.S. programs are urged to meet the practice standards of associations like the OBH Council, which has “initiated a systemic effort to create and promote safety standards, training, research, and stronger clinical models among wilderness programs” (Tucker et al., 2016, p. 33). The spur for accountability in the United States came after recurring reports of unethical practice and client deaths on wilderness therapy programs. Those events occurred as the cost
of such private-pay programs rose, an average now of USD $561 per day per participant (Gass et al., 2019).

In the article “Dangerous Discipline,” Griffin (1995) reported the story of 16-year-old Aaron Bacon, the “third teen to die in a wilderness program since 1990” (p. 94). Aaron’s parents elected to send their son to a wilderness therapy program with concerns of increasing substance abuse and deteriorating academic performance. However, after 30 days in the program and “losing 23 pounds, enduring 11 days without food and four near-freezing nights without a sleeping bag, Aaron died” (p. 94). Aaron’s personal journal was used in court to detail his experience. He wrote about feeling scared, dizzy, and weak. He complained of a stomach ache, but program leaders asserted he was faking. The autopsy deemed Aaron died of acute peritonitis, developed from stomach ulcers that were eating his intestine.

More accounts of abuse and neglect prompted a broad investigation by the U.S. Government Accountability Office (GOA, 2007), uncovering that particular programs ignored signs of exhaustion or dehydration, and occasions where program staff disregarded threats of suicide. In 2005, 1,619 employees at residential programs covering 33 of the 50 U.S. states were involved in reports of abuse. The investigation also found programs crafted unique definitions of adventure and wilderness therapy, making the inquiry more challenging for investigators to find appropriate programs.

Mooney and Leighton (2018) spoke to the macro sociological and criminology context of the troubled teen industry in the United States; the growth of which dates back to the ‘tough love’ movement of the 1970s. These private, semi-regulated programs emerged in response to a lack of a criminal justice system for the non-poor. Often, the result of trauma and adverse childhood experiences, mental health issues and problematic behaviours, such as substance use and self-harm, have increased among middle-class adolescents, according to Currie (2005), who argued these social classes are “quick to punish and slow to help” (p. 47).
What emerged, as is discussed throughout my thesis, is a field of practice focused on alleviating adolescent deviance based on the pursuit of “unquestioning compliance” (p. 155). Mooney and Leighton (2018) concluded their exploration of the U.S. troubled teen industry, expressing concern that this industry undergoes more criticism from journalists than academics. Ongoing criticism of this private residential treatment industry in the United States has raised concern that, “as family economic resources increase, youth are more likely to enter this troubled teen industry” (p. 612). Though a sociological and criminological perspective of the U.S. troubled teen industry is warranted, my inquiry is focused on the adventure therapy experiences of program participants and practitioners.

The result of these issues hurt the public image of not only wilderness therapy but the residential troubled teen industry, a term used throughout literature in the United States. It caused its advocates to reflect on the ethics of program delivery (Becker, 2010). Scholars have since focused on creating a safe distance between themselves and these allegations (Norton, Tucker, et al., 2014). In one sense, a name change or rebrand can be seen as a metaphorical line drawn in the sand where U.S. wilderness therapy began to be referred to as outdoor behavioural healthcare (OBH). Because OBH is a specific field of practice within wilderness therapy, I will refer to specific OBH programs as such. To become an accredited OBH program, organisations providing wilderness therapy undergo an extensive evaluation and agree to adhere to a set of standards and practices. Organisations, such as the Association for Experiential Education and the National Association of Therapeutic Schools and Programs have also continued to provide membership and accreditation for organisations, adhering to firmer standards of delivery and safety (Behrens et al., 2010).

These events also sparked research into the physical safety of such programs. Javorski and Gass (2013) found programs were presenting young clients with less physical risk than they would encounter while living among the general population. Russell and Harper (2006)
explored the rates of incidents, including therapeutic restraints, illness, injury, and runaways, from 2001 to 2004. The authors reported the “demand for these programs appears to be directly related to an overall demand for quality behavioral healthcare services, which at present time are not meeting the needs of adolescents” (p. 86). Although their review found rates of these incidents were on the decline, they concluded that safety among adventure-based programs had room for improvement.

Focusing on accountability, safety, and ethical delivery has had its effects. In adventure therapy, Norton et al. (2014) described “significant strides in the areas of research, recognition within allied clinical fields, and acknowledgement from government agencies as a promising clinical intervention” (p. 54). However, a recent scoping review of wilderness therapy literature, by Harper (2017), raised three ethical concerns worthy of further consideration: involuntary admission, use of transport services, and publication concentration from a limited number of researchers, namely, those from the OBH Research Council. OBH researchers Involuntary admission occurs in wilderness therapy when a young person does not consent to residential treatment but are admitted to the program by their parents (Tucker et al., 2015). This is a legal right for parents in the United States.

Involuntary treatment is common for private pay wilderness therapy programs in the United States and if the adolescent remains unwilling to engage, parents can hire specialised services to deliver their child to a program (Tucker et al., 2018). For example, parents concerned about their adolescent’s safety and wellbeing can hire secure transport services, also referred to as escort services, to ensure their child is moved from home to the wilderness therapy program. According to Tucker et al. (2015), if an “adolescent physically resists, the transport staff may use physical force (i.e. therapeutic holds or physical restraints) to maintain the safety and completion of the transport” (p. 672). Harper (2017) pushed for revisiting the ethics of practice since adolescents can be coerced into treatment or escorted
prior to any psychological or medical evaluation. Similar efforts have occurred around the world to end coercive practice in mental healthcare (Gooding et al., 2018). Additionally, because the transport experience may be potentially traumatising for program participants, practitioners, and parents, the risk and benefit of such practices should be considered.

Participant experiences of being transported to wilderness therapy are explored in Chapter 6, and future discussion revisits the ethical considerations of coercive and involuntary practice, which may be at odds with professional associations, such as the National Association of Social Workers (NASW; 2016).

The history of adventure therapy in each setting cannot be untied from the cultural context. For example, private-pay programs are common in the United States, but government or community-funded programs dominate most of Australia’s adventure therapy practice, at no cost to the program participant. Although what may be common is the intentional use of outdoor settings, cultural context plays a role in how adventure therapy is viewed and the hurdles different countries jump for recognition as a bona fide option for helping at-risk young people (Harper et al., 2017).

Historical and cultural context is important for understanding the developments of adventure therapy. As I present throughout my inquiry, different countries practice adventure therapy very differently. In the following section, I provide an initial outline of my thesis. The following chapter includes a more in-depth review of the relevant literature.

**Outline of My Inquiry**

Chapters 1 to 4 help to position the theoretical and methodological conceptualisations of my inquiry. Chapters 5 through to 9 discuss the findings, and Chapter 10 revisits the research process and provides an overview of the findings with implications for the helping professions and future research.
Forming my literature review in Chapter 2, I examine the outcome research and qualitative studies to inform our ways of understanding adventure therapy experiences. Limitations to the current view of adventure therapy are discussed to position this pragmatic approach to my inquiry.

I present my epistemology and ontological commitments in Chapter 3. I have based much of this on the philosophical work of John Dewey. Being an essential, but maybe overlooked, contributor to early experiential education and subsequently adventure therapy, it was important to go back to the beginning to see how these original philosophies have changed or impacted the field over time. I define and discuss what there is to be known and why theoretical frameworks, such as social constructionism and humanism, are useful to narrative inquiry and the analysis of people’s experiences. My theoretical stance is also linked to a solution-focused approach to conducting psychotherapy.

Chapter 4 presents my methodological decisions and the research process. My narrative inquiry used semistructured interviews and participant observation for data collection. Observations took place at adventure therapy programs in Norway, the United States, and Australia. In relation to the research questions presented in this chapter, the aims, objectives, and significance are further addressed in the chapter.

Chapters 5 through 9 present and discuss the findings from my inquiry of adventure therapy experiences. Chapter 10 provides a final discussion and conclusion bringing together the findings of my inquiry. Chapter 5 explores specifically who conducts adventure therapy and who receives it. Adventure therapy practitioners described personal healing experiences in the outdoors and demonstrated the interdisciplinary status of the field. Adventure therapy participants and their immediate interpersonal relationships experienced little hope for therapy after numerous failed therapy experiences.
In Chapter 6, excerpts from program participants are presented to describe how they arrived at their respective adventure therapy programs. The participants describe their previous experiences in therapy and those from the United States share their experiences of being escorted in the early morning from their bedroom to wilderness therapy programs.

The chapter also describes the varieties of adventure therapy experiences in which participants engaged, from long-term wilderness therapy to community-based programming. Programs varied in how they managed participants, with some enforcing strict rules such as not allowing participants to talk freely to each other and providing participants with no future information. Readers will notice the diversity and similarities in practice.

I use Chapter 7 to investigate the participants’ experiences of the therapeutic relationship. Program participants and practitioners reported the importance of relationships that include authenticity, democracy, and transparency. Given the therapist’s unique role in U.S. wilderness therapy, where the participants live throughout the program with outdoor instructors, referred to as field staff, but are visited weekly by a licensed psychotherapy, I use this chapter to explore how participants experienced this specific type of relationship.

Chapter 8 presents an analysis of the adventure therapy setting and unique elements of adventure therapy, like learning to make a fire by friction as a technique that can elicit a sense of success and mastery. These outdoor survival skills are referred to as hard skills, such as navigating with a map and compass. Conversely, soft skills are emotional skills, such as practising patience when setting up a shelter. Discussion includes interpreting the outdoor setting as a place for therapy to take place and one inherently therapeutic in its own right.

All but two of the participants in my inquiry took place in adventure therapy programs operating away from the program participants’ home and community. Chapter 9 describes the experience of returning home and life after adventure therapy with some program participants describing subsequent experiences in therapy. I closed this chapter with
space for practitioners and program participants to provide their final reflections on their experiences of being involved in the field. I use Chapter 10 to bring together a contextual understanding of adventure therapy and provide implications for further research and practice.

Conclusion

I conducted my first interview with a participant named Angela (pseudonym) on the 17th of March 2017. She attended a wilderness therapy program in the United States at 15 years old in 2010. As we were concluding our discussion, Angela asked if she could show me the tattoo on her arm. Intrigued, I said of course. She lifted her sleeve to show a collection of brightly coloured roses and thorns illustrated to appear as if they are piercing in and out of her skin. Angela got the tattoo a few years ago to symbolise the “rebirth” she experienced as a result of her life changing wilderness therapy experience.

I interviewed Thomas the following day. He went to the same program just a year after Angela. As Thomas was telling me about depression, his love for summer camp, and his parents’ ultimate decision to send him to the program, he paused. He was struggling to finish his sentences. “So, I think the woods,” he said, “was a big contributor to this overall impression and that impression was that . . . trying to think of how to phrase it.” He paused again. He was gazing around the room. “This program was perhaps one of the worst . . . ” Another Pause. Another deep breath. “. . . perhaps the worst experience of my life. And I wouldn’t wish it upon anyone cause of the emotional trauma that it caused.”

As I interviewed more people, the diversity of experiences grew. Some narratives were powerful and inspiring, like Angela’s; others alarming, like the one from Thomas. The narratives and observations that follow are used to build a contextual understanding of the adventure therapy experience. Controversy follows, but this thesis ultimately leads to a
hopeful conclusion with implications privileging the adventure therapy participants’ experiences of care and feedback.

This Chapter outlines my personal motivations for conducting this narrative inquiry and presented an international exploration of adventure therapy practice. Although the literature is dominated by a perspective from the United States, I incorporated European and Australian literature to the history of adventure therapy, adding additional cultural context to adventure therapy practice. Chapter 2 reviews the available literature, exploring the effectiveness of adventure therapy and participants’ previous experiences. I present this literature within the broader context of psychotherapy, illustrating some of the limitations in our current understanding of adventure therapy.
Chapter 2: Review of Literature

The moment philosophy supposes it can find a final and comprehensive solution, it ceases to be inquiry and becomes either apologetics or propaganda. -John Dewey (1938)

This Chapter presents a review of adventure therapy literature beginning with a presentation of quantitative outcome research. This discussion is followed by an exploration of participant experiences and qualitative research to explore how different approaches to inquiry inform our understanding of adventure therapy. I will conclude this review with discussion about how adventure therapy fits among the broad psychotherapy literature.

Search Methods

To incorporate the most literature as possible, I conducted a search (see Figure 1) through EBSCOhost (All) Research Databases using the terms that fit within the umbrella of adventure therapy outlined by Harper et al. (2014). The final search, conducted on 23 February 2019, found 975 results. I stored the references in EndNote X8 and removed duplicates \(n = 168\). I screened the remaining articles by title and abstract to remove all nonscholarly publications \(n = 245\), those focused on experiential or outdoor education \(n = 36\), papers that did not meet the definition of psychotherapy put forth by Wampold and Imel (2015; \(n = 22\)), publications that focused on a psychotherapy other than adventure therapy such as yoga or mindfulness \(n = 8\), and finally, those in a language other than English \(n = 8\).

The remaining 484 publications were coded by the first author’s country, the population served, and various keywords, such as ropes course, that emerged in the full text. The majority of the publications came from the United States (67%). Australia (9%), Canada
(7%), and the United Kingdom (6%). Norway and Denmark showed a recent trend with recent publications over the last decade. Articles also came from Belgium, the Czech Republic, Germany, Hong Kong, Ireland, Israel, Malaysia, New Zealand, the Philippines, Portugal, Russia, South Africa, and Sweden. The search located seven meta-analyses, 13 book reviews, and 25 literature reviews. The majority of papers found were theoretical discussions about adventure therapy (41%), quantitative or mixed-methods studies (25%), and qualitative inquiries (16%). In the following section, I explore the outcome literature surround therapy outdoors.
Efficacy of Adventure Therapy

In their review of previous outcome studies, Gass et al. (2012) found two primary outcomes for participants: “(1) the positive significant development of self-concept from participants in a wilderness therapy intervention, and (2) the development of adaptive and social skills” (p. 291). The authors argued adventure therapy may be “effective for unmotivated youth who otherwise may have not wanted to enter treatment, or were even unaware that their behavior had become a problem” (p. 295). It is possible, in this case, that the young person is not the one with the problem, but that it is the significant adults in their lives who seek external support. Hoag et al. (2014) found many adolescent participants to be struggling with depression, anxiety, substance abuse, family conflict, academic difficulties, experiences of trauma, and risk-taking behaviours. Additionally, participants may have responded poorly to talk therapy or other traditional mental health services (Clark, et al., 2004; Gabrielsen et al., 2015).

The most extensive study to date, conducted by Australian psychologists Bowen and Neill (2013), meta-analysed 197 outcome studies including 17,728 individual participants with an average age of 17 engaging in adventure therapy programs around the world. The study reported “positive, significant short-term changes in measured outcomes between the beginning and end of adventure therapy programs” (p. 40) versus no significant changes for the alternative or no-treatment control groups. Short-term in this case is defined as the length of the program and does not refer to the sustainability of the outcomes. It is unclear what was considered an alternative treatment group and whether these were direct comparison trials, comparing adventure therapy to another therapy on equal ground. The authors found outcomes for the adventure therapy participants were sustained and suggested using their findings as a benchmark for outcomes, as adventure therapy was moderately effective in quickly achieving behavioural, emotional, and psychological changes.
Most adventure therapy research focused on wilderness therapy programs in the United States and used the parent and adolescent self-report versions of the popular Youth Outcome Questionnaire (Y-OQ; Burlingame et al., 1996). Russell (2003) found in the study of 523 adolescent participants that 372 of their parents reported “reduced behavioral and emotional symptoms of clients immediately following treatment” (p. 33). With a sample of young adults, Hoag et al. (2013) reported significant change by the fifth week of a wilderness therapy program. According to the authors, change was maintained when the Y-OQ was administered a year after discharge from the program, though only seven of the 297 initial participants returned the completed survey, hardly making the results generalisable. Clark et al. (2004) used the Y-OQ along with other clinical measures to demonstrate “statistically significant improvement on immature defense and maladaptive behavior scores, and on dysfunctional personality patterns, . . . and clinical syndrome scores” (p. 225) for 109 adolescents who attended a 21-day wilderness therapy program. Bettmann, Russell, and Parry (2013) found significant change on the Y-OQ was sustained six months post program, though only 41 of the 189 total sample had complete datasets. These incomplete datasets exist throughout the adventure therapy outcome literature.

Recently, Gillis et al. (2016) conducted a meta-analysis of the effects of wilderness-based programs versus nonwilderness treatment programs using both the parent and adolescent self-report versions of the Y-OQ from intake to discharge. Interestingly, parents, who did not take part in the wilderness program, reported higher changes in wilderness-based programs for their children, while adolescent participants preferred nonwilderness programs. Behrens et al. (2010) meta-analysed the effects of both adventure therapy and residential programs, finding decreases in anxiety, depression, substance abuse, suicidal ideation, sleep disruption, and violence.
The characteristics of participants have also been used to examine outcomes. Tucker, Smith, and Gass (2014) endeavoured to see how the presenting problems of clients influenced outcomes based on the Y-OQ. Using intake data of 1,058 program participants with an average age of 15.7 from 15 different residential programs, the study found 32.6% of the participants showed no significant improvements at discharge from the program, with 84.6% of these participants having attended OBH programs and the remaining at residential treatment centres. The authors pointed out that 66.7% of the OBH participants reached the reliable change index on the YO-Q. The reliable change index is a statistic used to determine if reported change on an outcome measure is significant. These findings are comparable to findings from other therapies, which suggests 64% to 74% of therapy participants experienced reliable change (Bertolini & Miller, 2012). I further contextualise this outcome literature and the implications for adventure therapy throughout this Chapter.

Tucker et al. (2014) found females more than three times more likely to experience improvement than males. In their study, both males and females provided equivalent scores at intake, though Russell (2003) had found females provided more severe intake scores than males. However, when using the self-report Y-OQ, adolescent females indicated 49% greater improvement than males. Tucker, Zelov, and Young (2011) also found females to show significantly better outcome scores, as did Tucker et al. (2013) when adolescents were provided with adventure therapy services as an adjunct to community-based counselling services. Tucker et al. (2014) concluded it was unclear why females consistently outperform males in OBH programs but speculated it may be due to the empowering impact of wilderness therapy challenges.

Only a few studies have routinely monitored outcomes, which involves using quantitative measures to inform and direct practice, throughout an adventure therapy intervention. Gillis, Kivlghan, and Russell (2016) used the Outcome Questionnaire-45.2
(OQ-45; Lambert et al., 2011) to correlate outcomes with perceived group engagement throughout a 90-day substance abuse treatment program in Canada. Weeks where program participants “generally saw the group as more engaged . . . compared with other weeks, were associated with improvement in OQ-45 scores” (Gillis et al., 2016, p. 413). Russell, Gillis, and Kivlighan (2017) used the newly established Adventure Therapy Experience Scale (Russell & Gillis, 2017) in correlation with the OQ-45.2 “to explore how the therapeutic factors inherent in a mindfulness-based experience through adventure work to effectuate outcome” (Russell et al., 2017, p. 276). The authors found a “client’s perceptions of how helpful the experience was for them during a 2-week period, coupled with how mindful they were during a 2-week period, explains a significant amount of variance in treatment outcome” (p. 277). In this study, mindfulness is defined as including “specifically nonjudging and nonreactivity factors” (p. 278), whereby the program participants were ‘mindful’ of their treatment goals during their adventure therapy experience. To me, this is quite a particular definition of mindfulness as it sounds more like a discussion of engagement in the treatment process and consensus between practitioner and program participants around treatment goals. While levels of engagement significantly correlated to positive outcomes in this study, Harper (2009) found no correlation between the therapeutic alliance and treatment outcome, raising questions about “practice and future research considering how alliance in adolescent wilderness treatment may relate to: (a) the therapist/leader, (b) the wilderness effect, and (c) involuntary treatment” (p. 54). Studies using outcome and alliance measures to gauge the benefit of the program for each participant, providing therapists with real time and continuous feedback about a participant’s outcome or alliance measure scores, have not yet been published (Dobud, 2017; Dobud, Cavanaugh, & Harper, 2020).

This section has explored the efficacy of adventure therapy. Based on this review, one should have no reservations for declaring that, yes, the adventure therapies are effective. That
said, it should be noted that the majority of quantitative outcome literature stems from a small collection of researchers in the United States. Other countries, however, have provided important contributions to the literature. Gabrielsen et al. (2019) conducted a mixed methods study in Norway to find their wilderness therapy program to be “perceived as valuable” (p. 282) by the participants and to “contribute towards improving the mental health of many participants” (p. 282) one year following participation on a number of psychometric measures. It is clear from this review that taking therapy to the outdoors is a viable option for adolescent participants.

**Qualitative Research in Adventure Therapy**

Researchers using qualitative methods have explored the perceived experiences of adventure therapy participants and reported outcomes from parents when their child returns home. One study investigating the relationship between adventure therapy and attachment theory, by Bettmann, Olson-Morrison, and Jaspersen (2011), found that, prior to their adventure therapy experiences, adolescents reported conflicted relationships with parents, specifically with their mothers. Despite involuntarily attending, participants reported “increased openness, trust and felt security in parental relationships” (p. 188) after leaving this particular program. The researchers urged adventure therapy practitioners to stress the importance of how parental engagement and incorporating psychoeducational components for parents to learn about attachment theory. Tucker et al. (2016) further described the importance of engaging the family in wilderness therapy, as opposed to adolescent-only treatment, can improve efficacy. I am interested, however, in how these residential programs emphasise family involvement and, in particular, bring a focus on attachment when adolescents are away from their caregivers for extended amounts of time.
Norton (2010) shared the case study of 16-year-old Lisa, who had been abusing drugs and alcohol, and disengaging from school. Her parents, worried about the downward trend in behaviour, decided to have Lisa attend a 28-day program that involved camping and rock-climbing activities. Lisa struggled to adapt to the challenging outdoor setting but left the program feeling more resilient and less depressed. Upon returning home, she engaged in family therapy, and her academic performance improved. For Norton (2010), this study provided “more rationale for referring clients to wilderness therapy programs in order to treat . . . aspects of adolescent depression” (p. 233).

Through participant observation, semistructured interviews, and exploring participant documentation, such as their psychological assessments, Caulkins, White, and Russell (2006) presented eight impacts of a backpacking expedition for adolescent women. The program lasted 6-12 weeks and included backpacking in a desert setting in the southwestern United States. Participants took part in letter writing with parents, individual therapy with a licensed counsellor, learning survival skills, and interacting in a group environment. Themes included timelessness, awareness of surroundings, awareness of self, and awareness of others. The participants in the study reported that changes occurred due to self-efficacy, reflection, perceived competence, and a sense of accomplishment. The authors described the impacts of backpacking as a therapeutic endeavour based on potential cognitive, emotional, and physical factors. First, backpacking provided program participants time to think, confidence, a different perspective, and increased awareness. Second, there was a sense of accomplishment, feelings of peace, emotional stability, and an increased sense of self. Third, the physical activity evoked a sense of competence, physical strength, and distraction-free time. That said, not all program participants enjoyed backpacking and a limitation to the study was the range of narratives describing backpacking as meaningful or simply physical discomfort. Informing
my inquiry, I asked program participants about the specific activities they engage in, to build knowledge surrounding people’s experience in adventure therapy.

Karoff et al. (2017) provided a case vignette of introducing adventure therapy into a high school setting for adolescents diagnosed with autism spectrum disorder (ASD). For these authors, the power of adventure therapy lies in experiencing real behaviors, in real time, and reflecting on how they are either helpful or limiting to a participant’s life, and then learning new ways of behaving, thinking or feeling, and providing a space to practice those new behaviors before trying them out in the real world. (p. 403)

Although there is little in the literature about adventure therapy with those diagnosed with ASD, the authors shared the case of a student named Adam, who struggled socially. He did not make eye contact with his peers, would walk the halls looking at the ground, and disengage when frustrated. Throughout the program, Adam “gained consistent practice in social interactions, first through participation when invited to engage, and then gradually becoming more comfortable with initiating interaction” (p. 402). Through this new program, the authors also noted a change of culture in the school as ASD and other cognitive disabilities gained increased awareness.

Eggleston (2000) interviewed past participants of a wilderness-based rehabilitation program in New Zealand more than a year after their completion of the month-long program. The 12 participants each discussed the importance of their relationships with their social workers. Themes emerged relating to talking, healing, listening, trust, and respect.

Adventure therapy has also been used as an adjunct to other therapeutic models and with adolescents struggling in areas beyond mental health. Jelalian et al. (2006) studied the benefits of using peer-enhanced adventure therapy along with cognitive–behavioural therapy
(CBT) for overweight adolescents. Their study randomly assigned 76 participants to either a CBT group with adventure therapy or a CBT group with aerobic exercise. At 10 months, the researchers found the adventure therapy group had a weight loss of 35% versus the 12% of the CBT and aerobic exercise group. Stevens et al. (2004) explored the experience of 11 Canadian adolescents with cancer and five healthcare professionals participating in an adventure therapy expedition. Through videorecorded unstructured interviews, themes of developing connections, creating memories, rebuilding self-esteem, and togetherness were interpreted from the experience. Both the adolescents and the professionals described experiencing something ‘special,’ having a sense of pride and accomplishment, adventuring with positive role models, and creating important memories. The authors hypothesised that the outdoor setting minimised distractions, providing the adolescents with ample reflection time. Adopting what appears to be a psychodynamic approach, they believed wild environments can breakdown “inappropriate defenses” and “denial” (p. 279) through experiences of success and mastery. Due to the role the outdoor therapy setting plays in the adventure therapy literature, I focus in Chapter 8 on people’s experiences of therapy outdoors.

With any out of home intervention, be it a psychiatric hospital, boarding school, incarceration, or wilderness therapy, the biggest challenge for participants can be returning home to their natural environment and re-integrating with the general population (Bolt, 2016). In their overview of parental involvement in adventure therapy programs, Tucker et al. (2016) noted, “Research has indicated that youth treated separately from their families or home environments may lose gains made in treatment . . . or even show an increase in negative behaviors upon returning home” (p. 39). Russell (2003) mentioned that adolescents might struggle with the “return to home, school, and/or peer environments that prior to treatment may have perpetuated problem behaviors” (p. 374). Exploring the experience of
life two years after a wilderness therapy program for adolescents but including family members in the treatment process, Russell (2005) found families engaged in aftercare services, such as family therapy, academic support, or drug and alcohol counselling, fared better than those who had not recommended follow-up as a “crucial component in facilitating the transition from an intensive wilderness experience to family, peer, and school environments” (p. 205). Behrens et al. (2010) also found the youth in their study to show improvements in academic and work functioning. More longitudinal research continues to emerge to inform how gains are transferred to life at home.

A longitudinal study by Davis-Berman and Berman (2012) used in-depth interviews with four adults who had participated in a 10-day wilderness therapy program as an adjunct to traditional talk therapy 25 years prior to participating in the study. Three female participants described having children at a young age, while two reported marrying an abusive partner. None had stability with their career and struggled to complete their education. The researchers acknowledged that although the wilderness therapy program “did not appear to be dramatically life changing or life altering, all said that some of the effects of the trip still remained” (p. 335). Mainly, the participants reported learning coping skills, improving relationships with family members, and gaining life lessons they could share with children of their own. The effects were gained through experiences of self-sufficiency, reflecting on their priorities in life, and experiencing time removed from the troubles of everyday life, such as verbal or physical abuse.

Qualitative research is also present outside the US context. In Australia, Conlon et al. (2018) collected data from 11 adolescents who participated in a wilderness therapy program. The participants benefitted from staff encouragement and support. improved self-esteem, efficacy, self-worth, and management skills. Reported outcomes included improved self-esteem, efficacy, self-worth, and management skills. In Ireland, McIver, Senior, and Francis
(2018) presented narrative outcomes from staff and participants in a wilderness program. The participants stressed the importance of their relationships with staff and peers and the healing potential of nature.

Draper et al. (2013) looked to identify the “unique patterns in long-term success” (p. 72) among adolescents and families returning home from residential treatment, including wilderness therapy. Participants reported continued drug and alcohol use, negative peer relationships, and unchanged family environments as the most common obstacles of the 173 families interviewed. According to Draper et al. (2013), adolescents attributed “positive incentives, encouragements, and praise” (p. 84) from parents to help consolidating the gains made during residential treatment. Parents found professional support helped them to understand that structure and boundaries could be perceived as an expression of affection and care. Since many U.S. wilderness therapy and residential programs run for a minimum of 28 days, exploring patterns of success and failures as participants return to their respective communities is important for improving the effectiveness of these programs.

It is common in wilderness therapy programs in the United States for participants to go on to further treatment at a residential treatment centre or a therapeutic boarding school (Mooney & Leighton, 2019). To me, this is mistakenly referred to as “aftercare.” To explain this phenomena, Bolt (2016) described wilderness programs as essentially intensive care units. Without intensive support after the program, gains may not be consolidated. Bolt specified that, in fact, one U.S. program refers 95% of their participants to more long-term and intensive care, though only 80% of families decide to follow the referral. Bolt felt wilderness therapy, though effective, should not be viewed as the solution. Norton et al. (2014) noted the average length of stay at a residential program is two years, and the 55 adolescents in their study benefited from a 25- to 30-day wilderness therapy program prior to enrolling into a long-term residential program. Based on the robustness from the data from
Gillis et al.’s (2016) meta-analysis, participants were graduating wilderness therapy programs, including the one cited by Bolt (2016), with outcomes well into the recovery range according to the Y-OQ. Despite literature supporting the efficacy, I find it difficult to suggest this model of wilderness therapy, OBH to be specific, is responsible for sustainable change given participants are sent, typically involuntarily, from one residential treatment to the next.

As I discussed in the previous chapter, cultural differences do impact the structure of adventure therapy services. For example, U.S. programs state that eight weeks of residential, intensive treatment is short term, despite adventure therapy programs outside the United States have demonstrated similar outcomes in much less time (Bowen, Neill, & Crisp, 2016; Dobud, 2016; Fernee et al., 2015; Margalit & Ben-Ari, 2014). Together with a colleague, I conducted a scoping review of the available direct comparison trials comparing specific components of adventure therapy (Dobud & Harper, 2018). We found no difference in outcomes across varying amounts of time spent on different adventure therapy programs (Dobud & Harper, 2018). This area warrants future research as the available evidence was limited.

Fernee (2007) attempted to examine the ‘black box’ of wilderness therapy outcomes, by using the available data from seven qualitative studies to propose a refined wilderness therapy clinical model. This model begins with believing an outdoor environment “to be a healing place that for some clients might facilitate change in itself” (p. 125) the ample opportunities for reflection. The challenges of outdoor living and hiking are proposed to enhance self-awareness and self-efficacy. In the psychosocial domain, small treatment groups aid in the development of new and more positive relationship skills, while stigma and resistance begin to decrease as the treatment is more natural compared with other talk therapies.
Quality and Rigour of Adventure Therapy Research

A common critique of adventure therapy is the lack of experimental research designs in the adventure therapy literature (Becker, 2010; Gabrielsen et al., 2015; Gass et al., 2012). Randomised clinical trials, though generally considered the “gold standard” of efficacy research (Wampold & Imel, 2015), also come with their drawbacks. These limitations were realised by a team of Norwegian researchers who looked to evaluate their newly established adventure therapy program (Gabrielsen et al., 2015). The innovative program worked with voluntarily participating adolescents aged 16 to 18. In the first year of the program, the researchers hoped to conduct a clinical trial to explore and justify the program’s funding and effectiveness.

The mixed-methods study first located adolescents appropriate for the adventure therapy intervention planning to place them randomly into two groups: (1) the adventure therapy group and (2) the control group receiving talk therapy services (Gabrielsen et al., 2015). In efficacy studies, treatment-as-usual, or TAU, can refer to many things. In this case, the researchers referred to a common model of individual, weekly psychotherapy. Because the adolescents volunteered to participate in the adventure therapy program, the authors felt the adolescents allocated to the TAU group viewed the assignment to TAU as a treatment failure. The participants had preferred adventure therapy but had it taken away. As one of the researchers put it, “It felt like I had first handed out a Christmas gift, then retrieved it to do a draw with the neighbour kid to decide who was actually to get it” (p. 8). The researchers eventually did not remove the adolescents’ preference for the sake of randomised research. The clinical trial was abandoned.

In the U.S. context, Tucker et al. (2016) described most parents as unwilling to agree to place their child on a waitlist or control group and that “placing participants on a waitlist who are in need of treatment is a violation of treatment ethics” (p. 40). Because many of the
adolescents engaging in adventure therapy report higher levels of distress with more previous treatment failures, clinical trials may be difficult to conduct as “the members of a control group are pre-conditioned to respond more poorly to the health care that they are offered” (Gabrielsen et al., 2015 p. 9). Thus, it may not be appropriate to have participants in a no-treatment control group in the first place.

Adventure therapy’s efficacy studies and meta-analyses have reported therapeutic outcomes on par with other models of therapy (Bowen & Neill, 2013; Gillis et al., 2016; Gillis & Speelman, 2008). My interest in this review is exploring the specific factors unique to adventure therapy and questioning their relationship to outcomes. Hill (2007), for example, similarly asked “what specific factors are most therapeutic and what is the long term benefit of participation” (para. 16) in adventure therapy. Whether it is the therapeutic alliance, time spent in nature or away from home, team initiatives, or group dynamics, the literature contains numerous claims as to how and why adventure therapy works (Fernee et al., 2017; Russell et al., 2017). Linking back to the scoping review by Dobud and Harper (2018), I could not find one study to suggest adventure therapy was responsible for better outcomes than any other therapy. Claims of superiority, such as those in Bolt (2016), DeMille et al. (2018), and Gass et al. (2019), are problematic, as they do not meet the standards of scientific rigour.

A concern with demands for more scientific verifiability involves addressing what methods of inquiry should be privileged. Given the inclination towards clinical trials, I consider the ethics of what these studies actually imply. For what was once required for evidence-based status on the National Registry of Evidence-based Programs and Practices (SAMHSA, 2012), two randomised clinical trials must demonstrate the efficacy and cost effectiveness of a particular intervention. In a discussion about methodological concerns when identifying evidence-based therapies, Wampold (1997) addressed questions about what
therapies are being compared to. Most common in psychotherapy trials is comparing specific therapies to no-treatment or waitlist control groups. These studies do not clarify if outcomes were achieved because of the specifics of the type of therapy or if being engaged in any therapy is better than no treatment at all. Less often, direct comparison trials attempt to address this by comparing two or more therapies with intentions that both could be effective. Historically, these studies have not found significant differences across theoretically and structurally different types of therapy (Ahn & Wampold, 2001; Asay & Lambert, 1999; Bacon, 2018; Wampold, 2010).

While my review has provided some justification for the option of taking therapy outdoors and using experiential treatment methods, no evidence existed to suggest adventure therapy provides better or worse outcomes for participants when compared to therapy without adventurous components. For example, one study by Magle-Haberek, Tucker, and Gass (2012) found no differences in outcomes when comparing residential programs and wilderness therapy. The findings leave me questioning if the specific ingredients of adventure therapy, such as time spent in the outdoors, are responsible for the outcomes. Although evidence is available to suggest physical and mental benefits of nature immersion (Harper et al., 2019; Hinds & Sparks, 2008; Roberts, Hinds, & Camic, 2019), there is a lack of research comparing the effectiveness of outdoor settings to the indoors in psychotherapy.

Although Dobud and Harper (2018) acknowledged some of the limitations of clinical trials in psychotherapy, and Harper (2010) outlined the cautions against a research agenda driven by political and economic forces, researchers have continued attempting to construct control groups to compare outcomes with adventure therapy. For example, DeMille et al. (2018) compared the effects of adolescents engaged in OBH to what they referred to as a TAU group. The authors described TAU as a group of participants whose parents elected to “seek treatment within their community” (DeMille et al., 2018, p. 243). The study found
OBH participation nearly three times more effective than seeking treatment in the adolescents’ communities, but it is unclear whether an adolescent completed any treatment in their community and what treatment specifically OBH was compared to. Additionally, all participants in the OBH group completed their treatments, and no percentage of treatment completion was provided for the TAU group. I find it troubling that the TAU group fared so far below previous benchmarks of psychotherapy outcomes, indicating that this study would not meet the criteria of a direct comparison trial of two equal and evidence-based psychotherapies (Wampold & Bhati, 2004). Like all psychotherapies, the available evidence has not found an active ingredient specific to adventure therapy’s effectiveness. In the following section, I present some of the areas worthy of future research and provide more criticism about our understanding of psychotherapy and adventure therapy in particular.

**Discussion and Implications**

My review of literature positioned adventure therapy as an effective and viable intervention for adolescents who may have experienced previous treatment failures. However, my review, along with the ethical discussion of adventure therapy presented in Chapter 1, illustrates a history tainted by poor judgement and unethical practice. Based on history and psychotherapy evidence, I feel it is imperative practitioners do not become blinkered by their model (Meichenbaum & Lilienfeld, 2018). Research evidence from outside adventure therapy is clear that contextual factors, such as the participant’s experience of empathy, the therapeutic alliance, and consensus on goals provide more than double the variance in outcomes when compared to the treatment model itself (Miller et al., 2013; Wampold & Imel, 2015). These types of questions have yet to be explored with any rigour in adventure therapy, which my inquiry attempts to address.
Being a narrative inquiry, I also searched for research that uses narrative approaches, of which I found few. Loynes (2010) did, however, conduct a narrative inquiry, similar to mine, on an outdoor program called the Stoneleigh Project for marginalised young people in the United Kingdom. Participants in the study described “significant life changes” (p. 127) and Loynes (2010) positioned narrative as a useful approach for understanding the transformative potential of experiential programs. For example, participants described reducing substance use, resolving difficult relationships with parents, and having new found hope for the future after returning home from the program.

While some qualitative research has presented the perceptions from participants on adventure therapy programs, the gap I found was a lack of literature focused on how adventure therapy narratives unfold in time. As I present in Chapters 3 and 4, narrative inquiry is a qualitative approach to research which focuses on the temporal unfolding of experience. Context and sequence are essential theoretical underpinnings, informed by pragmatism, and allow for a unique interpretation of therapy experiences.

I found pragmatism a useful lens for exploring “how our values and ethics, our politics and epistemologies, and our world-views as researchers directly influence our actions and our methodologies” (Evans, Coon, & Ume, 2011, p. 2). From the pragmatist perspective, the actions taken by researchers are always aligned with their beliefs and values (Morgan, 2014). Adventure therapy scholars in the United States have made obvious their ambitions towards evidence-based recognition (DeMille et al., 2018; Norton, Tucker, et al., 2014; Tucker et al., 2015). Gass et al. (2019), for example, was clear their study was conducted to influence private health insurance companies in the United States to provide third party reimbursement for OBH programs. Others have commented that due to replicated findings which find no differences in outcomes when two distinct models of therapy are directly compared, adventure therapy included, this pursuit should be abandoned and a research
agenda should promote the participant experience as the primary beneficiary of research (Dobud & Harper, 2018; Harper, 2010; Miller et al., 2013). To this end, my inquiry attempted to build knowledge from adventure therapy experiences, using pragmatism to bridge these distinctions between efficacy and lived experience. I use the following Chapter to develop my discussion on pragmatism, and link my theoretical perspectives with social constructionism, narrative ways of knowing, and humanistic principles.
Chapter 3: Theoretical Framework

A million white swans can never establish, with complete confidence, the proposition that all swans are white, one black swan can completely falsify it.
—Guba & Lincoln (1994, p. 107)

In this Chapter, I outline the theoretical underpinnings made throughout my inquiry. The importance of presenting this discussion is that without clarifying these assumptions and perspectives, it is difficult, if not impossible, to define what research has been done and what it is trying to communicate. Crotty (1998) suggested that, “without unpacking these assumptions and clarifying them, no one (including ourselves) can really define what our research has been or what it is saying” (p. 17). For Morgan (2014), pragmatism goes beyond traditional epistemological questions of reality and what can be known, to discuss how specific choices affect the knowledge built throughout the life of an inquiry.

For preparing my inquiry, I returned to the philosophical work of William James, John Dewey, and Jane Addams, and provide, in this chapter, a brief history of their pragmatic philosophies. I intentionally present the history to present a better understanding of context, as James himself found the historical context of knowledge to be critical, followed by a dialogue on the ontology of experience, narrative ways of knowing, humanistic theory, and social construction. This chapter sets the stage for my methodological considerations made throughout my inquiry.

When, Where, and Why of Pragmatism

Emerging from the United States at the end of the 19th century, pragmatism was “shaped by the seminal contributions of William James and John Dewey” (Borden, 2013, p. 261). Although James credits the philosopher Charles Sanders Pierce (1878) as the pragmatists’ original theorist, the theory was not referred to as pragmatism by James until more than a decade later.
Pragmatism stemmed from long discussions in The Metaphysical Club in Cambridge, Massachusetts as the turn of the 20th century. At the time, realist and positivist philosophies were increasing in popularity. Philosophers like Durkheim, Comte, and Mill were questioning “whether or not social scientists could and/or should “borrow” the methodology of the physical sciences” (Smith, 1983, p. 6). Comte, in particular, contested that “all ‘fictitious’ or ‘negative’ philosophical speculation about the human realm should be given up and, in its place, the ‘positive’ or scientific study of human beings should be undertaken” (Polkinghorne, 1992, p. 17); the idea being that the objects of study could be treated as physical things. Human relationships, interactions with environments, culture, and interpretations of art could be bounded and quantified by some objective observer using mathematics, the often viewed “queen of the sciences” (Guba & Lincoln, 1994, p. 104). Conversations on human experience, truth, and reality developed at The Metaphysical Club in response to the push for scientism in the humanities.

James, a contributor to the early psychology as well as the co-founder and third president of the American Psychological Association, a philosopher, and author of the classic *The Principles of Psychology* (1890), wrestled with the clash between science, religion, and morality. He was impatient with theories that neglected the realities of everyday life (Robinson, 1993). He felt that “never were so many men of a decidedly empiricist proclivity” (James, 1907, p. 14), whom he labelled “the orthodoxers.” James (1898) felt scientific theories were becoming mistakenly dichotomous to real life experiences.

For James, pragmatism was a method for reconciling scientism with the assertions of religious experience. He preferred a pluralist view where “no single system of thought can encompass the multiplicity and complexity of human life; we can never synthesize our experience into a unified whole” (Borden, 2013, p. 261). These dichotomies are similar to
those found in the social sciences today, such as those found in positivist, constructionist, and feminist orientations (Crotty, 1995).

After James, the key contributor to pragmatism was Dewey, a philosopher and educator who joined the movement with aims towards developing discussions about ethics, politics, research, and a new curriculum of education; one with an experiential foundation (Hookway, 2016; Quay, 2016; 2013). In the 1890s, Dewey founded the University of Chicago Laboratory Schools to experiment with progressive education. He became absorbed in contributions from pioneering social worker Jane Addams, becoming a regular visitor to the celebrated Hull House, a settlement “for some socially conscious members of the new generations of college educated women to use their recently acquired skills to alleviate the worst effects of industrialization on the waves of immigrants crowding into the inner city” (Seigfried, 1999, p. 212). Seigfried (1999) further suggested it was these conversations with Addams and her pragmatic feminist positions that helped form Dewey’s model of social democracy. It is worth noting here, the influence of Addams’ work on the development of pragmatism. James referred to Addams’ (1902) first book *Democracy and Social Ethics* as the greatest of his time, appreciating its celebration of diversity.

Addams’ contribution to pragmatism is often omitted in the literature (Schneiderhan, 2011). When Hull House opened its doors, most of her scholarship focused on her actions. Schneiderhan (2011) perceived Addams as a “practical pragmatist” as she resisted the urge to label the work she had been doing. Addams urged that if people wanted to see a world of “social morality,” people must consider the moral experiences of many. This framework became embedded in the ethos of Hull House, and the ethos was simply to make a difference. Addams were no fixed rules or dogma to particular approaches of helping.

Similar to Addams, Dewey theorised that pragmatism was the logical and ethical exploration of scientific inquiry, an approach that led to rejecting dichotomies about specific
ways of knowing (Hookway, 2016). Philosophical distinctions between ‘knowing’ and ‘doing’ were problematic for Dewey (Borden, 2013). The knowledge found in a particular inquiry could not be separated from the actions and beliefs of the researcher. Dewey preferred the principle of ‘learning by doing,’ a philosophy appreciated in both adventure therapy literature (Gass et al., 2012, Quay, 2016) and the experiential philosophies of Kurt Hanh (1960).

Pragmatism’s influence declined after Dewey (Hookway, 2016; McDermid, 2006). After the 1920s, analytic philosophy took centre stage and the influence of James and Dewey diminished. Campbell (2007), however, claimed pragmatism’s influence as always inflated and that a period of dominance never truly occurred. That said, scholars such as Rorty, Putman, Rescher, Habermas, Hack, Brandom, and West, to name a few, have made clear the inspiration they take from American pragmatism.

It is clear the helping professions have taken a turn away from pragmatism and the influence of James, Dewey, and Addams has been eclipsed (Marchel & Owens, 2007). For example, in psychology, “Quantitative methods, replicable truths, the study of isolated and controlled variables, and the objectivity of the researcher are the hallmarks of contemporary psychological research” and, despite practitioners continuing “to rely on first-person accounts of diagnosis, thus using introspection and clinical judgment, mainstream psychology has long passed the point of relying on subjective analyses” (p. 302). Because pragmatism can be used to bridge various forms of inquiry, James and Dewey may have favoured the social sciences to be influenced by various forms of knowing and lived experience.

Morgan (2007) argued that instead of sharp contrasts, such as induction versus deduction, which position the theoretical positions against each other, the pragmatist uses abduction to “search for useful points of connection” (p. 71) between different theories. Similarly, intersubjectivity is privileged over contrasts of subjectivity and objectivity. While
complete objectivity is no more possible than complete subjectivity, the pragmatist acknowledges varying worldviews are part of everyday life and influence the actions taken by those involved in a study (Morgan, 2014). Here, the workability of my inquiry is in how well the study can communicate to people from different viewpoints.

The final dualism presented is between quantitative research’s generalisability and the context-dependent nature of qualitative approaches. Morgan (2007) did “not believe it is possible for research results to either be so unique that they have no implications whatsoever . . . or so generalized that they apply in every possible historical and cultural setting” (p. 72). Here, he presented transferability, borrowed from Lincoln and Guba (1985), which discusses how findings can be transferred to different settings.

Informing my inquiry is the pragmatist emphasis “to unstiffen all our theories” (James, 1909, p. 73, emphasis in original) and focus on experience and action. As I mentioned briefly in Chapter 1, practitioners from all theoretical orientations bring with them their own interpretation of therapeutic interactions. Meichenbaum and Lilienfeld (2018) reported the existence of over 600 different types of therapy, and while my inquiry is focused on adventure therapy for adolescents, I do not ascribe to the notion that one therapeutic framework is more appropriate or effective than another for interpreting psychotherapy experiences. That said, I have practiced solution-focused brief therapy for over 10 years, and I am inextricably drawn to this framework. Some of these solution-focused underpinnings and the assumptions of human experiences will emerge throughout my exploration of the real life experiences of adventure therapy practitioners and participants by maintaining this ontological commitment to experience.
Ontological Commitment to Experience

The theoretical perspective of experience as ontology is helpful for inquiring into storied adventure therapy experiences. While the original adventure therapy experience contains more than can be represented in a single book, article, or even what I can illustrate throughout my thesis (Quay, 2016), it is my ontological commitment to experience which allows for a rich exploration. For Caine, Estefan, and Clandinin (2013), this “ontology implies that experiences are continuously interactive, resulting in changes in both people and the contexts in which they interact” (p. 576). This knowledge-in-action is developed by people’s ongoing exchanges with the natural world and is not transcendental but transactional.

Clandinin and Rosiek (2007) stressed that Deweyan theories of experience were central to the ontological and epistemological stances of narrative inquiry. Dewey (1976) defined experience as the “notations of an inexpressible as that which decides the ultimate status of all which is expressed; inexpressible not because it is so remote and transcendent, but because it is so immediately engrossing and matter of course” (p. 325). Noting the continuity of experience, James (1909) believed parts of any experience are held together by what occurred before or after that experience. No experience or activity consists of independent movements simply occurring one after the other (Polkinghorne, 1991). Any attempts to splinter, freeze, and compartmentalise the many factors contributing to everyday experience may lead to a narrow description of what is occurring.

Narrative researchers Clandinin and Connelly (2000) continued emphasising this continuity as

the idea that experiences grow out of other experiences, and experiences lead to further experiences. Wherever one positions oneself in the continuum—the imagined
now, some imagined past, or some imagined future—each point has a part
experiential base and leads to an experiential future. (p. 2)

Dewey (1905) also challenged whether an inquiry can capture the true nature of an
experience, describing experiences as “double-barrelled” (p. 241), meaning experience
contains not only what is being experienced, but how it is experienced. To illustrate his point,
he sketched a story of being scared by a loud noise. Once he found out the loud noise was
simply a shade banging against a window in the wind, his fear dissolved. He felt embarrassed
by his fright but was no longer fearful of the wind or the noise. The reality of the noise being
scary had changed, but the experience of the fright itself remained true, “otherwise there
would have been no experience at all” (p. 396). The first experience of being startled by the
noise was real. The second experience of recognising his fear only to be the wind and shade
was simply the continuation of experience.

Throughout my inquiry, I have collected and analysed data from people’s reflections
which occurred at the time of the interview. The original events, which cannot be captured in
their entirety at the time of the experience, are turned into objects with meaning once they
were communicated. As Clandinin and Rosiek (2007) explained:

If the reality we seek to describe is presumed to be independent of our representations
of it, then there is no need to tell the story of how our representation of the world
emerged within a stream of experience nor how it returned to that experience. (p. 40)

In essence, the story people tell of these experiences, or their narratives, may be appropriate
for representing them within that time and context.

Dewey (1981) cautioned against ignoring experience as a basis of understanding. He
argued that any form of inquiry which casts a cloud over the realities of everyday, or ordinary
experience, may be a waste of time or energy. Researchers may struggle to apprehend a particular phenomenon if they cannot attend to the ordinary experience. It is through experiences “that people’s lives are composed and re-composed” (Caine et al., 2013, p. 576).

For Guba (1981), attempting to untie the specific variables of an experience can do “violence to the phenomena” (p. 84).

I bring to an ontological commitment to experience and adopt this lens for exploring therapeutic encounters. This stance appreciates the complexity of human interaction, accepting people’s narratives cannot be stripped of sequence and consequence (Riessman & Speedy, 2007). I focused on the subjectivity of people’s experience and their self-determination. Each therapy experience is unique and full of complexities (Borden, 2013). It is this focus on experience, as opposed to linear explanations of change that inevitably shape my interpretation throughout.

Dewey (1998) viewed individuals as “the carrier of creative thought, author of action, and of its application” and saw the human mind as the “vehicle of experimental creation” (p. 12). Each human experience takes something with it from that moment, bringing it along to a future human experience. This stance is useful given my interest in what meaning people have constructed from their adventure therapy experiences.

As I have outlined how pragmatism has positioned my inquiry, I continue this Chapter discussing how I chose to study storied lives and experiences through narrative. Marchel and Owens (2007) characterised James’ (1902) book Varieties of Religious Experience as one of the first uses of phenomenological research, a qualitative approach focused on the common lived experiences of specific groups. Throughout the book, James criticised scientists for ignoring the unseen and unmeasurable ways in which people experience everyday life. He was not interested in the legitimacy of someone’s religious experience, but the effect. As a qualitative methodology, narrative inquiry is interested in
these firsthand human experiences, as James was in 1902. Moving on from the ontological commitment to experience, I used narrative ways of knowing to inform my methodological positions.

**Narrative Ways of Knowing**

Beginning in the 1960s was what scholars have referred to as the ‘narrative turn’ (Connelly & Clandinin, 1990; Riessman & Quinney, 2005). Here, professions such as anthropology, sociology, psychology, history, and teaching turned towards the use of language in the social sciences. Pinnegar and Daynes (2007) found four themes illustrating this movement. First, the authors included a relational commitment between inquirer and research participant, and an understanding that the researcher and the researched are in knowledge building relationship. Second, there was a shift to the use of words as data instead of numbers. This was not a rejection of using numbers in the social sciences, but acknowledgment that numbers cannot capture the details of experience like words can. Third, there was a shift from the stance of universal laws and generalisability to a privileging of first-person accounts of specific experiences at specific times. And fourth, there was a broadening acceptance of alternative ways of knowing and understanding human experience. So-called “neo-pragmatists,” Rorty and Habermas positioned this ‘linguistic turn’ and focus on historicism as explicitly born from early pragmatism (McDermid, 2006, Morgan; 2014).

Social scientists began adopting methodologies to explore meaning through the storied lives people live. Bleakley (2005) explained that narrative stems from the Latin *narrare* meaning “to know” and noted that “storytelling involves knowledge production and shaping of experience, not simply transparent recounting of events” (p. 536). Staging narrative in the social sciences, Connelly and Clandinin (2006) explained,
People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Narrative inquiry, the study of experience as story, then, is first and foremost a way of thinking about experience. Narrative inquiry as methodology entails a view of phenomenon. To use narrative inquiry methodology is to adopt a particular view of experience as phenomenon under study. (p. 375)

Through narrative inquiry, knowledge is co-constructed through the actions taken by the inquirer, in this case, interviews and observations. People are continuously connected to their original experience, which is constantly evolving as more meaning is attributed to their experiences. In a given study, the narratives of the inquiry and research participant “become, in part, a shared narrative construction and reconstruction through the inquiry” (Connelly & Clandinin, 1990, p. 5). From this perspective, ‘inner lives’ are found within relational spaces and not in isolation of social context, similar to psychotherapy interactions (Larsson & Sjöblom, 2010).

I bring to my inquiry a certain focus on human experience and the inner lives, from the theoretical underpinnings of solution-focus brief therapy. When interpreting these adventure therapy experiences, I focused on how emotions related to social context and experience (Miller & de Shazer, 2000). Therapists do not maintain any more privileged knowledge than their clients (Bacon, 2018), or anything to suggest they understand what emotions really convey. I, instead, treat emotions as linked inevitably to action; only available for interpretation when specific words give meaning to them.
Humans attach meaning and stories to various objects as they are continuously processing their immediate environment (Polkinghorne, 1991). For example, people may experience the object in their house as a chair or separate pieces of wood, glue, and nails, or even a collection of atoms to help relate and configure their experiential encounters. Accordingly, “a child can be experienced as a student, a ball player, or someone with a scratched knee, depending on the interpretive frame used to give meaning to the experience” (Polkinghorne, 1991, p. 136). Likewise, a therapy participant can be described as an active participant or simply a passive recipient. They can also be described as depressed and helpless or resilient for coping through such difficulties. My view of self-determination is supported by Ratner et al. (2012) who suggested that for “each account of hardship there is a story of struggle, for each setback a story of perseverance, and for each misfortune a story of survival” (p. 56). If we believe people are capable of self-determination and can attach meaning to objects and experiences, we must believe they are essential for and capable of defining the outcome of psychotherapy.

A practitioner’s theoretical orientation influences how they interpret and analyse therapeutic interactions. For example, a psychodynamic practitioner might view the person they work with as a collection of unconscious processes and defences, while a cognitive-behavioural therapist may explore how a person’s cognitions lead to specific behaviours and consequences. As a solution-focused therapist, I pay close attention to the therapeutic interaction, the best hopes of people, and what happens in between our therapeutic encounters that is particularly helpful, or unhelpful (Ratner et al., 2012). This also reflects Beels’ (2009) description of narrative practitioners being de-centred from the therapy process. For example, Beels (2009) suggested narrative approaches “changed the definition of the process from ‘therapy’ performed by a master director–dramaturge, and interpreter, to a form of consultation focusing on the client’s initiative” (p. 364). In this case, practitioners do not
assign blame to their clients for a lack of progress in therapy and should avoid believing positive outcomes are the result of the model of therapy delivered.

Such ‘blaming’ of adventure therapy participants have occurred in the literature. Gass et al. (2012) described most wilderness therapy participants as unmotivated. In addition, Hill (2007) described adolescents as the most difficult of participants to work with in therapy. Labelling therapy participants as resistant, in denial, precontemplative, or unmotivated, risks further isolating the participant, and removes responsibility from the therapist to deliver a service the participant finds useful.

Solution-focused practitioners focus on what changes occur between therapy sessions and what is improving for participants. There is little interest, or need, to focus on defining the problem, but instead work towards constructing a more hopeful future for the participant. Solution-focused practitioners place little significance on ‘why’ questions as they can lead to over simplifications of causal explanations, which can seem ‘scientific’ (Miller & de Shazer, 2000). I use this perspective to respect the inner lives of the participants in my inquiry, acknowledging that I cannot attend to their private experiences any more than they can attend to mine, but only focus on what emerges during our interview pertaining to their adventure therapy experiences.

The above deliberate focus requires description for how experience is explored. For Polkinghorne (1991), the elements of experience are ordered in two primary relations: spatial and temporal. Spatial organisation involves the physical relations like up and down, or inside and next to. Temporal organisation relates to the causal and connecting relations. Attending to these relations sets the stage for conducting a narrative inquiry.

Narrative inquirers Connelly and Clandinin (2006) provided similar dimensions for narrative inquirers to attend: temporality, sociality, and place. For them, temporality emphasises the past, present, and future and the continuity of experience, which inquirers
represent through narrative. Sociality recognises how our interactions, within family or culture, for example, shape our identity of self, which we understand through narrative. Finally, place can also influence our personal experience depending on our culture, the environment we live in, or our immediate surroundings. Haydon and van der Riet (2017) found the “visibility of the interconnectedness of the three dimensions is obvious; where (spatiality), when (temporality), who and why (sociality) became vital parts of the person’s narrative” (p. 87). Attending to a participant’s experience through narrative ways of knowing provides an opportunity to conduct a study of human experience. The ontology of experience and narrative ways of knowing do not come without criticism, however, and are discussed at the conclusion of this Chapter. Discussion of these dimensions are developed further in Chapter 4.

Stepping beyond the narrative literature, I have also incorporated assumptions from the humanism, social construction, and solution-focused brief therapy literature. Because of my narrative inquiry’s relational commitment to people’s storied experiences (Clandinin & Murphy, 2009), these theories are useful tools for informing how I perceive human experience and the methodological decisions I made.

**Humanism, Social Construction, and Solution-Focused Assumptions**

William James has been referred to as a humanist at heart as he avoids mechanistic explanations of human behaviour (Blum, 2006). Polkinghorne (1992) also described how pragmatism supports the development of humanist theory, though it was psychologist Carl Rogers who championed humanism in the 1960s and 1970s. Change was defined as inevitable and no experiences are identical and being static is an illusion. People are not isolated from their environment or by mechanical orders in the biology of their being. C. R. Rogers (1961) described, in a similar way to James, that “a person is a fluid process, not a
fixed and static entity; a flowing river of change, not a block of solid material; a continually changing constellation of potentialities, not a fixed quantity of traits” (p. 122). In this case, humanism takes seriously a person’s ability to create meaning and act deliberately regardless of previous experience. When it comes to research, humanistic inquirers are not bound by one method of inquiry but to an interest in the everyday human experience. Accordingly, methods chosen must attend to the complexity of the human condition (Polkinghorne, 1992).

This understanding of human experience challenges our understanding of experiences in therapy (Payne, 2003; C. R. Rogers, 1957). Instead of focusing on unconscious processes or neurobiological theories of pathology, practitioners assume people hold the keys necessary to enact changes in their lives. It is through an experiential relationship, between practitioner and therapy participant, that change is constructed and acted upon. In this case, therapy is an experience in which a therapy participant acts freely to construct meaning. Though there are numerous ways of knowing and multiple stances an inquirer could take for interpreting psychotherapy experiences, I have aligned my thesis with Bacon (2018) who argued psychotherapy to be best understood through social constructionism.

Social constructionists discard any notion of an objective truth that is merely waiting to be discovered. In constructionism, “knowledge is established through the meanings attached to the phenomena studied” (Krauss, 2005, p. 759). It is in the experience of an interview or observation that meaning is, again, given to experience. For example, the qualitative interview is itself a new opportunity for the interviewer and interviewee to reflect on the phenomenon under investigation. Through asking specific questions, participants provide specific descriptions attach specific meaning to their lived experience. Meaning is defined as “the cognitive categories that make up one’s view of reality and with which actions are defined” (Krauss, 2005, p. 762). New experiences can generate and enrich meaning, while meaning also provides clarification and guidance for an experience. In this
case, meaning is constructed, not discovered, throughout an inquiry, during data collection, analysis, and interpretation (Morgan, 2014).

Berger and Luckmann (1966) described people as capable of apprehending and interpreting the knowledge of everyday life. Throughout my inquiry, I refrained from causal or general descriptions of cause and effect, or generic hypotheses, and instead attempt to account for the ‘often taken-for-granted’ experiences within adventure therapy (Polkinghorne, 1992). I demonstrate this perspective by participating and observing in adventure therapy programs, and discussing some of the overshadowed experiences of adventure therapy experiences.

Theories of constructionism emphasise that knowledge is generated through personal experience without the necessity of predictions or law like bodies of knowledge. While positivists will look to contain their biases, I have openly expressed my preconceived ideas and values instead of eliminating them. For example, I have mentioned that I approached my inquiry with experiences as an adventure therapy practitioner, and as a solution-focused social worker. In this case, my actions and interpretations are not bracketed from the study.

Informed by constructionism and humanism, I do not view research participants as objects (Tuli, 2010), nor therapy recipients as passive. This view can empower people as meaning makers equipped to share their reality towards the production of new knowledge. While there can be no perfectly balanced relationship between the researcher and the researched, constructionists aim to conduct inquiries based on cooperation, demonstrating a shift to an interactional research paradigm (Lincoln & Guba, 1989). Though data collection took part in an interview or observation, knowledge was constructed within a relational space and was dependent on the context of each unique interaction.

The context in which I conduct my inquiry, and in which a participant wishes to contribute, is rich with significance and circumstance, such as a research participant’s
motivation to engage with me in the first place. That said, I can be seen as both the researcher responsible for data collection and analysis, as well as the instrument, such as would a survey or measure in quantitative research. This is a worthwhile trade-off for understanding that there are as many experiences of reality as there are people in the world. When connecting with a research participant or interacting during participant observation, intersubjectivity is a given. People’s experiences are influenced during scientific observation. Instead of seeking further detachment from those being researched, I elected to seek engagement and involvement. It was important that I presented my personal history as well as my methodological decisions; acknowledging that I am a part of the study, both in the exploration of human experiences, as well as in the retelling of such experience.

**Criticisms and Final Thoughts**

Shavelson et al. (2003) presented significant concerns to narrative ways of knowing, asserting that “there is nothing in the use of narrative form . . . that guarantees the veracity of the content of the account or which vitiates the need for the usual epistemic warrants used in science” (p. 27). Shavelson et al. (2003) did not raise methodological concerns, but theoretical issues around claiming narratives are not rigorous enough to classify as truth. The sharing of a storied life experience is not concerned with whether the story is objectively true or false. No matter the methodological decisions made by a researcher, no representation can capture an original human experience (Morgan, 2007). Concerns, such as these, provide justification for why it was essential that I outlined these epistemological and ontological commitments, and the perspectives demonstrated throughout my analysis. The authors’ orthodox positivist position stresses the importance of mechanical processes (Caduri, 2013), but, as already mentioned, people do not act in mechanical ways (Polkinghorne, 1982).
Caduri (2013) was further troubled that because narrative research does not meet the epistemic requirements of the hard sciences, narrative inquirers should focus on how to be taken seriously by claiming that although findings are not justified, people are “intellectually entitled to accept them if they provide a plausible reconstruction of events” (p. 50, emphasis in original). Clandinin and Rosiek (2007) addressed these criticisms, stating such epistemic requirements of inquiry risk leaving large aspects of human experiences, such as love, hate, spiritual experiences, or personal meaning out of bounds. Instead of searching for knowledge outside human experience, I sought to build knowledge of human experience. This is not to say that positivist or post-positivist stances pose less strength, but rather that these positions build just one form of constructed knowledge intended for particular purposes (Crotty, 1998). Adopting a pragmatist stance, I do not view one theoretical perspective as less appropriate than the next, though I do not seek impossible standards of objectivity and truth. Instead, I critique research based on the individual rigour, philosophical commitments, and methodological decisions made by each inquirer.

**Conclusion**

Crotty (1998) and Morgan (2014) emphasised that inquirers justify their methodologies and methods through their theoretical stance. Throughout this Chapter, I accounted for my philosophical stance of pragmatism and the ontological commitment to experience. These epistemological perspectives influenced me to explore narrative ways of knowing (see Figure 2). Although adventure therapy literature contains experiential philosophies, and early literature cites Dewey’s pragmatic philosophy (Gass et al., 2012; Walsh & Golins, 1976), I positioned my inquiry to provide a unique study for interpreting adventure therapy experiences. In the following Chapter, I present the methodology of narrative inquiry and the methods I used to conduct my inquiry.
Figure 2: Elements informing my methodological decisions
Chapter 4: Methodology

Not everything that counts can be counted, and not everything that can be counted counts.
—William Bruce Cameron

In the previous chapters, I explored the available adventure therapy literature and the theoretical perspectives I have applied to my inquiry. Informed by pragmatism, narrative ways of knowing, and my background in solution-focused brief therapy, my inquiry sought a broad understanding of the experience of practitioners and program participants of adventure therapy. In this Chapter, I present the significance, aims, and objectives of my inquiry followed by a description of methodology. I discuss my process for data collection through interviews and participant observation. The Chapter ends with discussions about the procedure of analysis and ethical considerations for conducting humanistic research.

Significance

My inquiry provides an in-depth look into participants’ experiences in adventure therapy. While there are other qualitative studies present in the adventure therapy literature, the pragmatic and narrative underpinnings I have provided rich descriptions of what occurs during adventure therapy experiences, based on various contexts.

Privileging people’s experiences in therapy provides a helpful learning opportunity. Their experiences and perceptions, whether adventurous or not, may hold clues to what helped or hindered the delivery of a particular service. The gap in understanding human experience in adventure therapy appeared throughout my review of literature in Chapter 3. There was little voice from program participants or practitioners, and when there was, their words were often reduced to themes deprived of context and environment (Draper et al., 2013).
My inquiry explored the lives of participants before, during, and after their adventure therapy experiences. Not often in the literature have the stories of practitioners and program participants been explored through the same study. This exploration provided an opportunity to see the perspectives from the practitioners and participants. Inviting specific perspectives of human experience, such as theories of humanism and self-determination, informs an alternative discourse about experiences in therapy.

My inquiry explored the lives of program participants before, during, and after their adventure therapy experiences. Not often in the literature have the stories of practitioner and program participant experiences been investigated through the same study. Inviting certain theoretical positions of human experience, such as pragmatism, social constructionism, humanism, and self-determination theories, brough a unique stance for interpreting adventure therapy. My inquiry also provided a global study of adventure therapy. For example, I compared the structure of programming based on cultural context, which is also limited in the literature. Though Harper et al. (2018) offered a cross-cultural exploration of adventure therapy practice in Canada, Norway, and Australia, my inquiry built knowledge from interviewing program participants and adventure therapy practitioners, as well as from my participant observation on these adventure therapy programs. Focusing on participant experiences in adventure therapy allowed the opportunity to focus on potentially traumatic or demoralising aspects of programming. For example, wilderness therapy in the United States, often synonymous with OBH, has undergone previous critiques of unethical practice, such as the lack of informed consent and involuntary treatment (Becker, 2010). I aimed to provide the opportunity for rich descriptions of how such adventure therapy programming was received by the participants.
Aims and Objectives

Throughout my inquiry, I explored the experiences of practitioners and past program participants who have been involved in adventure therapy. The primary objective was to represent these experiences as narratives to inform the helping professionals working in adventure therapy about participant experiences. I intended to understand and build knowledge around

- Program participants’ adventure therapy experiences,
- practitioners’ adventure therapy experiences,
- the varieties of adventure therapy,
- the implications for the adventure therapy practitioners around research and practice.

The aims and objectives for my inquiry were informed by the gaps highlighted in my review of the adventure therapy literature.

Research Questions

I used the following research questions and sub questions to support my exploration of adventure therapy experiences. These questions were informed by the gaps in the available literature and my ontological commitment to experience.

1) What are people’s experiences in adventure therapy?
   i. What were past participants’ adolescent experiences in adventure therapy?
   ii. What are practitioners’ experiences in adventure therapy?
   iii. What is a therapeutic relationship in adventure therapy?
iv. What would program participants and practitioners change about their adventure therapy experiences?

The specific questions I used while interviewing practitioners and program participants are presented later in this Chapter (see “Interviews”). In the following section, I discuss qualitative research and narrative inquiry followed by the methodological decisions made throughout my inquiry.

Methodology

To begin the presentation of methodology, I discuss my intentions for undertaking a qualitative study. As mentioned in Chapter 3, the actions taken within a study are often tied to beliefs of the researcher (Morgan, 2014). Different theoretical frameworks lead researchers to different methods and the pragmatist is interested in how an inquiry would unfold if different actions were taken. My presentation of methodology is important for considering my preference to conduct a qualitative study.

In their first Handbook of Qualitative Research, qualitative scholars Denzin and Lincoln (1994) provided the following description of qualitative research.

Qualitative research is multimethod in focus, involving an interpretive naturalist approach to its subject matter . . . Qualitative researchers study things in their natural settings attempting to make sense of, or interpret, phenomena in term of the meanings people bring to them. Qualitative research involves the studied use of and collection of a variety of empirical materials . . . that describe routine and problematic moments and meanings in individuals’ lives. (p. 2)
A qualitative approach made sense for capturing the rich meaning and broad scope of adventure therapy experiences. Bryne (2015) described the approach of narrative inquiry to embrace many approaches to “data collection, analysis, and representation” (p. 37). My understanding from Byrne’s idea is that narrative inquirers could focus not only on how to consolidate their findings, but how to ‘represent’ their research participants’ experiences in different authentic ways. By adopting some of this frame, my approach was to pay careful attention to collecting thick descriptions (Clandinin et al., 2007) of social interactions, and to have the chance to examine rich representations of people’s experiences in adventure therapy.

I wanted to observe the structure of specific programs and hear from those involved. Based on my theoretical perspectives, I view people in therapy as active participants equipped with the self-determination to freely construct meaning from their therapy experience. Similarly, it is because of self-determination and humanistic principles that I believe the service user is the best voice for defining the outcome and describing what helped or hindered therapy progress. My ambition was to provide a voice to the many people who have engaged on adventure therapy programs.

Using the definition of qualitative research from Denzin and Lincoln (1994), I preferred to conduct as naturalistic an inquiry as possible. The term naturalistic does not refer to the action taken by a researcher but a methodological paradigm. Bowen (2008) described naturalistic inquiries as studies conducted in natural, real-world settings, using qualitative methods and inductive analysis. Humility is taken in the presentation of findings and inquirers aim for trustworthiness as a criteria for determining the credibility of their study. There are many ways to arrive at a certain finding, and I explore throughout this Chapter how I aimed to conduct a trustworthy inquiry. Relating to the aims of my inquiry, I have adopted the methodology of narrative inquiry and utilised unobtrusive methods to build knowledge about people’s adventure therapy experiences.
Narrative Inquiry

I chose to conduct a narrative inquiry to construct knowledge and meaning around adventure therapy experiences. Though social work practice is based on talking and the interpretation of life experiences, I was surprised to see the little amount of quality narrative research in the field, which made it challenging to determine what is or is not narrative inquiry; how it differentiates from other narrative approaches to research, and discuss what makes for a quality narrative inquiry (Clandinin et al., 2007; Riessman & Quinney, 2005). For my inquiry, I use a definition of narrative inquiry, presented below, put forth by Connelly and Clandinin (2006):

Arguments for the development and use of narrative inquiry come out of a view of human experience in which humans, individually and socially, lead storied lives. People shape their daily lives by stories of who they and others are and as they interpret their past in terms of these stories. Story, in the current idiom, is a portal through which a person enters the world and by which their experience of the world is interpreted and made personally meaningful. Viewed this way, narrative is the phenomenon studied in inquiry. (p. 477)

Narrative inquirers “explore the stories people live and tell,” which are “the result of a confluence of social influences on a person’s inner life, social influences on their environment, and their unique personal history” (Clandinin & Rosiek, 2007, p. 41). A narrative inquiry requires collaboration between the researcher and researched based on some social interaction (Clandinin & Connelly, 2000).

Narrative inquirers have many research methods available for gathering data. Generally, extended interviews, field work, historical texts, and reviewing of case notes have
been employed (Bleakley, 2005; Clandinin et al., 2007). Loynes (2010), for example, used “participant observation, collaborative inquiry, focus groups, interviews and case studies” (p. 130) in a narrative inquiry about an outdoor retreat program for marginalised youth. Narrative inquiry has been more thoroughly used in studies of education, community, anthropology, occupational therapy, and nursing than in social work, psychotherapy, and medicine (Clandinin et al., 2007). For example, Bleakley (2005) used the following example to describe the lack of narrative in medicine. The telling symptom is characteristically flat and removed from the story and experience of the patient, doctor, and team of specialists contributing to the patient’s healing. There is more of a need for understanding people’s experiences in medicine, which researchers can use to bridge with data driven from numbers and statistics. I, similarly, argue for more approaches to inquiry in psychotherapy that go beyond outcome measures, and depersonalising diagnoses, to incorporate an understanding of the often taken-for-granted human experiences in care.

Riessman and Quinney (2005) and Riessman and Speedy (2007) critically reviewed the limited literature of narrative inquiry in social work and psychotherapy and presented what they deemed exemplars of using this methodology in the helping professions. Riessman and Speedy (2007) found demands for scientific evidence, in the United States specifically, to prevent the helping professions from adopting narrative inquiry as a methodology for exploring therapeutic experiences. As I highlighted in my review of literature, adventure therapy scholars in the United States have used questionable research methods (see Gass et al., 2019), in pursuit of evidence-based recognition.

One criterion differentiating narrative inquiry from other qualitative methods is in the analysis and presentation of findings. Riessman and Quinney (2005) reported that although social work researchers have claimed to have conducted some type of narrative analysis in previous studies, their papers incorporated small snippets of transcripts stripped of sequence.
The authors warned against strategies for analysis that mirror reductionist techniques where “lengthy accounts of lives [are] abstracted from their contexts of production, stripped of language, and transformed into brief summaries” (p. 398). When people’s stories are coded into categories, the data collapse with no developmental dimension (Bleakley, 2005). With this in mind, I avoided dissecting narratives into smaller units, which tends to happen in thematic coding (Haydon & van der Riet, 2017). Informed by Dewey’s (1938) ontological commitment to experience, the stories shared in my inquiry are represented with sequence and context; appreciating the continuity of experience.

Analysis in narrative inquiry is aligned to the dimensions of experience provided by Connelly and Clandinin (2006): temporality, sociality and place. These dimensions were introduced briefly in Chapter 3.

*Temporality* refers to the continuity of experience. People, events, and experiences are always in transition, with a past, present, and future. Focusing on continuity, experience cannot be examined in isolation from its temporal nature. Attending to the continuity of experience may be appropriate for examining different experiences of healing, for example, such as the experience of living with a chronic illness or the process of a specific medical treatment (Bleakley, 20015). Adventure therapy experiences cannot be isolated from previous experiences and the meaning constructed after each time they are revisited by the participant.

People are social beings who live in different social contexts, which inform their *sociality*. Dimensions of this common place include personal and social conditions. Personal conditions are considered to be the hopes, feelings, and aesthetic reactions (Connelly & Clandinin, 2006), while social conditions refer to the surrounding factors, such as culture and environment, influencing a person’s experience. Another aspect of sociality includes the relationship and interactions between the inquirer and the respondent, similar to the
interactions between a therapist and therapy participant. There is a predictability in such engagements, where the questions asked, invite certain answers.

Narrative inquiry involves an ontological commitment to relationship and experience, which aims to represent people and their experiences, not by separated categories, but as self-determining humans with complex, artistic, and aesthetic lives. Haydon and van der Riet (2017) referred to narrative inquiry as “a compassionate methodology” (p. 86) that pays particularly close attention to the relationship between the researcher and researched. Throughout an inquiry, the relationship itself becomes part of the phenomenon being explored. Through this relationship, data are gathered and meaning co-constructed.

For Connelly and Clandinin (2006), the final dimension, place, refers to “the specific concrete, physical and topological boundaries of place or sequence of places where the inquiry and events take place” (p. 480). All experiences occur in some place. For my inquiry, I make special consideration to the environment in which experiences take place, considering how these places may factor in the experiences under investigation. Cultural and political factors may influence the development and delivery of different adventure therapy programs. These are noted throughout my presentation of findings.

From their review of narrative inquiry in social work literature, Riessman and Quinney (2005) presented what they referred to as good enough narrative inquiry. The authors stated that any narrative inquiry should be based on systematic observations with analysis attending to both sequence and consequence. Inquirers should focus on their relationships with research participants and inspect transcripts with particular attention to language. Epistemological and methodological commitments should be taken seriously, as they are not a given in any form of inquiry. In presenting the studies they viewed as models for narrative inquiry, the authors preferred a,
reliance on detailed transcripts; focus on language and contexts of production; some attention to the structural features of discourse; acknowledgment of the dialogic nature of narrative; and (where appropriate) a comparative approach—interpretation of similarities and differences among participants’ stories. (Riessman & Quinney, 2005, p. 398)

The above criteria informed my analysis of data collected through participant interviews. During the presentation of findings, I focused on how I represented each participant’s experience and ensured that I did not lose these dimensions of their experience.

In Chapter 3, I discussed the theoretical perspectives directing me to conduct this narrative inquiry. In the following section, I present the methods I chose to recruit research participants, gather data, and broaden knowledge of the adventure therapy experience.

**Methods**

I conducted semistructured interviews with adventure therapy practitioners and past program participants and engaged in participant observation on three different adventure therapy programs around the world. Below, I present the criteria for participation in my inquiry and how data were collected.

**Research Participants**

The study used three nonprobability, purposive samples (Alston & Bowles, 2018). First were past adventure therapy participants, aged 18 to 25, who had completed an adventure therapy program or intervention during their adolescence. Based on the literature presented in Chapters 1 and 2, I was interested in exploring experiences for those who had engaged in adventure therapy between the ages of 13 to 20, as this was a common age for
engaging in adventure therapy programs. During the recruitment process, however, I received interest from potential participants in the age range of 25 to 27. With approval from the Human Research Ethics Committee, I extended the age range from 18 to 30. While I had initially intended to interview each participant with as little time as possible between their adventure therapy experience and interview, the additional participants did provide examples of how adventure therapy programming had, or had not, changed over time. That said, I did not interview any participant who had engaged in adventure therapy before 2008. I was only interested in experiences following the U.S. GAO’s (2007) report as this is referenced as a time of change for U.S. wilderness therapy.

The second group were adventure therapy practitioners. These were professionals able to deliver adventure therapy in their respective countries. Maintaining an international focus was important to consider. In Australia, social workers with an undergraduate degree are ‘qualified’ to deliver therapeutic services and become accredited mental health social workers, wherein the U.S., a postgraduate degree is compulsory to become a licensed clinical social worker. Still, I was interested in those providing services fitting with my adaptation of Wampold and Imel’s (2015) definition of psychotherapy presented in Chapter 1. I contacted those providing services that took place within a therapeutic relationship with therapeutic intentions. Locating practitioners and experiences that were or were not adventure therapy posed a difficult task in establishing criteria not too broad or too narrow. For example, the director of a summer camp for young people with disabilities expressed a desire to participate in my inquiry. The camp was run by volunteers and had no specific therapeutic relationship or psychological rationale, so they were not included.

To locate potential participants, I contacted professional bodies, such as the OBH Council, the Association for Experiential Education, the Australian Association for Bush Adventure Therapy, Inc., the Nordic Outdoor Therapy Network, and the International
Adventure Therapy Committee, to ask if they could share the information sheet (See Appendix C) with past participants. I also published posts on the many related social media groups, such as the Therapeutic Adventure Professionals Group, the International Adventure Therapy Group, and many of the wilderness therapy groups, such as Wilderness Program Graduates. I emailed the different programs I could find online and posted on their Facebook pages if they were made public.

Over the past decade, I have attended conferences where I have spoken with colleagues about my research, such as the Australian Bush Adventure Therapy Forum in 2016 and 2017, the Association for Experiential Education Conference in 2017 in Montreal, and the 8th International Adventure Therapy Conference in 2018. Being a state representative for the Australian Association for Bush Adventure Therapy and a member of the local organising committee for the 8th International Adventure Therapy Conference, I was confident in the connections I had with other practitioners from around the world.

The third group included adventure therapy programs I visited to engage in participant observation. This sample was used to provide further understanding of the structure and programming of different programs in different cultural contexts. In this process, I emailed programs in the United States, Norway, Australia, the United Kingdom, Ireland, and Israel. In the end, I was invited to visit programs in Norway in June 2017, the United States in November 2017, and Australia in April 2018. I was also invited to the United Kingdom, but funding constraints prevented my travel. In the section about my participant observation, I discuss my role in each of these programs, none of which I had worked with before, as each organisation asked different commitments from me in fitting in with their group. In my literature review, I demonstrated how outcome studies have provided support for adventure therapy in a variety of settings and contexts, such as whether programs are (1) outpatient versus residential treatment, (2) whether participants engage voluntarily or
whether they are mandated to care, (3) the program’s location and environment, (4) program length, and (5) what follow-up or aftercare services were provided after the program. Exploring these diversities was necessary due to their significance in adventure therapy literature.

I located 30 past participants and 26 adventure therapy practitioners. Most of the past participants had engaged in U.S. wilderness therapy programs \((n = 24)\). I was also connected with some who had engaged with programs in Australia \((n = 2)\), Denmark \((n = 2)\), Canada \((n = 1)\), and Israel \((n = 1)\). Of these, 14 were male and 16 were female. While I hoped for more international participants, they were more difficult to find as many programs did not have websites, or my emails were not responded to when I asked if they could share my information sheet. With thousands of participants attending wilderness therapy programs each year in the United States, there were many social media groups that agreed to share my information sheet.

The practitioners I interviewed came from a much more diverse group. This group was made up of people practising in the United States \((n = 15)\), Australia \((n = 3)\), Spain \((n = 2)\), England \((n = 2)\), New Zealand \((n = 1)\), Canada \((n = 1)\), Denmark \((n = 1)\), and India \((n = 1)\). Eighteen of the practitioners that took part were male and eight were female. Within this group was a diverse range of practice, with some working on wilderness therapy programs, in private practice, with people with disabilities, in community settings, and as school-based counsellors. There was a variety of different theoretical integration as to how each practitioner perceived the benefit or rationale for adventure therapy. Solution-focused, psychodynamic, trauma informed, cognitive–behavioural, and existential were some of the theoretical orientations listed by practitioners during our interviews. Practitioners also presented with different levels of experience and qualification.
Interviews

With the sample of practitioners and past adventure therapy participants, I conducted semi-structured interviews. The purpose of these interviews was to gather in-depth information about lived adventure therapy experiences. The interviews took place between March 2017 and March 2018 and were conducted either face-to-face, by phone, or by Skype. Each interview was recorded and transcribed verbatim. Two participants in particular from Denmark were not comfortable with their conversational English and preferred to write their answers. After receiving their responses, I sent follow-up questions, to which they responded accordingly. Although these responses were limited in richness and depth when compared to others, they did provide context to one specific adventure therapy practice in Denmark. The practitioner I interviewed from Denmark asked to have a friend present to help translate certain responses to English.

Savin-Baden and Van Niekerk (2007) encouraged narrative inquirers to use open-ended questions, avoid ‘why’ questions, elicit memorable stories, and use follow-up statements to elicit a more in-depth understanding of different experiences. For example, I may say, “You said earlier that you found the solo experience of your program particularly helpful; can you say more to that?” Given my experience as a social worker, these interviewing techniques felt natural to me. Some participants thanked me at the end of our interviews, reporting they felt comfortable and they believed they could trust me to share their stories appropriately. Although I have worked with different adventure therapy programs around the world, I adopted the role of ‘not knowing’. This is a common strategy in solution-focused interviewing, where the practitioner does not take the role of expert and all knowing. While a research interview is different from interviewing in clinical practice, similar skills are useful for gathering a richer description of people’s storied lives. This is not a non-critical stance, but rather about being in the moment with the interviewee; to really
listen to the way ideas can be shared in order to reach a solution together (Ratner et al., 2012). Informed by Beels (2009), I avoided adopting an active stance as expert interpreter and instead focused on how these participants constructed meaning from their adventure therapy experience.

The interviews with past adventure therapy participants were based on the following questions to attend to temporality of the adventure therapy experiences:

1) How did you get involved with your adventure therapy program?
2) Can you tell me about any previous therapy experiences?
3) What were your initial thoughts about the experience?
4) What moments stood out to you as impactful, or not?
5) Can you tell me about the nuts and bolts experience; what did you do each day/session?
6) What was your relationship like with your therapist?
7) What did your therapist do that was particularly helpful or unhelpful?
8) How did your adventure therapy experience come to an end?
9) Looking back now, what have you taken away, if anything, from the experience?
10) If you could go back, what would you change to make it more beneficial?

Interviews, in general, took between one and three hours. Clarifying questions were asked to gain more detail about the experience. When interviewing practitioners, I used the following guide:

1) What got you to become an adventure therapy practitioner?
2) In your opinion, how does adventure therapy work?
3) Do you have a story of adventure therapy that was particularly effective for a client/group?

4) What does a therapeutic relationship look like in the adventure therapy setting?

5) Where would you like to see the field of adventure therapy in the future?

In narrative inquiry, interviews are informal and casual, lending themselves to more storytelling (Kramp, 2003). Instead of viewing the interview as a static means of data collection, the richness of the interview depended on the relationship I could form with each participant and went beyond the normal question–answer schema (Jovchelovitch & Bauer, 2000). A. G. Rogers (2007) argued against reducing our understanding of qualitative interviews as simply questions and answers. An interview is a joint product, and the interviewer is far from objective. As I mentioned previously, the questions chosen by an interviewer can become predictive in eliciting certain responses. Interviews can lead to a mutual co-construction of meaning, and responses are full of social context. I kept notes about the time, setting, and environment in which the interview occurred. I also selected prompting questions and a few themes for the interview, such as the therapeutic relationship. I chose these based on themes from psychotherapy and adventure therapy literature, which I discuss in the literature review. For example, the therapeutic relationship is considered the biggest predictor of psychotherapy outcomes. The context of this relationship might be considered unique, especially when practitioners are living with their clients for extended periods of time, making this a factor worthy of examination.

After transcribing the interview, I emailed the relevant transcript back to the participants, providing them with the opportunity to add, delete, or edit any parts of the transcription, which in turn could increase the accuracy and trustworthiness of the data (Caine et al., 2013; Loh, 2013). I followed the research practice recommendations of Alston
and Bowles (2018); I removed identifiable information, such as their names, names of those involved, the program’s name, and specific locations that could risk the anonymity for those involved.

**Journal Records**

Along with field notes, I kept a journal consisting of my perceptions, referred to as tacit knowledge, which developed during the interviewing process and while completing fieldwork (Connelly & Clandinin, 1990). I submitted a short reflection after each interview and each day of participant observation. Cope (2014) recommended using a reflexive journal throughout any inquiry to include “the awareness of the researcher’s values, background, and previous experience with the phenomenon that can affect the research process” (p. 90). Lincoln and Guba (1985) described that if a researcher’s journal showed no change in their predispositions, then it is clear the research had not produced new knowledge. I used the journal to write openly, linking back to my previous experiences as an adventure therapy practitioner and social worker in various settings.

**Participant Observation: Field Notes of Shared Experience**

Participant observation is an effect primary tool for narrative inquirers (Connelly & Clandinin, 1990) and I engaged in participant observation with adventure therapy programs in Norway, the United States, and Australia. The decision to engage in observation was to add further context to different types of adventure therapy experiences. After my ethics application was approved, I contacted various adventure therapy organisations via email and social media groups to enquire about visiting the programs. I shared an information sheet and spoke with the directors of the programs who shared the information sheet with the participants and their parents.
In order to protect the confidentiality of the adolescent participants on each program, I did not focus my field notes on the participants themselves or the identifiable behaviours of the practitioners. I shared my field notes with each program director to make sure they were comfortable with my data. I was interested in the structure of the program, what we did each day, and the therapeutic intent of each activity as described by the practitioners (see Appendix A.

Observing an adventure therapy group required careful precautions to ensure my ‘invisibility’ as a researcher, and to guarantee I did not interrupt the established structure, therapeutic intervention, or progress made with a participant. Seeking consultation from colleagues and my research supervisors, we agreed that I would become an active participant with each group I visited; engaging with both participants and practitioners as I would typically. By engaging as a participant, rather than as a ‘fly on the wall’ or withdrawn observer, I was able to take part in all program activities and converse freely with participants and program staff. While I held no clinical responsibility during my visits, at times there were expectations of helping out with activities, such as cooking dinner or teaching a skill like how to start and maintain a campfire. I was participated in group therapy sessions as openly and transparently as possible.

All group therapy sessions took place in Norwegian. I was only filled in as to what happened by participants who felt comfortable translating their contributions in English, and I still participated in English. Given the participants and practitioners in Norway spoke English, among other languages, engagement in this program felt very comfortable for me. The Norwegian program leaders invited me to return for future programs whenever possible.

Being that I lived with participants and practitioners in the outdoors, I did my best to be approachable and helpful with the group. I talked with the participants, answering any questions they had about the purpose of my study and what I was hoping to achieve. I let
them know I was not interested in evaluating or assessing their experiences but in observing how different programs operate. Again, even with these informal and impromptu conversations, I did not keep any identifiable information in my journal.

After returning to my shelter each night, I wrote what happened throughout the day. I noted different events that took place. Some participants asked me what I was writing, and I showed them. With the small language barrier in Norway, I often asked participants and practitioners to help with translating the topic of group sessions or journal assignments. I also asked for information about the location we were walking through and the environment. Following my time with each program, I typed my notes about the program and sent them to the clinical director of each to ensure accuracy.

Analysis

Transcripts and field notes were stored on a password-protected external hard drive on the data management software NVivo. The recorded interviews were also stored on the hard drive. Transcripts averaged 5,000 to 10,000 words and were 10 to 20 pages long. While transcribing the interviews, I removed all identifying information of the participants and the information from their stories that could risk the anonymity of programs and those involved. After transcribing, I listened to the interviews and followed along with the transcript to ensure accuracy.

Analysis in narrative inquiry differentiates itself from other qualitative methodologies based on the absence of thematic analysis or the representations of findings in small snippets of text (Riley & Hawe, 2005). I used NVivo for storage purposes, but was cautious in the use of its coding features. That is, while I was interested in exploring the similarities of people’s experiences, I was reticent in dismantling each person’s narrative, and taking things out of
context (Manankil-Rankin, 2016). I was careful not to risk reducing people’s experiences to a few key words, but instead, used larger chunks of text so as to not lose context and meaning.

Narrative analysis could be interpreted as another form of content analysis, especially as coding has taken place and both arose from social construction (Yang, 2011). Where coding for specific themes may look to find ‘what’ is present in the findings, narrative pays close attention to the ‘how’ and ‘why’. I emphasised context and the realities of everyday life. Still, there are many similarities between the two worth acknowledging, such as coding processes.

My analysis examined the continuity of experiences, and I took special care in how I represented lived experience. Narrative analysis contextualises “the sense-making process by focusing on the person, rather than a set of themes” (Riley & Hawe, 2005, p. 229). Examples of my coding process are illustrated in the maps I have placed throughout the findings chapters, which are discussed in the following sections.

Savin-Baden and Van Niekerk (2007) felt that interpreting too many narratives could fragment people’s lived experiences and marginalise their voice. While the person who lived the experience took on the role of narrator, and I the listener during the interview, my analysis risked becoming a less personal process when I began interpreting multiple research texts and breaking them down. For example, including 56 narratives into my thesis did require having to omit certain texts in order to accommodate others. To address this, representations of narratives in the findings chapters include long sections of text that showcase the complexity of people’s lives, while providing context to what the participant was discussing. I address the limitations of my inquiry in Chapter 10. These include that 56 interview transcripts collected and journal entries from three rich field visits affected the ability to represent experiences with the thickest description possible.
Procedure for analysis

The process I used for analysis is recommended by Kear (2012) and Clandinin and Connelly (2000). I began by revisiting transcripts and my journal records, and listening over the interviews, attending to the three dimensions of narrative inquiry: temporality, sociality, and place. The process of turning field texts into research texts required particular attention so as not to lose the ‘narrative account’ or the representation of how participants’ lives unfolded (Clandinin, Lessard, & Caine, 2012). While rereading the transcripts, I made notations and searched for patterns of experience, called “narrative threads,” or plotlines threaded throughout a research participant’s narrative. I searched for similarities in the narratives and gave names to the threads of experience, using the participants’ words as often as possible (Riessman & Quinney, 2005).

Kear (2012) defined narrative threads “as meaning that which runs through the whole course of something, connective successive parts or two or filaments twisted together” (p. 35). Bleakley (2005) provided examples of plot marks that could occur in people’s experiences of breast cancer treatment. Narrative threads which emerge from such experiences could be hair loss due to chemotherapy or having a mastectomy. In adventure therapy, threads could be the experience of being involuntarily mandated to a program or the learning of a specific skill, such as to navigate with a map and compass.

Due to the sheer amount of data I analysed, I created mind maps to help with organisation and portrayal of each narrative thread (e.g. see Figure 3, p. 108). The advantages of these visual representations is the illustration of my coding process and organising of narrative threads. These representations, using the participants’ words, improve the trustworthiness of the findings (Whiting & Sines, 2012). The maps, however, do not replace the presentation of findings following this Chapter. This participants’ quotes do not capture the richness of their experiences. The direct quotations provided in the mind maps are
simply signposts. The context of these quotations come to life in the presentation of findings and ensuing discussion.

I revisited the transcripts regularly to become more familiar with the data. As I began to distinguish narrative threads, I looked at where different experiences compared with each other and areas of contrast or tension. I paid particular attention to similarities and differences among participant narratives (Riessman & Speedy, 2007). For example, one participant did not have previous experiences in therapy, and this was noted to provide a contrasting narrative. Additionally, not all participants were involuntarily sent to an adventure therapy program. These types of contrasting experiences are presented in my findings.

The final stage was to discern the resonant threads represented in the discussion of the findings chapters (Kear, 2012). Resonant threads are the echoes of meaning overlapping across participant narratives and my interpretation. These threads are not fixed or frozen but contextual in nature. They are temporal and unfolding.

As mentioned throughout this presentation of narrative inquiry, I avoided turning participants’ experiences into piles of codes and snippets absent of context, sequence, and consequence. I avoided ‘losing the person’ and their told experience during my analysis. As discussed further in the following section about representation, there are ethical considerations that narrative inquirers take, in order to make sure they do not become colonists of a person’s story, in the retelling (Robert & Shenvav, 2014). During the write-up of my inquiry, I paid close attention to how the participant experiences were represented.

**Representation of findings**

Representing the findings took the most consideration when I came to write my thesis. I had concerns about linking 56 narratives and three rich field visits in the space of this thesis, though still quite long, without stripping sequence, consequence, and unique
individual context. Returning to the common places of narrative inquiry helped to make sure my analysis, and representation of findings, affirmed my theoretical commitments. Careful consideration must be taken, based on the theoretical commitments made in narrative inquiry, to consider how all the findings are not only analysed, but ‘represented’

I chose the following sequence of finding chapters to adhere to the temporality of experience. Chapter 6 looks at life before adventure therapy for the program participants and how adventure therapy practitioners became involved in the field. Chapter 7 explores the variety of adventure therapy experiences, paying close attention to how program participants journeyed through their programs and the different social properties of those experiences, such as program structure and the specific therapeutic rituals taking place. In Chapter 7, I explore the therapeutic relationship in adventure therapy settings, and in Chapter 8, I present how the adventure therapy setting impacted the experience. Chapter 9 explores life after the adventure therapy experiences and the program participants’ futures.

While I acknowledged I could not represent the richness of the actual experiences that took place for those in my inquiry, nor the narratives I collected, I made sure to provide the richest participant descriptions to show similarities and contrasts. Excerpts from the transcripts are given to illustrate the sequence of the person’s unfolding life and adventure therapy experience. Representation of these findings required particular ethical considerations, which are presented in the following section.

**Ethical Considerations**

Josselson (2007) urged narrative-oriented researchers to move beyond the traditional biomedical view of ethics; encouraging a relational attitude to ethics with considerations that may be less explicit. Thus, I have broken this section into two subsections. The first presents
the explicit steps I took regarding informed consent and protecting the anonymity of the participants, followed by a discussion about the relational attitude towards ethics.

The Charles Sturt University’s Human Research Ethics Committee approved my ethics application on 28 February 2017, which was gained through the National Health and Medical Research Council’s Human Research Ethics Application I submitted for my inquiry (see Appendix B). Information sheets and consent forms (see Appendices C, D, and E) were provided prior to interviews and observations taking place. Participants were asked if they were comfortable with having their interviews recorded. No participant declined the invitation. While transcribing the interviews, I assigned each program participant a pseudonym and removed all identifying information, including the names of other people they mentioned from their experience and the name of the adventure therapy program they engaged with. Because of the small, tight-knit community of adventure therapy practitioners, I elected not to describe where each practitioner was from in the findings as this could risk their anonymity.

Because of the intimate and sensitive nature of the interviews, especially in the case of discussing potentially traumatic experiences, I made it clear to the program participants before the interview that they were free to share as much or as little with which they were comfortable. Attached to the information sheet was a list of services available in their country should they wish to seek additional support. I did consider Josselson's (2007) ethical stance on warning research participants about the potential effects of the interview, given the power of suggestion. However, I followed the Ethics Committee’s recommendations and attached a list of services to the information sheet in case the research participants wished to contact one of them on their own.

During my interviews, I provided participants with the time to ask about my background, my interest in adventure therapy, and any concerns they had about the study. I
ended each interview inviting participants to reach out and contact me if they had any more information useful for the study.

As mentioned previously, I saved the recorded interview on a password-protected hard drive in a locked file cabinet in my locked office. In accordance with Australia’s National Statement on Ethical Conduct in Research, identifiable information was removed from the transcripts, and a pseudonym was provided for each participant. In my journal, which was also kept in my locked cabinet, I kept information regarding who was allocated which pseudonym. As recommended by Josselson (2007), I arranged the identifying information in such a way that only the researcher can reconstruct the narrative.

**Trustworthiness and Credibility**

Where quantitative studies are historically evaluated by their rigour, validity, and reliability, qualitative studies are valued by their trustworthiness and credibility (Cope, 2014; Guba, 1981). For Kornbluh (2015), these considerations “support the ethical obligation of researchers to accurately present participants’ lived experiences (particularly those who have been historically marginalized in research) by identifying and addressing potential power dynamics between themselves and participants” (p. 398). Below, I outline the criteria I used and the steps I took to ensure the highest possible quality of the research. These criteria include *credibility, confirmability, transferability,* and *authenticity.*

Credibility is concerned with the truth value of the data and the way they are represented throughout an inquiry (Cope, 2014). To account for this, I provided a rich description of the steps and decisions I made. In the case of my inquiry, I emailed the written transcript to each participant and invited them to read it to ensure I captured an accurate description of their experience.
Confirmability raises questions about a researcher’s biases and implores researchers to address their neutrality in the study (Guba, 1981). While narrative inquiry allows space for the researcher to become a part of the study, it is important “the data represent the participants’ responses and not the researcher’s biases or viewpoints” (Cope, 2014, p. 89). Because a trustworthy representation of participants is a key ethical attitude of the narrative inquirer, I provide space for rich and vibrant quotations from participants’ narratives using their words so “the reader can personally critique the credibility of the study and substantiate the interpretations” (Cope, 2014, p. 90). I then provide my interpretation, and discuss how interpretations and conclusions were made, including my biases towards theoretical perceptions of pragmatism, and my experience as a solution-focused social worker.

If the implications from my inquiry can be applied in other settings, the study will meet the criteria of transferability, which is also an important criterion for the pragmatic researcher (Morgan, 2007). That said, the findings and interpretations included in my inquiry will become based in the historical context of when and how data was collected, as well as my data analysis. Transferability is judged by the reader and what meaning my inquiry has for them. For example, my aims were not to make claims of generalisability (Kornbluh, 2015), but to provide implications for practitioners about what these participants reported to help or hinder therapeutic progress. These stories inform practitioners about the program participant’s experience to inform adventure therapy practice. An important aspect of transferability is transparency (Kornbluh, 2015). I have specified openly for the reader, my theoretical commitments of my inquiry; methods, analysis, and interpretations.

Authenticity is a criterion relating to the manner in which a researcher captures authentic exemplifications from participants (Guba & Lincoln, 1994). The theoretical commitments I have made centred on the lived experience and self-determination of each participant. While representing the participant narratives, I used as much of the participants’
words as possible. Headings are used for each program participant’s excerpt, including their pseudonym, country of origin, and the type of program on which they engaged. Practitioners’ headings include their pseudonym, qualification, and their type of adventure therapy programming.

To build on trustworthiness, Clandinin et al. (2007) listed the central elements to consider while conducting a narrative inquiry. First, researchers should provide justification for undertaking their study. My inquiry provided a unique lens of pragmatism, Dewey’s (1938) ontology of experience, and my solution-focused assumptions to examine adventure therapy experiences. Second, narrative inquirers should be clear about the phenomenon under investigation. I have explored the lived adventure therapy experiences of program participants and practitioners. Third, the research methods should be made clear, and these include semi-structured interviews and participant observation. Fourth, any narrative inquiry should be well-positioned. I used Chapters 1 through to 3 to position my inquiry based on the history of adventure therapy, the relevant literature, and my theoretical perspectives. Fifth, and along with any research pursuit, narrative inquirers should aim to study particular phenomenon in a way that could not be known by others’ methods or theories. I bring to my inquiry unique adventure therapy experiences in the United States and Australia, as well as perspectives of narrative uncommon in the literature. Sixth, ethical considerations should be presented and taken seriously. In this Chapter, I have presented the relational and biomedical ethical considerations I have used. These ethical decisions also relate to the fifth criterion, which relates to the representation of participant narratives. During the analysis and writing of my inquiry, I attended to the consequence and sequence of the particular excerpts I used in each of the narrative threads. Care was taken not to lose the human experience during my analysis. Table 1 illustrates how I addressed these essential elements for my inquiry.
Table 1: Addressing Clandinin et al.’s (2007) Central Elements

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Justification</td>
<td>My inquiry provides space for the telling and retelling of people’s stories, giving rich descriptions of adventure therapy experiences in a variety of settings.</td>
</tr>
<tr>
<td>Naming the Phenomenon</td>
<td>The phenomenon under study is the lived experience of adventure therapy practitioners and past participants. These experiences are represented narratively in the context of the personal, social, and environmental landscapes in which they take place.</td>
</tr>
<tr>
<td>Describing Methods</td>
<td>Past participants and practitioners each took part in an in-depth interview. I also conducted participant observation on three adventure therapy programs around the world.</td>
</tr>
<tr>
<td>Positioning the Inquiry</td>
<td>Whereas reductionist approaches are in the mainstream of the adventure therapy literature, my inquiry aims to give vivid accounts of experiences of programs.</td>
</tr>
<tr>
<td>Provide Unique Understanding</td>
<td>By providing thick descriptions, my inquiry offered the potential for a unique perspective of lived experience. Informed by social constructionist, pragmatist, and Deweyan philosophies, this is a unique lens through which to explore adventure therapy.</td>
</tr>
<tr>
<td>Ethical Considerations</td>
<td>Narrative inquiry requires a relational framework of ethical considerations going beyond the traditional concerns of consent. This includes building rapport with participants, being transparent about the purpose of the study, and taking care in how I represent participants’ narratives.</td>
</tr>
<tr>
<td>Representation of Narratives</td>
<td>Representing people’s experiences needs to have a temporal unfolding of people and places, including the inquirer and the research participants and the contexts in which these experiences take place.</td>
</tr>
</tbody>
</table>
Conclusion

In this Chapter, I presented the methods used in my inquiry. Where the previous chapter detailed my theoretical orientation, here, I showed how I inquired into experiences in adventure therapy. The following Chapters 5 through to 9 present the findings, and Chapter 10 provides an outline of this thesis and final Conclusion. Chapter 5 presents findings in relation to the participants’ lives before adventure therapy and how practitioners became involved in the field.
Chapter 5: The Beginnings

Until the lion has his or her own storyteller, the hunter will always have the best part of the story.
—An African Proverb

This Chapter relates to the characteristics of adventure therapy participants and practitioners, and focuses on how participants became involved in adventure therapy. The first narrative thread discusses some of the contexts of participants who engage in adventure therapy (See Figure 3). The second thread, the “Varieties of adventure therapy practitioners,” discusses the journey for practitioners to becoming involved in adventure therapy and presents the many theoretical orientations informing their work (See Figure 5). The resonant threads presented in this Chapter include discussion about Frank and Frank’s (1991) original demoralisation hypothesis and an examination of the issues of professionalism within adventure therapy practice. Table 2 is presented on the following page to present and define these threads.

Diversity of Adventure Therapy’s Participants

This narrative thread represents some of the plotlines that found these particular people in an adventure therapy program. Table 3, which I have placed on the following page, provides a brief background to the participants and introduces them into my inquiry. The descriptions in this Table, describe the events which brought each participant to an adventure therapy program, the type of program they engaged in, and their lives after their adventure therapy experience. However, the discussion that follows, in this Chapter, presents the experiences of these participants prior to adventure therapy.
<table>
<thead>
<tr>
<th>Narrative Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diversity of Adventure Therapy Participants</td>
<td>This thread explores the life of program participants prior to adventure therapy. They experienced a range of concerns, such as substance use and family conflict.</td>
</tr>
<tr>
<td>Adoption and Identity</td>
<td>Experiences of adoption, especially multicultural adoption, led program participants to questioning their identity.</td>
</tr>
<tr>
<td>Exhausting Local Resources</td>
<td>All but one participant engaged in therapy prior to their adventure therapy experience. This thread examines how participants perceived their previous therapy experiences. Participants described these experiences as boring, stereotypical, and not effective. Many program participants were diagnosed with numerous disorders and trailed various medications.</td>
</tr>
<tr>
<td>Varieties of Adventure Therapy Practitioners</td>
<td>This thread contains two subthreads, listed below, and explores the qualifications, theoretical orientations, and personal journeys into adventure therapy of the practitioners interviewed.</td>
</tr>
<tr>
<td>Personal Experiences in the Outdoors</td>
<td>Practitioners provided narratives about working as outdoor guides and attending summer camp as influencing to gaining qualifications necessary for providing therapy in outdoor settings.</td>
</tr>
<tr>
<td>Diversity of Adventure Therapy Practice</td>
<td>This narrative thread relates to the range of theoretical orientations and models of adventure therapy adopted by the practitioners.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resonant Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Healing Experiences in Nature</td>
<td>As practitioners described their personal experiences in the outdoors, some found time in nature to be healing. This resonant thread provides discussion as to how practitioners can use their personal experiences in nature to help package the rationale for their adventure therapy practice.</td>
</tr>
<tr>
<td>Issues with Professionalism</td>
<td>Due to the variety of adventure therapy practitioners, there is difficulty in defining how practitioners should train in adventure therapy and how it could be defined. This could lead to issues in professionalism.</td>
</tr>
<tr>
<td>Identity: Who Am I? Am I a Hybrid?</td>
<td>Participants described seeking connection and asking questions about who they were. This thread includes discussion about implications for working with adopted young people and those who have experience family conflict.</td>
</tr>
<tr>
<td>Therapy Veterans</td>
<td>Program participants had numerous experiences in therapy, which ultimately led to a lack of hope that therapy of any kind could help. This section provides consideration for working with experienced service users.</td>
</tr>
<tr>
<td>Demoralisation</td>
<td>The resonant thread of demoralisation builds on Frank and Frank’s (1991) hypothesis that a common thread among therapy participants is the experiencing of demoralisation.</td>
</tr>
<tr>
<td>Distribution of Dysfunction</td>
<td>Despite being sent to therapy, the factors that led to their adventure therapy referral were distributed across the program participants’ many systems, such as family members, negative peer groups, interactions with therapists, and schools.</td>
</tr>
</tbody>
</table>
Table 3: Participant Background Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Country</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andy</td>
<td>USA</td>
<td>Andy described being “bullied” in school and reported to have been engaged with a psychologist from the age of six. Andy was diagnosed with multiple disorders and trialled numerous medications. Andy’s parents sought the help of an education consultant to have him securely transported to a continuous-flow wilderness therapy program where he remained for seven-weeks. After graduating from the program, Andy was referred to therapeutic boarding school, which he described as a “hellhole.” Andy was removed from the therapeutic boarding school by his father and he returned home to graduate high school at his local public school.</td>
</tr>
<tr>
<td>Angela</td>
<td>USA</td>
<td>Of Hispanic background, Angela was multiculturally adopted into a Caucasian family. She reported feeling different from those in her community and began seeking connection by engaging with a negative group of peers. With this came substance use and more risk taking behaviour. Angela’s parents discussed the idea of a continuous-flow wilderness therapy program, which she agreed to attend voluntarily. After three months in the program, Angela returned home and graduated high school at an alternative school. She trained to become a social worker and is a single mother of a young daughter.</td>
</tr>
<tr>
<td>Andrea</td>
<td>Denmark</td>
<td>Andrea reported being in the “mental healthcare system” since age 13 and had seen “twelve psychologists.” She described herself as a trauma survivor who struggled with anxiety and self-harm. A friend of Andrea’s had engaged in a community-based adventure therapy program for young women and encouraged her to try it. Andrea hopes to remain engaged in the adventure therapy programs and feels more open, with improved self-esteem.</td>
</tr>
<tr>
<td>Barry</td>
<td>Australia</td>
<td>Barry described himself as bullied and going “off the rails” at 15-years-old. He reported drinking, smoking, and shoplifting. One day, Barry’s substitute school counsellor shared a pamphlet for an adventure therapy program and Barry felt intrigued. Barry’s mother learned about the 10-day expedition and drove him to the program. When Barry returned home, there was a large conflict at school, involving bullying. He left school and entered the workforce. Barry is currently married and employed full time as a mechanic.</td>
</tr>
<tr>
<td>Name</td>
<td>Country</td>
<td>Details</td>
</tr>
<tr>
<td>--------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Brady</td>
<td>Australia</td>
<td>Brady grew up in a remote Australian town and was the only participant in the study to have no previous experiences in therapy. He was selected by his school to take part in the an eight-day contained expedition, as he was becoming more disengaged with his studies and his alcohol use was increasing. Brady “loved” his expedition and returned as a mentor for future expeditions to help other first time adolescents. He is currently a police officer.</td>
</tr>
<tr>
<td>Clare</td>
<td>USA</td>
<td>Clare reported struggling with depression, self-harm, and family conflict in her adolescence. Her parents found a 28-day wilderness therapy expedition, which Clare engaged with voluntarily. The program was structured in that each week was focused on learning a new activity, such as rock climbing and white-water kayaking. Clare described herself as “a stronger person” as a result of her adventure therapy program and graduated from a local high school. She is currently enrolled in university.</td>
</tr>
<tr>
<td>Connor</td>
<td>USA</td>
<td>Connor was as an excellent student who, after being caught with marijuana on one occasion, was influenced by his parents attend to a continuous-flow wilderness therapy program. Upon arriving, he was shocked by the strip-search and being instructed not to talk to other participants. Connor remained in the program for eight-weeks and was referred to ongoing family counselling upon returning home, though his parents did not engage. Connor started “partying” and skipping school, though he did graduate high school and holds a four-year university degree. Connor reported having a fractured relationship with his parents due to the wilderness therapy experience.</td>
</tr>
<tr>
<td>Craig</td>
<td>USA</td>
<td>Craig drove to himself to a continuous-flow wilderness therapy program after being persuaded by his parents, who had found homosexual porn on his computer and learned that he had been talking to older men on the internet. Craig, feeling the program was more suited to substance-abuse issues, did not respond favourably to the power differences. After nine-weeks, Craig graduated to return to his local public school and is currently enrolled in a 4-year university degree. Craig reported that he “didn’t really heal any behaviours” that got him there.</td>
</tr>
<tr>
<td>Name</td>
<td>Location</td>
<td>Story</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Emma</td>
<td>USA</td>
<td>Emma reported having strict parents who did not like the boyfriend she “refused to break up with.” Emma was securely transported to a wilderness therapy program and was told by staff her the program length was 30 days. She remained at her wilderness therapy program for four months. Emma reported becoming religious after her program and returned home to go to “a Catholic prep school” where she graduated and is currently pursuing a four-year university degree. Emma credits her wilderness therapy experience for helping her build a “good sense of morality” and being “more appreciative” and “humble.”</td>
</tr>
<tr>
<td>Frank</td>
<td>USA</td>
<td>Frank reported having seen many therapists due to his self-harming behaviours. His mother, a single parent, told him they were going to visit a boarding school but dropped him off at a continuous-flow wilderness therapy program. After two months in the program, Frank was referred to a therapeutic boarding school. After leaving the boarding school, Frank reported struggling to adapt to life at home. Frank enjoyed the boarding school experience but holds ongoing resentment to his mother for sending him to wilderness therapy. Frank is currently pursuing a PhD.</td>
</tr>
<tr>
<td>Jeanne</td>
<td>Canada</td>
<td>At 16 years old, Jeanne was diagnosed with cancer and after completing a successful chemotherapy treatment, Jeanne saw a brochure on the wall of the hospital advertising an adventure therapy expedition for young people affected by cancer. Jeanne’s expedition lasted 10 days and most of the time was spent white water rafting and camping. Jeanne described herself as more outgoing as a result of the expedition. She is currently training to become a psychologist.</td>
</tr>
<tr>
<td>Katy</td>
<td>USA</td>
<td>Katy described not knowing how her depression came about and reported having seen many different specialists. She trialled numerous medications, which “made things get worse.” When Katy’s self-harming became more noticeable to her parents, she was encouraged to attend a wilderness therapy program. The program she attended did not allow for secure transport services and she graduated from the program after six weeks. For the majority of her stay, Katy was the only participant in the program until another female participant arrived on day 42. Katy was referred to a residential program in Utah where she stayed for nine months. She described the wilderness therapy experience as “very much life changing.” Upon returning home, Katy described the effects of an abusive relationship, but is in a healthier marriage with two children</td>
</tr>
</tbody>
</table>
Kelly was adopted to a large family of siblings and began seeing therapists at age five. She described being influenced by a “really terrible friend group” and her regular substance use inclined her parents to seek residential treatment. Kelly described attending “inpatient and outpatient mental hospitals” across the United States. She considered therapy as part of her normal routine. Kelly returned home after a two-month stay at a program and was securely transported to a wilderness therapy program after less than a month. She described “screaming” through the airport as she was sent to the program. Kelly remained at the program for 13 weeks and was referred to “an all-girls rehab” upon graduating, which made her “furious.” She remained in the treatment centre until she was able to complete high school. Upon returning home, Kelly went back to her previous substance use and her relationship with her parents remained turbulent.

Lance described himself as “out of control” and not productive. He was smoking marijuana daily and disengaging from school. Though he found individual therapy relatively enjoyable due to the interesting conversations, it was not bringing the outcomes his parents were seeking. Lance was securely transported to a wilderness therapy program where he stayed for four months. Lance described the family involvement programs particularly “eye opening” as he built better relationships with his parents. After graduating, Lance received aftercare support by phone from one of the program’s therapists. Lance is currently pursuing a doctorate.

Like many of the participants, Laura described seeing many “different specialists or counsellors” and said she was a “typical troubled teen.” Laura was caught selling drugs at school and her parents had her securely transported to a wilderness therapy program. Laura remained at the program for three months and was sent to another residential program. Laura reflected negatively on her wilderness therapy experience describing the program’s philosophy as “break you down to build you up.” Upon returning home, Laura described experiencing an abusive relationship, which impacted her wellbeing. She is currently married with children.
Louis was multiculturally adopted from Peru into a Caucasian family. He shared his experience of struggling with anger management and his own “self-identity.” Louis’ parents had him securely transported to a program and he was told he would remain in the program for 30-days. Louis remained in the program for seven months and, upon graduating, was referred to an alternative boarding school. Louis described his life “as a rollercoaster” though his wilderness therapy experience helped him to hold himself more accountable and take responsibility for his actions. Louis is currently pursuing a four-year university degree.

Mark was born in South Korea and was adopted into a Caucasian family. He described struggling with managing his anger from a young age. Mark found his previous experiences in therapy “boring” and described struggling with his identity. Mark reported struggling with depression, family conflict, and anxiety. His parents decided that Mark needed help and could not remain at home. After two months at a continuous-flow wilderness therapy program, Mark was referred to an all-boys therapeutic boarding school. He described the boarding school helped and “changed everything” as he embraced his Korean heritage. Mark is currently pursuing a four-year university degree.

May felt “forced” by her case manager to engage in a community-based adventure therapy program after growing concerns surrounding her anxiety and depression. She described herself as a “trauma survivor” and had been in Denmark’s mental health system since age nine. During the program, May spent time sailing and building fires in the forest. At the time of the interview, May reported hoping to remain engaged with the program, though she also engages with an external psychologist weekly for individual therapy. May mentioned that she feels participation in the program has led to her understanding that “not all grown men are evil.”

Michael was admitted to a residential program due to ongoing substance use. Along with two other participants, Michael ran away from the program, becoming homeless. Michael’s mother hired a private investigator who took Michael to a wilderness therapy program. Michael agreed to attend but felt “forced.” He was told the program would last a month but remained in the program for 14 weeks. When Michael graduated the program, he was referred to a therapeutic boarding school. Michael mentioned the program “change my life” and currently works full time in sales.
Michelle was an only child and described multiple experiences in therapy. She reported being trialled on multiple medications and receiving numerous diagnoses. While therapy did not achieve the outcome her parents desired, Michelle’s parents sought help from an education consultant who met with Michelle and provided various residential programs for Michelle to choose. Michelle chose a wilderness therapy program and found the experience to centre around “trying to break me.” After three months, Michelle was referred to a therapeutic boarding school, which she explained was the “best thing” to happen to her. Michelle is currently a practicing nurse.

Nancy described her parents decision to have her attend a continuous-flow wilderness therapy program came after numerous experiences in therapy. She reported one therapist having “no idea what to do with me.” Nancy attempted suicide by overdosing on her prescribed anxiety medication. While in the hospital, Nancy’s parents organised transport to a wilderness therapy program and told her the experience would be like a “summer camp.” Nancy graduated the program after seven weeks and felt angry about her parents’ deception. Upon graduating, Nancy was referred to a therapeutic boarding school. She described wilderness therapy helping her to feel more comfortable with her identity.

Oliver was securely transported to a continuous-flow wilderness therapy program after being expelled from his boarding school for selling illicit drugs. Oliver had previous therapy experiences but found them “absolutely boring.” While in the program, a therapist visited Oliver each week. Oliver described their work together as having “no impact at all.” After six weeks, Oliver was referred to a therapeutic boarding school. While Oliver described ongoing troubles in his life, he felt wilderness therapy “inevitably helped me out later on.”

Olivia’s parents elected to have her securely transported to a continuous-flow wilderness therapy program after continued substance use and disengagement from school. During the transport experience, Olivia reported not knowing if the escorts were going to “kill” or “rape” her. Though Olivia felt connected to her therapist, who visited her group weekly, she felt the secure transport eclipsed the whole four-month experience. She entered a relationship with another participant from the program, which she described as unhealthy. She is currently diagnosed with PTSD from her transport experience and still seeks psychotherapy. Olivia is married with children and works full time.
Sarah | USA | Sarah was securely transported to a four-week wilderness therapy expedition. Her parents were concerned about substance use and school disengagement. Sarah described her wilderness therapy experience as “tough-love” that aimed to “break you down.” Upon returning home, Sarah remained “angry” with her parents and described having to sort through the “parent betrayal” of being transported to the program. Sarah did not feel prepared for returning home and described the experience as having little impact. Sarah currently works in juvenile justice with adolescents as a psychotherapist.

Sophie | USA | Sophie was hospitalised frequently during her adolescence. She trialled numerous medications and described herself as “misdiagnosed.” While Sophie was seeing a psychotherapist and psychologist, her parents were working with an education consultant to organise Sophie’s placement at a residential program. Though Sophie was securely transported to her 21-day wilderness therapy expedition, she described herself as “lucky” considering the transport took place during the day and not in the middle of the night. Sophie felt the program was focused on substance use and did not address her emotional issues. Sophie struggled upon returning home and described issues with her medication. Sophie holds strong views about the U.S. troubled teen industry.

Thomas | USA | Thomas described having seen around 20 therapists and specialists to help with his “deep depression,” which came suddenly in middle school. Because Thomas grew up enjoying summer camp, his parents believed wilderness therapy was the right choice. Thomas was securely transported to a continuous-flow wilderness therapy program where he stayed for three months. Thomas described the experience as the worst of his life, due to the way the staff treated him. He returned home and quickly disengaged from school. Thomas is currently employed as a scientist.
Tony struggled in school and described himself as a “fuck up.” He was diagnosed with bipolar and was “heavily medicated.” Tony sabotaged his application to a boarding school and his parents sent him to a continuous-flow wilderness therapy program. Tony said his parents told him it would be “like a summer camp.” Though Tony liked his therapists’ direct approach and confrontation, he did not find the focus on learning skills to help him. After six weeks, Tony was referred to a strict therapeutic boarding school. Tony did not fit in with the school’s authoritarian approach and his parents had him attend a different boarding school outside the United States. Tony graduated from that school and completed a four-year university degree.

William was sent voluntarily by his separated parents to a wilderness-based therapeutic boarding school due to his poor academic performance and anxiety related issues. He was engaged in therapy and prescribed medications, which made him feel like a “zombie.” At the school, William reported to have lived in a “wilderness survival camp” and would walk to a school to take classes. He left the program after 18 months due to a medical concern. He returned home to live with his father and he “got straight As.”

Willow, a self-proclaimed “wild-child,” described that it was her substance use that lead her to be sent from the Netherlands to a 14-day contained expedition. Though she attended voluntarily, she reported that it was her father who decided to “ship” her to the program. Willow enjoyed being removed from everyday life and living in the outdoors. Upon returning home, Willow reported having increased “self-worth” and “self-esteem,” which helped her to realise she did not want to be around her father anymore, as he was an “alcoholic” and a “paedophile.” She left the Netherlands where her father lived and moved in with her mother in the United States.

Yosef described himself as an “awkward child” whose mother felt an outdoor therapy would be “a good fit.” Yosef’s program was influence by Jewish teachings though he did not go into detail about what this looked like. Yosef continued to return to his program each year in order to become a mentor for other first-time participants. Yosef is currently a high school teacher and reported his wilderness therapy experience having helped him to never “give up.” At the time of our interview, Yosef remains in touch with the program director.
In their teenage years, the program participants reported a range of factors leading them to become involved in adventure therapy (see Figure 3). Participants reported struggling with a range of issues during their adolescence, such as substance abuse, self-harming behaviours, depression, early childhood trauma, promiscuity, and school problems. Frank and Oliver, for example, were “kicked out” of school for behavioural reasons, such as anger management. Five of the participants reported being adopted, which led to issues with family and community identity. The topic of identity continued with three participants, all survivors of traumatic experiences, such as sexual abuse, who described problematic relationships with the adults in their lives.

Frank was the only male participant to report self-harming behaviours. Other female participants, such as Andrea from Denmark, and Clare, Laura, Nancy, and Katy from the United States struggled with self-harming behaviours. Like Sophie and Michelle, Katy reported the effects of being “misdiagnosed” with major depressive disorder when her “actual diagnosis was bipolar.” Andy and Barry described the effects of being bullied in school. Thomas had a similar experience to Sophie, Michelle, and Katy in that there was little understanding as to why depression came about and what could be done to help.

The following excerpts were chosen to demonstrate the range of factors leading these adolescents to adventure therapy. These excerpts cover the plotlines of self-harm, issues with medication, and the emotional and behavioural concerns. I have intentionally omitted more discussion about family dynamics in this section as these emerge in the resonant thread “Distribution of Dysfunction,” presented further in this chapter.
Michelle, USA, Continuous-Flow Wilderness Therapy

Michelle grew up as an only child. Her parents had a turbulent relationship. At age 12, she came home from summer camp with her “knees hurting” and feeling “really tired.”
Her parents began a “whole six-month rule out period” with visits to many practitioners to determine if this was a disease, parasite, or rheumatoid arthritis. Doctors tried many different courses of treatment and nothing worked. Michelle became “depressed and anxious.”

In ninth grade, I started cutting myself and started having panic attacks. They were usually surrounding things like going to sleep, because I used to have visual hallucinations around the time and sometimes when I was waking up. I’ve never had them since. I had been on a lot of different medications. They did that thing where they were like, “You’re on this medication then on this medication.”

Michelle told me she “didn’t cut to kill” herself. She was “meticulous” about it and would use ointments and bandages to make sure she did not scar. She carried razors in her backpack to school for whenever she felt the need to “punish herself.” She felt pressured to improve her academic performance and could “not self-regulate regularly.” Sophie also reported self-harming behaviours and the impact of trialling different medications on her mental health.

**Sophie, USA, Contained Expedition**

An only child, Sophie was 15 when she began going through a revolving door of frequent hospitalisations. Her “overprotective” parents were concerned as Sophie’s “self-mutilation and suicidal ideations” worsened.

At the time, I had been cutting my wrists. I had been prescribed different antidepressants for that. So, come to find out now, I have bipolar disorder. Bipolar disorder was diagnosed when I was younger, and I was put on the wrong medication for it. Antidepressants can make bipolar people very manic and over the top. What
happened . . . is that I was seeing a new psychiatrist, probably about a couple months before I was sent away to the woods, and my psychiatrist . . . said at the time “I think it’s bipolar disorder.”

Thomas was 13 and attending a Catholic high school when he suddenly “went into a very deep depression.”

_Thomas, USA, Continuous-Flow Wilderness Therapy_

I’m not even exaggerating, it was overnight. Maybe over a weekend. Monday, I couldn’t get up for school. I couldn’t even get out of bed. My parents gave me a few days, thinking I was tired from the first quarter of eighth grade being over. But then, a few days became weeks. And then I was taken to a therapist and they said depression. It got pretty bad. I went to an outpatient treatment program nearby and then I think around New Year’s Eve of 2008, I went into an inpatient at the local hospital and followed by that an inpatient stay at a second hospital.

While Thomas reported depression as the primary concern, other male participants in my inquiry were more likely to report issues at school and substance abuse, such as Frank, Lance, Oliver, and Michael.

_Frank, USA, Continuous-Flow Wilderness Therapy_

There was just a lot of trouble at home. My mom and I were not getting along. I was hurting myself a little bit and then on top of that I was just doing a lot of self-destructive things and I got kicked out of middle school three months in, so that didn’t go very well. I think with my mom, I was just the first kid, so she didn’t know how to
handle it. Things had been bad for about a year or so, so my mom tried different therapists and stuff first. I remember she sent me to one where they put these pads on my head to read my brain. It was crazy.

*Lance, USA, Continuous-Flow Wilderness Therapy*

Growing up, Rob was a talented guitar player. School, however, was not important to him, and he began using marijuana and drinking alcohol.

I was generally just being out of control and not being productive and partying a lot. Even stuff I really liked to do, like playing guitar, I wasn’t doing as much. I think that was a pretty big indicator to the people close to me. I knew my parents were thinking of sending me somewhere, but I convinced them to let me stay home. I told them, “I know my senior year is coming up and there’s all these things I want to do,” like I’m going to do it. Then I didn’t. So that was that.

Lance described having seen a “therapist for two years” and up until the “middle of 11th grade.” Lance knew he was an “alternative kind of kid” who would never fit in with school. He began smoking marijuana more often before his final year of high school, which alerted his parents to find more intensive support. For some of the participants, run-ins with the police informed their parents of their child’s substance use. Like Lance’s and Michael’s excerpts about substance abuse, Connor, Frank, Lance, Laura, Louis, Oliver, Olivia, and Willow described substance use as a concern leading them to adventure therapy.

In the above excerpts, it is evident that the participants in my inquiry were externally motivated to seek therapy. This is common for adolescents as it is often external pressure from family members or school teachers that encourages young people to engage in therapy.
This section has presented the range of concerns that led the family members of these participants to seek therapy in the first place. In the narrative threads that follow, experiences in therapy prior to adventure therapy are presented. In addition, the following section explores the narrative thread relating to adoption; a situation in which four participants are involved.

**Adoption and Identity**

This narrative threads of identity appeared throughout these pre-adventure therapy experiences. Adopted participants discussed feeling different to everybody else. This feeling of disconnection was not isolated to adoption, but also surfaced in participants who were survivors of abuse. The excerpts below are taken from Angela, Mark, and Louis who were multiculturally-adopted. Kelly was adopted, though not multiculturally, yet described similar difficulties as the others; she described not getting along with her adoptive family.

Angela was from a Hispanic background and, as she stated, “multiculturally-adopted” to a white family. Notwithstanding different skin tone, Angela reported feeling a “huge generational gap.” The excerpt below illustrates the unfolding of Angela’s life before adventure therapy.

*Angela, USA, Continuous-Flow Wilderness Therapy*

I went to a primarily Caucasian school. And the kids started noticing that my mom was white, and they started asking me, “Well, is your dad black?” I’m seven years old, what is race? I don’t know what that is. And because I didn’t know that, I started becoming very aware of skin colour and the things that made me different to my peers. I was a big girl. I had poofy hair. I wasn’t fat, but I was heavier set than my
peers. As a young girl, it hurts. From a very young age you start questioning your whole being.

So, my parents took me out of the Catholic school and put me in public school, which was a much better experience. You know, the diversity was substantially different, and it was great. I had friends from all walks of life. I hit puberty earlier than my peers. And when you’re that young, the hormones are nuts. It’s insane. And you add the crazy hormones to the past of “Who am I?” if that makes sense? The questions of who you are as a person. You can become very susceptible to your surroundings. I turned to sex among other things in that realm. I was promiscuous from all hell.

And with that promiscuity came disrespect, lies, and sneaking out at night and then you’re still vulnerable to your peers, so I got involved with some people at school who shoppedlifted from department stores and I was sneaking out almost every night.

Angela would go to sleep at night and set an alarm so she could sneak out in the middle of the night. Angela described getting “caught one day” and that was “when it all started.” Growing up in a predominately white neighbourhood made Angela more aware of what differentiated her from the others. She struggled to maintain healthy boundaries in her relationships. Getting caught sneaking out motivated her parents to seek more intensive help.

*Mark, USA, Continuous-Flow Wilderness Therapy*

Born in South Korea, Mark had a similar account to Angela. At a young age, he was adopted by two Caucasian, middle-class parents.
I was adopted from South Korea, and that created a lot of complications in terms of emotional perfectionism, the fear of abandonment, fear of a lot of different things that have led me to really be scared of losing things and people. And growing up, I didn’t really know what adoption meant until I was 8 years old. Then, I really understood it, and I got mad. I got really mad. I was lucky because I have another sibling who’s also adopted, and she helped me a lot. I was a good kid, but when I had anger, I had a pure anger. It was very pure.

*Louis, USA, Continuous-Flow Wilderness Therapy*

Louis was adopted from Peru to Caucasian parents. In 2011, Louis’s parents were concerned about arguments at home and reports of Louis’s poor effort at school and troubling behaviours, such as being “destructive” and “defiant.”

It was really probably the identity. Thinking back to the middle school. Who am I really? Am I hybrid of my adopted parents or there’s some hereditary personality traits maybe from my parents? I don’t know. I guess I was trying to find out who I am and fit in and I missed the boat on that one with middle school, identifying with wrong groups but then straightened it out later.

Angela, Mark, and Louis struggled with finding where they fit in the world. Having a different skin colour to their parents and looking different to other kids in school was obvious for them. Unsure of which peer group would accept them, they turned to strategies, such as promiscuity and substance abuse, to fit in. Kelly was born in the United States and she, too, was adopted into a large family, which she “always felt different from.”
Substance abuse, family conflict, and issues with school were the leading concerns that motivated parents to seek therapy for their adolescent. With this narrative thread of “Adoption and Identity,” I have illustrated how participants, like Angela and Louis, sought connection from negative peer groups. The following narrative thread, “Exhausting the Local Resources,” is related to the participants’ experiences in therapy, before adventure therapy.

Exhausting Local Resources: Previous Experiences in Therapy

Adventure therapy is seldom the first time an adolescent sees a therapist (Gabrielsen et al., 2015; Hoag et al., 2014; Russell, 2001), and some have argued working with adolescents can be the most difficult for practitioners (Hill, 2007). Bettmann et al. (2013) found families to utilise adventure therapy programs “as an alternative form of therapy when other methods, such as outpatient therapies, are not successful for teenagers with problematic behaviors” (p. 1039). During the interviews, I asked program participants about any previous experiences in therapy. Figure 4 illustrates the coding I conducted to map this narrative thread. Oscar, a social worker working in wilderness therapy, shared that “nine times out of 10, these students had already been in therapy.” I chose the following excerpts below to present these program participants’ pre-adventure therapy treatment experiences.

Thomas, USA, Continuous-Flow Wilderness Therapy

I must have seen 25 to 30 therapists. They’d all ask me the same questions, “Why can’t you go to school? Why don’t you go to school?” Honestly, I said to them all, “I don’t know. I just can’t.” And when I think about going to school, there was like a little voice in my head. Not a “voice voice.” Like a thought that said, “No, just no, I can’t.” I don’t have any better explanation.
Figure 4: Exhausting the Local Resources

Andy, USA, Continuous-Flow Wilderness Therapy

Andy shared the experience of having specialist after specialist attempt to help him improve his schoolwork and help overcome his experiences of bullying.

I had one primary psychologist that I remember visiting when I was in Alabama for about four years, from the ages of about 6 to 10. I was diagnosed with a bunch of other stuff, but I also tested gifted. I was placed in advanced placement classes, but as advanced as I was educationally, I was not so much socially. I didn’t make friends well. They said ADD [attention deficit disorder] because I was constantly doing stuff. Two different doctors said two different things. We went to one doctor for like a
month and we didn’t like her. The depression was diagnosed when I was 11 by a different doctor.

I do not honestly remember the order of the drugs; the ones I was on the longest was probably Adderall and Ritalin. Strattera and Effexor came later when I stopped eating on Adderall and Ritalin. I lost a lot of weight. I was very skinny. Nothing tasted of anything. I had no drive to eat. Then, they put me on Effexor, and I had an allergic reaction. They put me on Strattera and that worked for a while in terms of the eating disorder. That stopped. I didn’t have a personality. Then, at about 14, I said, “I’m done.” Even on those medications, I was still a problem child.

Andy’s description of not eating is a common side effect of stimulants like Adderall and Ritalin. Although Andy and his family were willing to try any medication and welcome all the diagnoses, his behaviour did not improve. He was “still a problem child.” As mentioned above, Katy trialled different medications, which did not help but “in fact, made things get worse.” Tony also experienced some of the effects of being medicated. Tony was diagnosed with bipolar disorder and referred to himself as “a little unusual.”

Tony, USA, Continuous-Flow Wilderness Therapy

I was a fuck up. I had been in individual therapy. I had a therapist. I had a shrink. I was starting to refuse to go to group therapy, too. I just wasn’t a functional person. I was very, very heavily medicated. I was not reacting well to my medicine and the medicine wasn’t particularly working.

Tony saw a therapist weekly and a “shrink every three months” to get his medications renewed. Getting thrown out of school and showing no visible signs of improvement, Tony’s
parents sat him down to discuss what possibilities they had. They had “run out of patience.” Though Tony was beginning to refuse to go to therapy, Kelly, in the excerpt below, describes feeling therapy was just part of her “routine.”

Kelly, USA, Continuous-Flow Wilderness Therapy

I had gone to inpatient and outpatient in mental hospitals and then I went to this learning centre in California, and then they sent me from California before I went to the wilderness program. I had been in therapy since I was 5, because I just started out as a kid having to go to therapy for just anger problems. I’ve been very used to therapy, and it was very normal for me. I never actually looked down upon it or was like, “Oh I hate going to therapy.” It was just something that was a part of my weekly routine.

Olivia, USA, Continuous-Flow Wilderness Therapy

As a 25-year-old looking back on her teenage years, Olivia felt the behaviour she was exhibiting as a 16-year-old was “a lot of normal teenager stuff.” Olivia was beginning to experiment with alcohol and marijuana but kept her grades up. She had previous experience in therapy, which began much younger for her when her parents got divorced.

I went a while without counselling and when I started doing the partying and skipping school, my parents were like, “Okay, we need to really get her into some counselling.” I never really got anything from those sessions. I just felt like I was being interrogated the whole time. I felt like they were working for my parents and not working with me, If that makes sense. I couldn’t trust them.
Olivia pointed to issues of trust and the relationship she had with her therapist. She was concerned about being evaluated and felt apprehensive about whether there existed a consensus on the goals for therapy. Like Olivia, Laura said there was “no trust at all” with her therapist. While some practitioners may place responsibility on Olivia to engage in the therapy process, a lack of progress in therapy is most likely due to relational issues, which can include goal consensus (Duncan et al., 2007). Similarly, William described therapy as a “closed-off process.”

**William, USA, Wilderness-Based Therapeutic Boarding School**

We did therapy, you know. Going to a therapist. I think it was a psychologist to talk about things, which for me, was a closed-off process. I wouldn’t talk as much to the therapist. In some ways, it’s more of a time waster. I just remember him walking in the office and it was just your typical, at least in America, your typical mid-40s, Caucasian, dress shirt and tie with some glasses and just asking questions. Very standard and very stereotypical. I think I saw him on and off for six months.

Seeing the psychologist was not leading to improvement at home, and William was disengaged. William was also provided a slew of medications and described “feeling like a zombie” as a result. Behind the scenes, things were put into motion, and his parents began contacting wilderness therapy programs and therapeutic boarding schools.

Andrea, from Denmark, also saw many practitioners prior to engaging in outdoor therapy to work on improving her self-esteem. She reported she had about “12 psychologists, and have been in the mental healthcare system” since she was 13 years old.

Participants reported some of the issues motivating them to disengage from the therapy process. They found therapy “boring,” “routine,” and “stereotypical.” Oliver, who
was struggling with substance abuse, described his therapy experiences as “absolutely boring.” Mark also found therapy “boring.” Although Michelle was used to both inpatient and outpatient therapy, she felt “nobody takes me seriously.” Like Kelly who described therapy as just part of her “routine,” Craig said therapy provided “a place to vent” and Lance reported “never really wanting to skip” his sessions. The sessions did not provide the expected relief for their parents, who continued to search for other options for their child. When progress was not being made, people involved with the participant, such as their parents or school teachers, sought adventure therapy services. For example, Nancy felt her therapist “had no idea what to do with me.”

This section on the “Diversity of Adventure Therapy Participants” has introduced the program participants in my inquiry (See Table 2) and presented some of the concerns that led their parents to seek adventure therapy services. I use the following section to introduce the adventure therapy practitioners. The narrative threads that emerge relate to their personal experiences in the outdoors and the diversity of qualifications and theoretical underpinnings.

**Varieties of Adventure Therapy Practitioners**

The 26 practitioners I interviewed are introduced through providing brief background information in Table 4. These introductions include the circumstances and motivations that led the person to adventure therapy, their training and qualification, and specific information about their approach. The practitioners referenced various backgrounds and different theoretical orientations they incorporated into their work. There was a variety of social workers \((n = 7)\), psychologists \((n = 8)\), counsellors \((n = 7)\), youth workers \((n = 3)\), and a school-based police officer \((n = 1)\). Psychodynamic, solution-focused brief therapy, art therapy, experiential therapy, trauma-informed practice, attachment therapy, early prevention,
<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Qualification</th>
<th>Background</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abigail</td>
<td>Psychologist</td>
<td>Abigail is psychologist working for a non-profit wilderness therapy program. She became interested in adventure therapy due to her personal love of the outdoors. She described her work as trauma-informed and incorporating components of art therapy and mindfulness. Abigail works mostly with adolescents.</td>
</tr>
<tr>
<td>Bella</td>
<td>Social Worker</td>
<td>While studying social work, one of Bella’s professors took note of Bella’s extensive “guiding experience” and recommended she look into adventure therapy. Bella is currently working in private practice and considers herself a trauma-informed practitioner. Though Bella works in an urban setting, she also facilitates programs in remote communities.</td>
</tr>
<tr>
<td>Brandon</td>
<td>Social Worker</td>
<td>Brandon worked as a field guide in wilderness therapy before returning to university to complete his degree in social work. He has extensive guiding experience, as he ran many expeditions for the National Outdoor Leadership School. Brandon currently works for a continuous-flow wilderness therapy program and describes his approach as being grounded in experiential therapy.</td>
</tr>
<tr>
<td>Charlotte</td>
<td>Psychologist</td>
<td>Charlotte reported wanting to spend as much time in the outdoors possible. While training to become a psychologist, she felt incorporating the outdoors to her practice “made sense.” Charlotte is currently employed at a residential program where she incorporates the outdoors to her work, such as using a ropes course or hiking trails. At the time of our interview, Charlotte was hoping for a career change due to many of the “militaristic” approaches her program uses with their young people. Charlotte described her approach as being informed by attachment theory.</td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Background and Experience</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Crystal</td>
<td>Psychologist</td>
<td>Crystal is employed by a charitable service working with people with disabilities, such as those with vision impairments. After completing a diploma in experiential education, Crystal felt her work was helping people, particularly men, on a deeper level than education. She pursued a degree in psychology and worked in a substance abuse facility. Crystal described her work as being influenced by experiential therapy.</td>
</tr>
<tr>
<td>David</td>
<td>Psychologist</td>
<td>David described himself as “fortunate” to grow up with his grandfather, an experienced mountaineer. It was these outdoor experiences that led to him wanting to work in similar settings. After completing his psychology training, David travelled the United States working and volunteering on various wilderness therapy programs. He currently runs a wilderness therapy program for adolescents and finds the experiential components of his practice to be essential.</td>
</tr>
<tr>
<td>Evan</td>
<td>Counsellor</td>
<td>Evan was a “head guide” for a wilderness therapy program before returning to university to seek a degree in counselling. He is currently employed at a non-profit wilderness therapy program. Evan felt the outdoor setting helps adolescents to adapt to the unpredictable environment. He described his training in experiential learning as foundational to his practice as a counsellor.</td>
</tr>
<tr>
<td>Felicity</td>
<td>Counsellor</td>
<td>Felicity described herself as a trauma-informed practitioner. She is currently working at a wilderness therapy program for adolescents and believed that the outdoor setting is helpful for establishing equitable relationships with young people. Felicity voiced concerns about coercive practice and the lack of trauma-informed approaches in wilderness therapy.</td>
</tr>
<tr>
<td>Glen</td>
<td>Police Officer</td>
<td>Glen is a school based police officer who runs adventure therapy expeditions for students who are about to be expelled from school. Glen described that it was his love for “fishing and camping” with his father that influenced him to start working intentionally in the outdoors. Having no clinical training, Glen did not stress any important theoretical positions, but instead discussed the important of working with young people using engaging activities.</td>
</tr>
<tr>
<td>Name</td>
<td>Occupation</td>
<td>Description</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Grace</td>
<td>Social Worker</td>
<td>Early on in life, Grace “loved the outdoors” and originally trained as an outdoor guide. After completing a two-week placement with a drug and alcohol rehabilitation program, she returned to university to pursue a degree in social work. Grace described her work as being informed by solution-focused brief therapy and is currently working for a non-profit community based program provided brief adventure therapy expeditions.</td>
</tr>
<tr>
<td>Jackie</td>
<td>Psychologist</td>
<td>Jackie is currently employed at a therapeutic boarding school, which incorporates adventure therapy interventions. She entered the field of adventure therapy after completing a course with the National Outdoor Leadership School. She described the important of trauma-informed practice and neurobiological understandings of adolescence as informing her work. Jackie raised concerns about “boot camp” mentality in present day wilderness therapy programs.</td>
</tr>
<tr>
<td>Jackson</td>
<td>Counsellor</td>
<td>Jackson described his love for spending time in the outdoors and adventuring to be important to his adventure therapy journey. He started his work as a field guide running expeditions for adolescents from rural communities. Jackson described the experiential components of adventure therapy and the power of shared adventure as essential to his approach to working with adolescents.</td>
</tr>
<tr>
<td>Kennedy</td>
<td>Youth Worker</td>
<td>Kennedy is a youth worker employed at a community-based organisation providing case management and adventure therapy services. Kennedy entered the field due his own passion for the outdoors and sharing natural environments with young people. Kennedy described his work as “rapport-based facilitation” and stressed the importance of therapeutic relationships.</td>
</tr>
<tr>
<td>Kevin</td>
<td>Youth Worker</td>
<td>Kevin described his experiences as a scout during his childhood as being informative for his love of the outdoors. He trained in outdoor education and became a foster carer to help young people in need. Following the advice of a friend, Kevin attended an adventure therapy program and became fascinated with trauma-informed practice. Kevin is currently the manager of a wilderness therapy program.</td>
</tr>
<tr>
<td>Name</td>
<td>Profession</td>
<td>Information</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Logan</td>
<td>Psychologist</td>
<td>While completing his psychology degree, Logan undertook a work placement on an island with groups of young offenders. Logan found the program inspirational as he had not seen the outdoors used therapeutically, despite his own personal experiences in nature. Logan described himself as a psychodynamic practitioner and uses the outdoor settings as a “mirror.” He is currently the director of a small wilderness therapy program.</td>
</tr>
<tr>
<td>Lynn</td>
<td>Psychologist</td>
<td>Lynn shared her experiences at summer camp to lead her to wanting to help people in the outdoors. She has provided training and consultations for adventure therapy programs around the world and currently manages a private practice. Lynn’s work is influenced by experiential learning and her previous work as an outdoor guide. She has completed a PhD on adventure therapy.</td>
</tr>
<tr>
<td>Marcell</td>
<td>Counsellor</td>
<td>Marcell described himself as an “outdoor person” who wanted to work outside for “selfish” reasons. His early childhood experiences at summer camp inspired him to become a guide and then go on to train in counselling. Marcell is currently a counsellor for a wilderness therapy program and described mindfulness as being foundational to his approach.</td>
</tr>
<tr>
<td>Magnus</td>
<td>Psychologist</td>
<td>Magnus currently run a community-based organisation providing adventure therapy for groups of young people. He described wanting to incorporate the outdoors to his work as he had experienced his own personal benefits. Magnus described his approach as informed by experiential therapy, where participants can experience success and mastery by completing certain activities.</td>
</tr>
<tr>
<td>Mary</td>
<td>Social Worker</td>
<td>Mary labelled herself a “trauma-informed social worker” and is currently employed at a continuous-flow wilderness therapy program. Mary works primarily with adolescent women and incorporates neuroscience to inform her approach. She felt that wilderness therapy programs can empower young women differently to how traditional, office-based therapies could.</td>
</tr>
<tr>
<td>Name</td>
<td>Profession</td>
<td>Experience and Approach</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Matthew</td>
<td>Psychologist</td>
<td>Currently employed at a wilderness therapy program, raised concerns about lack of trust, described experience at summer camp, returned to university to complete training.</td>
</tr>
<tr>
<td>Nathaniel</td>
<td>Counsellor</td>
<td>Was a career scientist and guest teacher, trained in counselling and solution-focused therapy, started private practice, referrals come from school counsellors.</td>
</tr>
<tr>
<td>Oscar</td>
<td>Social Worker</td>
<td>Trained in social work, worked with adolescents, trauma-informed practice and experiential learning, critical about cost and coercive practices.</td>
</tr>
<tr>
<td>Peter</td>
<td>Counsellor</td>
<td>Army veteran, described experience with trauma, outdoors as healing, provides therapy at 18-day wilderness therapy programs, uses art therapy and mindfulness.</td>
</tr>
<tr>
<td>Robert</td>
<td>Social Worker</td>
<td>PhD candidate, experience in community-based settings, avid rock climber and mountaineer, trauma-informed and experiential approach, criticizes coercive practices.</td>
</tr>
</tbody>
</table>
Shaun awarded Psychologist

Shaun credited his experience in scouts to help keep him from trouble. He finds mountain biking helps him with stress and he brings this focus to his work. Shaun credits his training in experiential learning as central to his approach to working with adolescents in wilderness therapy. Shaun felt the field of adventure therapy should focus on becoming more inclusive of different cultures.

Zach awarded Social Worker

For Zach, the outdoors were a place of “healing.” He found the neuroscience relating to trauma-informed practice to provide more justification to his work. Zach is currently employed by a wilderness therapy program where he works with adolescents. Zach voiced concerns about adventure therapists creating individualised treatment plans without taking into consideration the viewpoints of the participant.
Figure 5: Practitioner Characteristics
mindfulness, and CBT were some of the models of therapy these practitioners incorporated into their work. Practitioners worked in a variety of settings, such as residential treatment centres, wilderness therapy programs, therapeutic boarding schools, community-based mental health, and private practice, and shared different pathways to becoming adventure-oriented practitioners. Figure 5 provides a visual breakdown of the practitioners based on their qualification, theoretical orientation, practice setting, and previous experiences in the outdoors. I have separated this thread into two subthreads that emerged from the practitioners’ narratives. First is a presentation of (1) “Personal Experiences in the Outdoors” and (2) the “Diversity of Adventure Therapy Practice.”

**Personal Experiences in the Outdoors**

With different cultural contexts enlisting different definitions for what adventure therapy is (Harper et al., 2014), it is evident adventure therapy has a diverse range of practice, and the professional pathway to working in adventure therapy is varied. This narrative thread represents the factors which have influenced some of the practitioners to pursue careers in adventure therapy.

*David, Psychologist, Wilderness Therapy*

David’s experience was like others who exhibited a thirst for the outdoors. As a clinical psychologist and outdoor educator, David spent a month experiencing adventure as a setting for therapy to take place.

I’ve been in the mountains just for fun, leisure or doing some risky things with friends. The difference was the therapy part in it. The focus is on the personal path of every one of the participants. So that was really beautiful to see. I was there as just a
field guide. So, I didn’t take part in the one-to-one processes with the therapists, of course not. But still, I could see how nurturing, caring it was, the relationship between therapists and kids.

David now runs an organisation providing training for practitioners and develops different adventure therapy programs for various populations of participants. Early outdoor experiences impact David’s practice and he reported these positive memories informing his program’s development.

Other participants began their journeys to adventure therapy working in and studying outdoor leadership. Jackie, for example, described completing a “NOLS course,” referring to the National Outdoor Leadership School in North America. Brandon “began leading backpacking trips for incoming freshmen” after finishing his undergraduate degree. He began pursuing his social work qualification after these “personal experiences.” While studying social work, Bella told a professor she had extensive “guiding experience.” Her professor said, “Hey, you should do adventure therapy!” Jackson also described experiences in outdoor leadership and adventure guiding emphasising how personal interests and experiences can inform how practitioners approach their work. Other practitioners, such as Peter, described their own experiences of healing in outdoor settings.

Peter, Counsellor, Wilderness Therapy

Similarly, Peter, an army veteran and counsellor who facilitated 18-day wilderness therapy programs, found time in nature healing for dealing with his own trauma.

It was . . . my own experience with trauma, and spending years trying to find an answer. I looked everywhere. It was actually going on my own adventures, with my
own issues, and finding some relief in that. Look, it wasn’t like no one led me there. No one took me to the bush and said, “This is a place that you can do therapy.” I was doing that for five or six years, and then, randomly, at an outdoor education conference, I bumped into someone who invited me to an adventure therapy conference.

Since attending an adventure therapy conference, Peter had finished a master’s degree in counselling and had an interest in broadening his expeditions for adolescents to working with veterans. Other practitioners, such as Abigail, Shaun, and Zach, had experienced time in nature to be healing for themselves before becoming practitioners and bringing adventure into their clinical work. Marcell referred to himself as an outdoor person and established the program out of “selfish” and “egotistical” reasons, stressing that he enjoyed the outdoors and wanted to work there. Similarly, Charlotte said she spent “as much time in the outdoors as” she could.

I can relate personally to preferring to work in the outdoors as opposed to a traditional office setting, but I also question if these anecdotal and personal justifications for using adventure therapy magnify treatment outcomes for young people. Practitioners chose their approach based on personal experience and values. These values may not align with their participants, which could cause a rupture to the therapeutic alliance. Though time in nature can be healing for one, it can be dangerous, scary, and potentially traumatic for another (Harper et al., 2019). Each practitioner align themselves with a certain ‘theory of change’ and it is often linked closely with personal values (Caldwell, 2015). Imposing a specific modality on a therapy participant without considering their preferences and feedback could become at odds with the social work profession’s stance on anti-oppressive practice (AASW, 2010).
While practitioners described their previous work as adventure guides and their personal outdoor experiences, Lynn had a unique experience in that she had known from a young age she wanted to work with people in the outdoors. While attending a summer camp in the third grade, Lynn became “so upset” and wanted to go home. A camp counsellor sat with Lynn that night to talk with a clearly upset child.

_Lynn, Psychologist, Private Practice_

Partly, I remember it because I was writing in my diary. But she just sat next to me, and she just listened, and was, “Yeah, that sounds really sad. Hey, are you willing to spend the night and we’ll figure this out tomorrow morning? And if you want to go home, we’ll make that work. And we can figure out a way for you to get on the horses, we’ll make that work.” So, it wasn’t a, “You’re okay.” There was never anything that was dismissive about it. It was just a “This is really hard, and let’s get you through the night.”

And in the morning, when I got out of the tent, there was a new pair of boots waiting for me, and my counsellor. And before we even went to breakfast, she took me down to the horses, and had me on a horse. And that was the day that I wrote in my journal, “When I grow up, I want to help people in the outdoors.”

Lynn would go on to become a camp counsellor herself and earn an undergraduate degree in outdoor recreation and environmental education. She then earned her master’s degree in counselling to make her adventure therapy work “more intentional” and then completed a PhD. She currently works in private practice.

There was a variety of theoretical perceptions grounding these practitioners’ adventure therapy practices. Although the practitioners each discussed their personal
relationship to adventure and time in nature, it was embedding theory in adventure that made their work more intentional.

**Diversity of Adventure Therapy Practice**

Practitioners described a diversity of orientations informing their practice. This is supported by other research into the professionalism of adventure therapy (Natynczuk, 2016). The following excerpts begin with Kevin who described how his personal experiences and mentorship had led him to become a trauma-informed worker. Trained in outdoor education, Kevin became a foster carer and thought outdoor pursuits with his fostered children were causing “some really fantastic things to happen in terms of wellbeing”. Kevin attended a conference where a colleague told him to investigate his work through the lens of trauma-informed practice.

*Kevin, Youth Worker, Wilderness Therapy*

It was the experience of bad things happening that caused complex trauma or trauma, so adventure therapy is the opposite. It’s the experience of good things happening that provides an alternative pathway. And so, if experiences cause harm, experience can cause healing. And I don’t think that talking therapies sufficiently produce these experiences. Well, they do but we can’t expect the young person all the time to go off and make that experience happen off a few spoken moments. I think that’s a really, really difficult thing for people to do. It’s a different thing for someone to be there crafting and ensuring and protecting and encouraging, to make sure that experience is actually what we want for them. We’re not leaving them alone to figure it out for themselves.
Kevin decided, based on his learning about trauma-informed practice, to create a nonprofit organisation and began running expeditions for survivors of complex trauma. Like the narrative thread “Personal Experiences in the Outdoors,” it was personal experiences that influenced Kevin’s work. Abigail, Bella, Felicity, Jackie, Mary, Oscar, Robert, and Zach also reported being influenced by trauma-informed practice and used neurological language during their interviews. Emerging from these discussions and informed by Kevin’s excerpt above, trauma-informed adventure therapy seemed to emphasise the importance of positive experiences of success and mastery. Grace and Nathaniel described incorporating solution-focused brief therapy into their practice, and their examples are described below.

*Grace, Social Worker, Community-Based Organisation*

When I kind of think about the solution focus, like how does adventure therapy fit with solution-focused therapy, I think a lot of adventure-based programs are creating instances of success. You can ask those instances questions of, “What just helped you to be able to do that?” And highlighting those strengths and resources and abilities that they just used.

And then the next day, you’ve got that question of, “Well, how have you done this in the past? Well actually, you did it yesterday.” So all those things, like that, to me, really fits with adventure therapy.

With this excerpt, Grace is explaining how adventure therapy can facilitate instances of success and competence. Utilising a solution-focused approach, practitioners can ask participants to describe past instances of success (Ratner et al., 2012). Adventure therapy practitioners should aim to tailor their programs to construct such experiences for their participants. Experiences of success and mastery are examined further in Chapter 8.
Practitioners described other orientations such as art therapy, mindfulness, attachment theory, and psychodynamic. Logan, for example, described nature could work as a “mirror” for the participant, similar to how a therapist would in psychodynamic practice. For Marcell, wilderness therapy provides “the perfect setting” for experiential learning to take place, indicating that the outdoor group environment provides ample opportunity for participants to interact with each other and adapt to the new environment.

The diversity of adventure therapy practice is illustrated throughout the literature (Fernee et al., 2015; Harper et al., 2014; Tucker et al., 2013). While most of the available literature focuses on wilderness therapy practice in the United States (Harper, 2017), the practitioners I interviewed represented a diverse range of practice, including those in private practice and community-based mental health agencies. Bella, Lynn, and Nathaniel, for instance, provided adventure therapy services in private practice. Although Bella described being “contracted to provide some group work,” the three mostly worked with individuals. Crystal, Grace, Magnus, and Robert worked for nonprofit agencies, providing adventure therapy services in community settings.

When it came to background and clientele, two interviewees revealed contrasting experiences to the majority of practitioners: first, Glen, a school-based police officer coming from a crime prevention perspective, and Crystal, a psychologist providing adventure therapy services for people with disabilities. Like others in the interview, Glen’s personal background of enjoying the outdoors led him towards becoming involved in adventure therapy. Working a long career as a child protection police officer, Glen knew he had “posttraumatic stress issues” but “no interest in going to see a therapist.” Glen transitioned in his career to becoming a school-based police officer and began spending more time in nature.
Glen, Police Officer, School Setting

My job is really child protection and crime prevention. I have four or five main duties. One would be education to the kids. I go into a classroom and teach them about criminal law as it applies to their curriculum. I have a physical education teacher talking about sexuality. They might call me in so that I can give them the low down on what the rules of consent are and rape and the age of consent and all that sort of thing. Or the legal teacher obviously might call me in if they’re dealing with self-defence or provocation. So, I teach kids in general, so that’s one job.

Another job would be actually dealing as a first responder to anything where there is a criminal offence involved. That might be cyberbullying, that might be theft, that might be an assault in the school; I’ll respond to that as a police officer.

And then the third thing I would be doing is actually dealing with individual students who need some sort of police officer’s guidance. I guess that’s more the crime prevention role. Kids going off the rails. I’ll sort of target them and explain to them, do whatever means I can.

And then the last thing I do would be protection. So, I’d be looking at kids who are unsafe in their home environment and probably using my experiences with kids with child abuse in their lives to address those issues in whatever way I can.

Crystal, Psychologist, Community-Based

Crystal pursued a degree in psychology while working in a substance abuse rehabilitation program. She learned of an organisation focused on providing inclusive services for people with disabilities. While Crystal was an advocate for adventure therapy, she acknowledged in our interview the term was not commonly used in her cultural context.
This excerpt does relate to a narrative thread which I explore in Chapter 8, titled “The Stereotypical Therapist.”

The thing is that there’s a lot of stigma against therapy and getting help in general. That’s a huge thing for us, and our society is not really at that place where it’s okay to even tell someone that you’re getting help. Where I live, it’s a huge stigma. I actually think it would be beneficial if people don’t call it adventure therapy, and just take people out.

Over the last four years, Glen had become “satisfied” that he could run a small adventure therapy program “at a very grassroots level within a school,” which was “cheaper than sending kids away to another organisation.” Like Glen, Crystal’s introduction to adventure therapy came at a “grassroots level” when she was hired by a small, nonprofit community organisation.

Practitioners found adventure therapy through personal experiences in the outdoors. Whether this was for extracurricular activities, such as Kevin’s, David’s, and Lynn’s early childhood adventurous experiences, or overcoming personal issues, like Peter’s and Glen’s experiences of posttraumatic stress, the role of adventure held personal significance, which paved a path towards finding adventure therapy. Social worker Robert raised concerns “that some people do adventure therapy . . . because they love it” but “they don’t always make sure that it fits with whatever’s the best fit for that client.”

Most practitioners were involved in some adventure-oriented practice before they began using the term adventure therapy. This may illustrate the diversity of the path to adventure therapy. This situation may be problematic when questions around what is ‘proper therapy’ continue to distract from real and beneficial nature of adventure therapy. In a
qualitative study exploring professionalism in adventure therapy, Natynczuk (2016) found those with outdoor experience and limited training in the helping professions were more reluctant to call themselves ‘adventure therapists.’ Different cultural contexts, training standards, and standards of competency for facilitating outdoor activities have created a fractured field. Similar to my inquiry, Natynczuk (2016) found diverse theoretical stances practitioners use to inform their work, such as solution-focused brief therapy, mindfulness, ecotherapy, and clinical hypnosis, providing support that adventure therapy is a diverse field with practitioners bringing different perspectives to their work.

While this diversity of practice is common in all models of therapy (Caldwell, 2015), there are concerns regarding the use of the term ‘adventure therapy’ in the research literature. For example, Bowen and Neill’s (2013) meta-analysis provided substantial evidence for adventure therapy outcomes based on 2,908 participants from 197 unique studies. The authors suggested these 2,908 participants had similar experiences, though under the umbrella of adventure therapy, this seems impossible.

This could create problems for future studies as there may be as many types of adventure therapy as there are practitioners in the field. This might open the door for poorly articulated practices to occur under the guise of adventure therapy. The GAO report (2007), which I discussed in “A Short History of Adventure Therapy,” found many wilderness therapy programs crafted their own definition for their program. If practitioners are operating without oversight from a professional peak body with a code of ethics, it is difficult to know where clients can deliver their complaints. Additionally, practitioners may encourage participants to engage in adventure therapy because it worked in their personal context, without taking into consideration the program participant’s treatment preferences or motivation. Without including their preferences in case planning, practitioners could risk inviting an oppressive stance into their practice (Mitten, 1994).
This section explored the diversity of theoretical positions described by the practitioners I interviewed. I used this discussion to present some concerns about what adventure therapy is and how researchers describe the mechanisms of change. The following discussion presents the emerging resonant threads from this Chapter.

Resonant Threads

The findings in this Chapter relate to the program participants in my inquiry and explore their lives before engaging in adventure therapy. For practitioners, based on each practitioner’s unique personal history, it is evident that previous life experiences in the outdoors had interested them; their experiences highlight the diversity of professionalism in adventure therapy. Participants reported an assortment of concerns, such as substance abuse, depression, family conflict, and issues relating to identity, particularly by those multiculturally-adopted. For most participants, therapy was nothing new, some having been to prior residential treatment. Although some did not mind seeing different specialists and clinicians, many had not found therapy helpful.

The following section presents the resonant threads emerging from these narratives. First is a discussion about the practitioners involved in my inquiry; about who conducts adventure therapy. This is followed by an analysis of the program participants’ experiences before adventure therapy.

Who Conducts Adventure Therapy?

While professional training in adventure therapy was not present in my inquiry, practitioners held psychology, social work, and counselling degrees and incorporated personal and professional outdoor experience to their clinical work. Two resonant threads emerging from the presentation of practitioners is the importance of (1) “Healing Experiences
in Nature” and (2) “Issues with Professionalism” within the field of adventure therapy.

**Healing experiences in nature**

It is interesting to consider why a practitioner comes to practise in a certain field, and many reported personal healing experiences in nature as just that. Personally, I found summer camp experiences to provide great relief from the family conflict in which I grew up. It seems personal experiences motivate practitioners towards choosing a mode of working, such as wilderness therapy. According to Caldwell (2015), it is often personal values that lead practitioners to adopt certain models of therapy.

Given this resonant thread about experiencing healing in the outdoors, this may be an important component to effective work in therapeutic settings. To be considered a bona-fide psychotherapy, a coherent, psychological rationale is required for why the therapy should work (Wampold & Imel, 2015). The rationale is not only important for informed consent, but for demonstrating a clear link that therapeutic actions that take place are based upon the rationale. The rationale can help instil a sense of hope within the participant. In outpatient therapy, participants who feel therapy will be ineffective might not return (Garcia & Weisz, 2002). The power of hope and expectancy, a core common factor among all models of psychotherapy, lies within the therapeutic relationship and the rationale for why a specific therapy will work for a specific person (Hubble et al., 2010). Hope can be elicited when practitioners package a service into a symbolic message, allowing therapy participants to see the purpose of the therapeutic tasks or rituals and a clear path towards a desired outcome. Here, practitioners might self-disclose their preference for adventure therapy, and share some of their personal journeys to inspire participants, and to seek better engagement.

For example, army veteran Peter found his solo adventures to be useful for coping with PTSD. As he trained as a counsellor and began working with adolescents, he also gained
interest in wanting to start this work with other veterans. His stories of healing experiences, both his own and for some of his participants, could be shared during initial meetings with participants. Similarly, Shaun was “involved in scouting early on” and felt this “kept me out of trouble.” Scouting led him to mountain biking and hiking, which helped Shaun “build solid coping skills.” Detailed further in Chapter 7 on the therapeutic relationship in adventure therapy settings, practitioners’ self-disclosure was reported by some participants as useful for creating collaborative relationships and alleviating some of the uncontrollable stress of being involuntarily sent to adventure therapy.

**Issues with professionalism**

In Chapter 1, the discussion about what defines adventure therapy was shown to be contentious (ATIC, 2016; Gass et al., 2012). Raising critical questions of adventure therapy practice, Itin (2001) asked whether a practitioner’s professional discipline or the population being served were informative to defining adventure therapy as a bona fide profession. For example, can a social worker and a school-based police officer all work under the same umbrella as adventure therapy? He further questioned whether adventure therapy was a profession at all or simply a series of techniques practitioners of any theoretical foundation could incorporate to their clinical practice. Using a sample of 646 social workers, Tucker and Norton (2013) found a little more than one third of social workers to use adventure-based techniques in clinical settings. Itin (2001) argued that though there is enough of an academic tradition and practitioners working in universities around the world, the best way to define adventure therapy is as a truly interdisciplinary field, with a diverse range of practitioners. For example, while I interviewed practitioners who all considered their work ‘adventure therapy,’ there was great diversity in the profession, theory, and modes of service delivery.

Definitions and categories, however, create ‘turf battles’ within adventure therapy
Frank and Frank (1991) acknowledged that while most psychotherapy debates focus on what practitioners do, most of the differences among therapists lie in whom they are conducting therapy with. For example, practitioners will have different approaches to working with substance users as opposed to those reporting marital problems. Some practitioners referred to their adventure therapy participants as clients or consumers, some as young people, and others as patients. The diversity of practitioners might not rest in the obvious factors, such as professional discipline or theoretical orientation, but how practitioners approach their participants.

I have concerns about the quest for evidence-based recognition (Harper, 2010), especially given the diversity of practitioners. This concern was echoed by Russell and Becker (2010), who found the lack of common approaches and manualised treatments to prevent wilderness therapy, in particular, to gain acceptance as an empirically supported psychotherapy. While I consider myself a solution-focused social worker, I do not believe manualising any approach to be useful. First, I ground this in the research, which has found no improvement in outcomes for manualised approaches (Miller et al., 2013; Wampold & Imel, 2015). Second, therapeutic interactions are inherently contextual and interpersonal. Forcing practitioners to follow specific manuals will force practitioners to pay more attention to the manual, than the client. This is a thread that develops in the following chapters.

I find pursuits of certification to be misleading as specific certifications, such as becoming trauma-informed or solution-focused, have no evidence to suggest improved outcomes (Chow et al., 2015). If the journey to becoming an adventure-based practitioner is so diverse, important questions should be raised around possible certification of adventure therapy practitioners (Itin, 2001). For example, Strupp and Hadley (1979) compared therapy outcomes of ‘highly experienced’ therapists and ‘understanding’ university professors, finding equivalent outcomes. Given the growing number of adventure therapy outcome
studies, pursuits of professionalism and the possibility of certification should be met with evidence-based questions, namely, how exactly should adventure therapy practitioners be trained to elicit improved outcomes that would differentiate from their professional discipline, such as social work? As professional adventure therapy groups, such as the TAPG and AABAT, work towards the certification of adventure therapy providers, questions arise about the ‘cash value’ of such training. Those interested in certifications for adventure therapy should explore if such a certification will elicit better outcomes or improve the safety of participant prior to developing their standards of competency.

Who Receives Adventure Therapy?

Considerable effort has been made to explore characteristics of clients receiving adventure therapy; relating to their diagnostic criteria and individual characteristics (Hoag et al., 2014; Tucker et al., 2014). While the diagnosis of a mental disorder provides one lens for categorising a person’s functioning, the meanings, attitudes, and historical context are epiphenomena are not central to the diagnosis (Bleakley, 2005; Frank & Frank, 1991). For example, participants in this chapter have described being trialled on numerous medications and diagnosed with various mental disorders. These diagnoses tell little about family conflict, parenting styles, social class, or many other factors contributing to a person’s system. For the adventure therapy participants in my inquiry, three resonant threads that emerged were (1) “Identity: Who Am I? Am I a Hybrid,” (2) “Therapy Veterans,” and (3) “Demoralisation,” and (4) the “Distribution of Dysfunction.”

Identity: Who am I? Am I a hybrid?

Adoption- and attachment-related issues have been discussed previously in the adventure therapy literature (Bettmann, Demon, & Jasperson, 2017; Bettmann & Tucker,
Reporting on the clinical trends of wilderness therapy clients, Bettmann et al. (2014) noted 16.8% of the 400 participants in their study reported being adopted. By coincidence, my sample of 30 program participants included five adopted youth. Thus, 16.67% of my sample were adopted. While circumstantial, this finding is not generalisable outside of my inquiry. This trend of adopted adolescents being sent to therapy also occurs across the broad spectrum of clinical practice, and Bettmann et al. (2017) recommended therapists assess their own comfort level in talking about adoption-related issues. From my inquiry, adoption and the search for identity surfaced as something practitioners might attend to, when relevant.

Louis, Angela, and Mark described feeling like a “hybrid,” asking themselves questions like “Who am I?” In the searching for where they fit in, they resorted to risk-taking behaviours, such as promiscuity and substance use. As relationships with their adoptive families broke down, family members continued to seek support from therapists, and after a lack of progress, found adventure therapy.

Many of the program participants reported family conflict as one of their main reported issues. Bettmann et al. (2017) explored issues relating to family relationships through the lens of attachment theory, with literature they reviewed extensively. According to the authors, adopted adolescents are the most at risk of having insecure attachments to their caregivers, but all adolescents, including survivors of trauma, can experience insecure attachments. As an adolescent’s interpersonal relationships break down, their social network shrinks. Being able to share personal information and speak openly with caregivers has been linked to improved wellbeing and higher functioning (Riley & Meeks, 2005).

Bettmann et al. (2017) provided several implications for working with adolescents who may experience insecure attachments in wilderness therapy environments. First, because adolescents are often involuntarily sent to wilderness therapy programs by their parents, as examined in the following chapter, feelings of rejection can increase feelings of
demoralisation. Second, an outdoor environment may be more isolating for adolescents who lack secure relationships with adults. To combat some of these concerns, the authors advocated regular contact with family members through mediums such as letter writing or phone calls. The authors emphasised practitioners allow their participants to bring “transitional objects, such as a stuffed animal or piece of jewellery that connects clients to family members” that can “help decrease clients’ anxiety during separation and support healthy attachment relationship” (p. 128). The authors concluded that although adopted participants are overrepresented in therapeutic care, adventure therapy programs do not train their staff adequately in attachment-related issues. These ideas are developed later in this section in the discussion about the resonant thread of demoralisation.

**Therapy veterans**

For many of the program participants, therapy was not working. Some found therapy boring, routine, and time wasting, and felt their therapist was more aligned with their parents’ goals. Additionally, different diagnoses and the subsequent medications prescribed had little impact. When therapy was not working, parents continued to look elsewhere for support.

Gass et al. (2012) described adventure therapy as an effective option for adolescents with previous therapy experiences who may be unmotivated to engage or unaware if they had a problem in the first place. I challenge this concept given my solution-focused assumptions and believe there is no such thing as an “unmotivated client” (Ratner et al., 2012). Instead, solution-focused practitioners explore with clients their best hopes for the session. We believe it is perfectly legitimate for participants to say, “I’m only here because my parents made me”, since this admission can be explored further to co-construct a more hopeful future. This approach is informed by the evidence, which suggests that the specific type of therapy is most likely not to blame for the lack of progress (Miller et al., 2013; Frank &
More often than not, issues in the relationship and a lack of progress, as perceived by the participant, from early in therapy lead people to discontinue their therapeutic relationship or beginning to shop for a new therapist (Wampold & Imel, 2015). Garcia and Weisz (2002) explored in their study why adolescents do not return to therapy. First, the authors found the largest variable motivating an adolescent to continue in therapy is the therapeutic relationship. Specifically, therapists did not seem to do the right thing, did not understand, and did things parents did not like or think would help. Despite their practitioner’s advice to continue, adolescent dropout rates ranged from 25% to 85%.

Duncan, Hubble, and Miller (1997) described those who have received a lot of unsuccessful help as veterans of impossibility. Whether mandated to engage or not, participants’ experienced with many treatment failures may arrive with little hope, feeling more discouraged that all efforts to help, whether of their own or those around them, have failed. The authors illustrated ways in which therapy is destined to fail, the responsibility of which falls mostly on the therapist not adapting to the person’s preferences and feedback. One of these is anticipating failure. When therapy veterans arrive to see a new practitioner, they often do so with extensive records of previous diagnoses, numerous prescriptions, and various labels, such as resistant or in denial. Anticipating failure can do the opposite of eliciting hope, which is needed by both the practitioner and participant for therapy to be successful. In my practice, I avoid using labels like resistance, or any other term that blames the client for a lack of progress in therapy. Blaming the client removes the practitioner from the interaction, which I find particularly troubling given evidence has found, repeatedly, that some practitioners are more effective than others (Baldwin & Imel, 2013).

If participants do not experience hope that the services they are receiving are designed to help them, they are more likely to drop out (Garcia & Weisz, 2002). Based on my findings, I ask what happens when participants are kept in voluntary treatment, void of this hope, yet
required to complete the program as structured prior to their arrival? These types of experiences are examined throughout the remaining findings chapters.

The two resonant threads represented thus far, identity and previous failed therapy experiences, lead to the third thread of this chapter, demoralisation, a common characteristic for those entering therapy (Barish, 2009; Frank & Frank, 1991). I find this description useful to move beyond diagnostic criteria and claims that adventure therapy is designed for ‘unmotivated’ youth (Gass et al., 2012) and to honour the experience of those seeking, or forced to seek, help.

**Demoralisation**

Frank and Frank (1991) described demoralisation as a commonality for people entering therapy who are “conscious of having failed to meet their own expectations or those of others, or of being unable to cope with some pressing problem. They feel powerless to change the situation or themselves and cannot extricate themselves from their predicament” (p. 35). Barish (2009) described that demoralisation is not often discussed in therapy with young people; many of the presenting problems are due to a demoralised self. Aronson (2016) found that “youth treatment groups are often demoralized, with little self-worth, feeling that they have nothing of value to offer” (p. 3). In this case, the author recommended practitioners working with adolescents in groups should instil a sense of hope in the participant as soon as possible. Adventure therapy literature has described adolescents as unmotivated and often in a precontemplative level of change (Gass et al., 2012), but outcomes measures suggest adolescents arriving to wilderness therapy programs are self-reporting levels of wellbeing well below clinical cut-offs (Gillis, Speelman, et al., 2016).

Program participants like Thomas, who had seen more than 20 different specialists, and Andy, who had trialled nearly a dozen medications, reported nothing was working. They
did not want more therapy. This was a common thread throughout. The more therapy services one engages in, without gains, the more demoralised one can become. For Selekman (2005), “Youth and families who have experienced a great deal of trauma in the past, are demoralized by their chronic difficulties, or have had multiple negative treatment experiences” (p. 44). For adolescents who are sent from one therapist to the next, and subsequently sent to residential treatment, the state of demoralisation can increase.

Of course, not all presented feeling demoralised. For example, Jeanne from Canada had successfully completed chemotherapy and radiation treatment for cancer and saw an advertisement for an adventure therapy program for those affected by cancer. Excited by the idea, she decided to participate. Connor, who described himself as an excellent student, was caught with marijuana on one occasion and his parents decided to have him attend a wilderness therapy program. That said, demoralisation may be a useful narrative and is used as a thread for interpreting the experiences of adolescents arriving to adventure therapy programs (Tecuta et al., 2015).

Like most mandated participants, adolescents do not commonly seek therapy services on their own (Duncan et al., 2007). There are, of course, circumstances in which someone might seek therapy for a specific symptom, such as a phobia of heights, without feeling demoralised. Frank and Frank (1991) described many participants enter residential treatment feeling “hopelessness, helplessness, and isolation” (p. 35). Taking this into account, Frank and Frank (1991), as well as others (Aronson, 2016; Barish, 2009; Tecuta et al., 2015), argued for practitioners to focus early on in therapy to improve the subjective wellbeing of participants by working to “clarify his symptoms and problems, inspire his hopes, provide him with experiences of success or mastery, and stir him emotionally” (p. xvi). This the authors referred to as remoralisation. Building on the demoralisation hypothesis, Howard et al. (1993) argued establishing a trustworthy therapeutic relationship and eliciting the
participant’s hope through a collaborative therapeutic contract are the first steps towards remoralisation. Outcome data supports that when people experience hope and progress early in therapy, positive outcomes are likely to follow (Boswell et al., 2013; Miller et al., 2013; Wampold, 2015b).

For interpreting these pre-adventure therapy experiences, the demoralisation hypothesis provides a useful lens for understanding program participants’ experiences beyond behaviour or symptomology. While demoralisation can occur after every social rejection or academic failure, Barish (2009) described when demoralisation spreads, “the child may come to believe that there is ‘something wrong’ with him, and this shameful feeling is always accompanied, to some extent, by hiding and withdrawal” (p. 53). Young people can blame their parents or teachers for what is going wrong, as they struggle to believe they are capable for changing their immediate surroundings. This reflects some of the descriptions of adolescents who were adopted, struggled in school, or dealt with family conflict.

For the pragmatist, demoralisation is a useful lens for bridging medicalised views of mental disorders and humanistic or contextual approaches (Morgan, 2007). Although different theoretical perspectives and schools of therapy provide various lens for approaching psychotherapy services, the demoralisation hypothesis considers it common for most people arrive to or seek therapy experiencing demoralisation. For example, most people do not typically pursue therapy at the emergence of feeling distressed (Bohart & Tallman, 2010). It is after they, or those around them, have failed to cope when external support is sought. Many of the behaviours dictated, such as promiscuity, substance abuse, and self-harm, were also linked to issues around identity, trauma, and family conflict. For Selekman (2005), problem behaviours exhibited by adolescents are often techniques the adolescent has learned in order to cope with more distressing concerns, such as prolonged trauma and family conflict. For
example, Angela reported becoming promiscuous to feel accepted in her community.

As problem behaviours led to troubling consequences, such as run-ins with the police or exclusions from school, those around them sought additional support. Specialists attempting to help the adolescents and family, with either medications or ongoing therapy, did not elicit their preferred outcome. These multiple negative experiences in therapy could provoke a feeling of discouragement that any therapy could help, especially since some had seen so many helping professionals (Gass et al., 2012; Seleman, 2005; Tecuta et al., 2015). As those around the adolescent became more discouraged that anything could help, adventure therapy became the next possibility.

The resonant thread of demoralisation is used throughout my thesis. Because success and mastery are not only a common factor to all forms of psychotherapy (Frank & Frank, 1991), but especially prevalent in adventure therapy literature (Gass et al., 2012; Walsh & Golins, 1976), this is a useful lens for interpreting people’s experiences in adventure therapy.

**Distribution of Dysfunction**

It is common for practitioners working with young people in therapy settings to question who or what the problem is, what influenced the problem to occur, and who is responsible for the problem for arising (Duncan et al., 2007). Based on the evidence I have shared throughout this Chapter, there are many instances where the dysfunction that leads the young person to therapy is distributed across the many systems they interact with. The thread of “Distribution of Dysfunction” relates to the adverse experiences the young people were exposed to, in the first place. This leads to a different interpretation of these problem that brings someone to therapy.

The most common concern referenced by program participants related to family conflict or household dysfunction, which was followed by issues in school. Andy, for
example, described experiences of being bullied, and Andrea and May reported instances of trauma. The participants who were adopted reported seeking connection with others through risky behaviours, such as promiscuity. This could be an indicator of attachment-related issues. Many of the participants also reported living in separated homes and some, like Frank, having an absent parent altogether. These adverse experiences influenced their problem behaviour, which became the chief complaint from parents and schools for seeking therapy. In this case, I can see that the problems that placed them in therapy originated outside of the participant’s control.

Advocates for trauma-informed approaches (Kezelman & Stavropoulos, 2012) have stressed that practitioners avoid focussing solely on problem behaviour, such as substance abuse or self-harm, and explore what people have experienced in their lives. Referring to household dysfunction and childhood abuse as adverse childhood experiences, Felitti et al. (1998) found a strong link between exposure to early childhood adversity, including parent divorce or family dysfunction, to a range of health and behavioural risks, such as smoking and substance use.

Practitioners in this Chapter presented their views of trauma-informed approaches and adverse childhood experiences, which I find to be a useful lens for interpreting program participants’ lives before adventure therapy. These ideas are also supported by my ontology of experience that I presented in Chapter 3. Practitioners should be conscious that the problem behaviour, such as self-harm or substance use, is most likely a response to early childhood adversity. Because these adversities and household dysfunction occurred outside of the participants’ control, practitioners should take special precautions to help participants increase their locus of control and experience of success and mastery. Thus, practitioners acknowledging the impacts of adverse childhood experiences should privilege therapy participants’ voice and choice; voice of being able to choose, by providing opportunities for
people to reconstruct and act on their sense of control. Not doing so could prevent practitioners from building strong and meaningful therapeutic relationships. This thread will continue to resonate throughout my thesis as I examine the structure of various adventure therapy programs and therapeutic interactions.

**Conclusion**

This Chapter explored who conducts adventure therapy, who receives it, and how adolescents were introduced to it. Resonant threads that emerged related to practitioners having healing experiences in nature and the diversity of professionalism and interdisciplinary status in adventure therapy. For program participants, threads that emerged related to adoption- and identity-related issues, and having exhausted local resources when it came to previous therapy experiences. These threads link with Frank and Frank’s (1991) original hypothesis that a core thread for those seeking therapy is experiencing a state of demoralisation. Chapter 6 explores how participants arrive to adventure therapy and the varieties of their experiences.
Chapter 6: Varieties of Adventure Therapy Experiences

Where you stand determines what you see and what you do not see; it determines also the angle you see it from; a change in where you stand changes everything.

—de Shazer (1991, p. xx)

The present chapter presents the diversity of adventure therapy practice and how different contexts of practice inform program development. In this section, I incorporate field notes from the participant observations I conducted on three programs. First, I took part in a contained expedition in Norway. This program was provided through the psychology department in the local hospital. Second, in the United States, I observed a continuous-flow wilderness therapy program for young adults aged 18 to 23, and third, in Australia, I participated in an expedition provided by a nonprofit community-based organisation for adolescents affected by cancer.

The first section of this chapter presents the narrative thread (1) “The Call to Adventure” (See Figure 6), which compares and contrasts how participants became engaged in various adventure therapy programs. Next, I discuss the temporal structures of the various experiences, beginning with program participant’s arrival and ending with their graduation. The program participants engaged in various types of programs. Nineteen attended a continuous-flow program (see Figure 7), and seven attended a contained expedition with a fixed length of stay (see Figure 8). The differences in these expedition-based styles of programming were discussed in Chapter 2. In Denmark, two participants went to outpatient, community-based programming, often taking place in natural settings (see Figure 9) and one participant in the United States attended a therapeutic boarding school that took place in an outdoor environment where survival skills were a routine part of the curriculum (see Figure 10). These threads are presented and defined in Table 5 on the following page.
Table 5: Narrative and Resonant Threads within Chapter 6

<table>
<thead>
<tr>
<th>Narrative Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Call to Adventure</td>
<td>This narrative thread examines the experiences of how participants became involved in adventure therapy. This thread contains three subthreads which follow.</td>
</tr>
<tr>
<td>Education Consultations:</td>
<td>Education consultants are unique to the United States and can help parents to find appropriate schools and residential programs for young people. Participants described the impact education consultants had on their lives, often without meeting them face to face.</td>
</tr>
<tr>
<td>She Never Met Me</td>
<td></td>
</tr>
<tr>
<td>Secure Transport Services</td>
<td>Participants attending continuous-flow wilderness therapy programs described the experience of having escorts enter their bedroom to take them involuntary to wilderness therapy programs. This practice was only described in the United States.</td>
</tr>
<tr>
<td>Parent Deception: Almost Like a</td>
<td>Some participants were tricked into attending adventure therapy through parent deception. Participants shared experiences of their parents withholding information about the nature of the program, such as program length and the activities involved.</td>
</tr>
<tr>
<td>Summer Camp</td>
<td></td>
</tr>
<tr>
<td>Continuous-Flow Wilderness</td>
<td>Nineteen participants attended continuous-flow wilderness therapy programs, also known as outdoor behavioural healthcare, are residential programs characterised by no set graduation date and a qualified therapist visiting the group each week. New participants enter and graduate the group at various times.</td>
</tr>
<tr>
<td>Wilderness Therapy Programs</td>
<td></td>
</tr>
<tr>
<td>Contained Expedition</td>
<td>Seven participants engaged in a contained expedition. These programs included a closed group and a fixed length of time. Therapists typically remained with the group the entire time.</td>
</tr>
</tbody>
</table>
Community-Based Programming

This narrative thread reflects outpatient adventure therapy services. Two participants from Denmark, Andrea and May, described their experience which included being in the outdoors, bonfires, and archery.

Wilderness-Based Therapeutic Boarding Schools

One participant, William, attended a wilderness-based therapeutic boarding school which included living in an outdoor setting, practicing outdoor survival schools, and attending school each day in a traditional setting.

<table>
<thead>
<tr>
<th>Resonant Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gooning</td>
<td>Gooning was a term used by wilderness therapy participants to describe their experience of secure transport services. This resonant thread also links back to demoralisation and the ingredients of traumatic events.</td>
</tr>
<tr>
<td>They’re Trying to Break Me</td>
<td>Participants described the approach of many wilderness therapy programs as further demoralising. This resonant thread relates to the concerns about demoralising wilderness therapy programming in the United States.</td>
</tr>
<tr>
<td>Similarities in Wilderness Therapy Programming</td>
<td>This resonant thread includes a discussion about the similarities of wilderness therapy programming in the United States. Participants tended to use similar terminology and language, despite attending many different programs, such as impact letters, gooning, and the use of similar phases.</td>
</tr>
<tr>
<td>Shared Experience Versus Forced Experience</td>
<td>This resonant thread presents the areas of tension between adventure therapy practitioners describing the need for a shared adventure therapy experience while participants provided descriptions of approaches aimed at eliciting compliance through rigid programming.</td>
</tr>
</tbody>
</table>
The Call to Adventure

This section begins with an exploration of how participants became engaged in their continuous-flow wilderness therapy programs. The narrative thread includes three subthreads which emerged from the program participant interviews: (1) “Education Consultants: She Never Met Me,” (2) “Secure Transport Services,” and (3) “Parent Deception: Almost Like a Summer Camp.” The findings for this narrative thread are illustrated in Figure 6 below.

Education Consultants: She Never Met Me

Tucker et al. (2018) described education consultants as one of the main referral sources for wilderness therapy programs in the United States. Education consultants provide private services to assist parents in finding an appropriate placement for their child, whether in a therapeutic program or school. This referral can be made without clinical assessment (Harper, 2017). Andy, Sophie, and Michelle all discussed the education consultant’s role in them “winding up” in wilderness therapy. Andy did not know his parents had hired an education consultant when he was in high school. After years of trialling different psychiatric medications and being “bored” in different therapists’ offices, Andy’s parents took a different step.

Andy, USA, Continuous-Flow Wilderness Therapy

My whole life for the next year and a half from this point was controlled by a woman who I never met. She was called an educational consultant. She was basically an agent for all these different programs out there. She never met me. She read reports from a psychologist that I saw when I was 8 to 12.
Figure 6: The Call to Adventure
Sophie, USA, Contained-Expedition

My parents had an educational consultant at the time. I went and saw her a couple times. I thought they were going to be placing me in a different high school or something like that. Not a therapeutic high school. Just another high school in the area for more alternative education. I guess they were also hooking up my parents with wilderness therapy, so I was not really approached with it at all.

Sophie was still seeing a psychiatrist but did not know if her psychiatrist knew about the wilderness therapy program her parents had enrolled her in. Looking back on it, she felt her parents “were kind of stalling because they paid $30,000 to send me to this wilderness program.” Andy’s and Sophie’s stories illustrate the role education consultants can play in having an adolescent unknowingly referred to therapeutic programs, a thread which emerged throughout my inquiry. Along with Harper’s (2017) concerns about the lack of clinical assessment prior to OBH participation, there can also be a lack of communication from practitioners already engaged in a therapeutic relationship with the out-of-home placement.

Though Sophie’s and Andy’s experiences demonstrate how education consultants can operate without meeting the adolescent, Michelle sat with her education consultant who presented different treatment options. She chose wilderness therapy, which she explains in the excerpt below.

Michelle, USA, Continuous-Flow Wilderness Therapy

I was given the option by my education consultant to either go to an inpatient treatment facility, a day treatment facility, go to a therapeutic boarding school or therapeutic wilderness program. I was given the option to choose and I picked. I’ve done day treatment before and so I was choosing between day treatment and
wilderness programs. I remember looking at brochures for wilderness programs and remember picking one in particular because it was co-ed honestly. The other one I was looking at was just women. I had been at a school since fourth grade and I was in 10th grade at that time that was just women. I was like, “I don’t want it, I don’t want to go to a therapeutic wilderness program with just women or girls.”

Barry in Australia had a similar experience to Michelle, though not with an education consultant. Barry met with a substitute school counsellor to discuss program possibilities.

*Barry, Australia, Contained Expedition*

This particular counsellor was a substitute that came in whilst our regular counsellor was off sick. Being an older bloke that definitely had a few miles under his belt, dealing with youth, his ability to read people was really good.

Sitting with the school counsellor, Barry looked through the pamphlet. That night, he went online to the organisation’s website, but that “wasn’t much help.” The program existed in rural Australia.

My mum ended up calling them and organising for me to go up there and have a look and have the introduction interview and go from there. Three days later, she dragged me out of bed and bundled me into the car and when I woke up, we were in the country and heading on up to an interview. I got to the property and was like, “Yes I can do this.” It all happened very fast. It was a little bit surreal. As soon as I got onto the property, I’m like, “Yeah, this is where I want to be.”
It is not common for adolescents to actively seek therapeutic interventions (Duncan et al., 2007). For those whose parents began working with education consultants, wheels may be in motion behind the scenes and even more so with the use of secure transport. With the important roles hope and expectancy play in therapeutic outcomes (Frank & Frank, 1991; Wampold & Imel, 2015), it is interesting to explore how decisions are made without the adolescent’s voice and whether this interferes with the quality of participation.

Although Barry’s mother took an active role to engage her son on the program, both the school counsellor and his mother had open conversations with Barry about the program. Barry felt it was his “ticket out” of his negative peer group and an opportunity to become more responsible. For Sophie, Andy, and others, decisions were made to engage them on a wilderness therapy program without their knowledge or consent. This involuntary placement is common practice in the United States (Tucker et al., 2018) and can occur without any prior clinical assessment, medical evaluation, or court order (Harper, 2017). In Demark, Andrea had a “friend” who “suggested” that she participate in the program, and May felt “forced” by her case worker. In Israel, Yosef’s mother sat him down and said, “This might be a good fit for you.” Brady, from Australia, was “nominated” by his “school to go on the program” after he was becoming more disengaged with his studies. In Canada, Jeanne described seeing an advertisement for her program on the wall of the hospital and “signed up not really thinking anything would happen.”

There are many ways young people are referred, and coerced, into therapy services. It is most common for the parents to seek external support, but professionals, such as education consultants, can be hired to help navigate the helping professions to find an appropriate service. At the extreme end, parents in the United States are able to hire secure transport services to forcibly escort their child to therapy. These experiences are represented below.
Secure Transport Services

Many private-pay adolescent programs in the United States provide involuntary treatment. To get the adolescent to the program, secure transport services are common in standard wilderness therapy practice. In their article exploring differences in outcomes for transported versus nontransported participants, Tucker et al. (2015) explained,

The transport process typically involves one or two transport staff taking custody of the adolescent and bringing them from home to a treatment program. If the adolescent physically resists, the transport staff may use physical force (i.e. therapeutic holds or physical restraints) to maintain the safety and completion of the transport. (p. 672)

The authors supported the use of secure transport services in their study, and another examining the outcomes six months post program (Tucker et al., 2018). Throughout my inquiry, I interviewed U.S. participants Olivia, Kelly, Sophie, Laura, Sarah, Thomas, Louis, and Oliver who experienced what they referred to as “getting gooned” or “being kidnapped.” Having worked at programs where this was common practice in the United States, I was aware of the term to be gooned or escorted to a program. In this practice, a participant is usually awoken in the early morning in their bedroom by two escorts who take them to the program organised by the participant’s parents. These experiences are represented below.

With her parents fretful about Olivia’s recent substance use and missed days of school, they found a wilderness therapy program combined with the option of a therapeutic boarding school. Her parents hired an escort service to meet Olivia in the early morning and drive her to the program.
Olivia, USA, Continuous-Flow Wilderness Therapy

I know some people; their parents actually took them to the program and other people
had escorts that picked them up to take them there. That’s what my parents did. I
guess, whoever told them about the program was like, “A lot of these kids don’t want
to go. If you don’t think that she’s going to go for it, we have this option.”

The people that kidnapped me didn’t even tell me who they were or where I
was going. They told my parents not to be in the house when they came in, because,
they ended up telling me after the fact, if the parents are there and they see a kid going
through this, you might have second thoughts and you just don’t want to be there.
Nobody was in my house and these people just essentially kidnapped me from my
house and I didn’t know if they were going to kill me or rape me. I didn’t know where
I was going, anything.

The way they sent me there, by kidnapping me, I’ve been diagnosed with
PTSD [posttraumatic stress disorder] from that. I still to this day have really bad panic
disorder and generalised anxiety disorder that stem from that incident from my life.
There’s a part of me that’s bitter about that. I hate to say this, but I feel as if the
overall experience has been just shadowed by the trauma of how I got sent there.
Because, I can look back at being there and have fond memories, but I have had so
much of a mental health issue from the way that I got sent there that has impacted the
last nine years of my life that it’s hard to look past that to see the good that came from
being there. I think that if my parents would have sent me there a different way that
my life would be, not completely different, but just my mind would be different. I
hate to say that, but it sucks.
Olivia’s experience of being “kidnapped” triggered a reaction of fear in her. She did not know where she was going, and her escorts did not divulge any future information, another common practice in wilderness therapy. Upon hearing about Olivia’s transport experience, I reviewed the U.S. based National Association of Social Workers’ (NASW; 2016) code of ethics, which stated that in “instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of which clients’ right to refuse service” (n.p.). Wilderness therapy is often provided by social workers in the United States and it is clear that the nature of the services were not presented to Olivia. In this instance, intentionally withholding future information is a clear breach of the NASW’s code of ethics.

Although a contract of parent involvement was required prior to enrolling their daughter into the program, Olivia’s parents were not involved in getting her to the program. Olivia drove with the two escorts for a few hours into a small town where she walked into an office and was greeted by two of the program’s field staff.

The excerpt I have chosen from Kelly’s narrative illustrates how far removed some young people be from their homes to attend wilderness therapy programs.

*Kelly, USA, Continuous-Flow Wilderness Therapy*

I was transported to the program, so I didn’t know I was going. I grew up in Hawaii, on the island of Maui, so I was transported from my bedroom in Hawaii to the Appalachian Mountains. I was sleeping and then all of a sudden, my light came on and there were two, not police officers, but almost looking like bodyguards, just very big men in my room.

They threw me a pair of my clothes, and I was screaming, I didn’t know what was going on, and they were like, “You need to put these on, you’re coming.” I was
very, very confused. At the time, I was intoxicated so I didn’t really think much of it, besides okay. I did it, and then I came out in the hallway and my parents were both there with my dog, and my mom just looked at me and was like, “You’re not happy here.”

I got in a car and got to the airport. I actually started screaming in the airport, and I was like, “These people are kidnapping me. I have no idea who these people are.” I genuinely didn’t, and I was confused. I had been to treatment centres before, but they were all just like mental hospitals, maybe two to three weeks, maybe a month, and I’d just always come back home. But I had never been transported. My parents always took me, when I went to my treatment the previous site in California, my mom was with me. I was 14, so I was very, very lost.

After my interview with Kelly, I wrote in my journal about what people in the airport must have thought about a young adolescent woman screaming through the terminal being transported by two men. While she had experience sitting on a therapist’s couch, being admitted to treatment centres, and getting hospitalised, being woken up in Hawaii and, without knowing, travelling more than 6,000 miles for more than 24 hours to the eastern side of mainland United States felt troubling.

Below, I have provided to excerpts from Thomas and Oliver who described the intimidating nature of the escorts, based on their size and potential military background.

*Thomas, USA, Continuous-Flow Wilderness Therapy*

Two people came to my house at five in the morning and took me. Well I had no idea where I was or what it was. I had not been told anything about it. When I left my home that morning, I remember my father saying to me, it is so vivid I remember the
names of the people. There was Paul and Kendra. I’ll never forget their names. And he said this is Paul and Kendra and they’re here to take you to a wilderness therapy program. And I had no idea what it was, that was meaningless to me.

Oliver, USA, Continuous-Flow Wilderness Therapy

Some guy comes in the middle of the night, wakes you up, takes you to the airport. Fly all the way out. He had that look like oh do not fuck with him, so I just went along with it all willingly with him because I know when I’m at a loss.

Andy said he “was gooned,” and Laura described getting “picked up in the middle of the night by some ex-marine people.” Like Olivia, Sarah’s escorts “didn’t tell us where we were going.” Lance and Louis also shared their experiences of being woken up by the escorts.

Sophie’s experience contrasts with the others in that she was not transported in the middle of the night. Instead, her parents asked her to prepare for a family holiday before the escorts arrived at her front door.

Sophie, USA, Contained Expeditions

I was lucky in that it was not in the middle of the night. My parents were saying, get ready for a trip around. I thought we were going to go up to Maine or something like that for summer. I had just gotten out of school. And then two people just walked in my front door and like, “You’re going to Utah this week.”

Of the 24 participants I interviewed from the United States, 11 were transported. Some wilderness therapy programs however, such as the one Katy attended, have installed some principles against the use of transporting young people to programs.
**Katy, USA, Continuous-Flow Wilderness Therapy**

I was given three days’ notice of when I was going to leave. Something that I later found out, which I really loved, is that this program doesn’t allow the kids to be escorted there. Escorting is when, you know, like the big guy and the fast guy come into your bedroom in the middle of the night and take you out of the house. That’s escorting, but my program didn’t allow kids to be escorted there. Now, their parents can lie to them to get them there, but they can’t be escorted. Me and my dad got on a plane on August the 23rd of 2012, and we landed and drove north to the program. By the end of the day, I was out in the middle of the woods.

While two outcome studies have explored the effects of transportation services in wilderness therapy (Tucker et al., 2015, 2018), my inquiry explored the lived experience of secure transport. The studies found no difference in quantitative outcomes whether or not an adolescent is transported, but there is certainly a difference in results of experiencing a potentially traumatic experience. Though I have worked for programs that used secure transport, I now find the use of secure transport services irreconcilable. This is not because of quantitative outcomes, but because it can traumatise young people, disturb their wellbeing in the future, and leave them feeling more demoralised than before. This discussion about secure transport, will be linked with parent deception and issues relating to involuntary treatment in wilderness therapy in the resonant threads of this Chapter.

**Parent Deception: Almost Like a Summer Camp**

Not all participants in the United States were transported to the programs. Of those that were not, the thread of “Parent Deception” emerged during my analysis. An illustration
for this thread is provided in Figure 6 (p. 154). Frank, Tony, Michael, Angela, and Craig reported they, and at times their parents, did not know what they were getting into.

*Frank, USA, Continuous-Flow Wilderness Therapy*

When we left South Carolina, my mum told me that we were going to go tour a boarding school because she was going to send me to a boarding school. She didn’t tell me that after we toured that boarding school that we were going out to Colorado and that I was going to this thing, and so I got there and it kind of just like, “What the fuck?” But then I was also like, “Okay whatever, as long as I’m getting away from you, I don’t care.” I was young, like I said. I was 12 when I got sent there.

The two people who picked me up were really nice. They were older, I don’t really remember a lot about them. They offered to take me to get food but it’s one of those times where you’re too freaked out to eat really.

After Tony refused to go to therapy, his parents talked to him about wilderness therapy and convinced him to attend over the summer. Tony’s excerpt also shows how the word “gooned” is used across wilderness therapy programs in the United States.

*Tony, USA, Continuous-Flow Wilderness Therapy*

Honestly, they lied to me. They told me it was summer camp. I didn’t get gooned, I actually went willingly. I was told it was six weeks and then I’d be at home and ready to start my senior year of high school.
After running away from a residential program, Michael’s mother hired a private investigator to find him. While on the phone, his mother convinced him to go to a wilderness therapy program by telling him the program would last 28 days.

*Michael, USA, Continuous-Flow Wilderness Therapy*

And my mom goes, “You go there for one month, and I will come and get you and take you home.” And I go, “Okay.” I agreed willingly. And after one month came. This is the thing, I agreed with my mother and with the owner of this place. He was the owner and he also was the therapist. I agreed with both of them in a room that I would be there for one month. I was forced to, in a weird way. I mean I chose to, but I was forced. So, I get sent two and a half hours into the desert and after one month comes, my mom stops writing me, I stop hearing from her, and I was there for three and a half months.

Like Michael, Louis was told by his parents that he “can do anything for a month.” Emma also believed her program was only “30 days.” Louis remained in wilderness therapy for seven months and Emma for four.

Parents of Angela, Craig, and Nancy withheld information about the program to convince them to attend willingly. Angela, who had a negative-influencing peer group and disliked going to school, agreed to attend after her mother told her about some of the activities she would be engaging in. Craig was the only participant who drove himself to the program. Upon arriving, Craig soon realised his parents had not divulged what the program actually entailed.
Angela, USA, Continuous-Flow Wilderness Therapy

They told me they found a camp where I could ride horses and go fishing and I could do all this outdoor stuff that I loved to do. I’d be gone for a month in utopia. My only question was, “Do I need to go to school?” No. So I’m there.

Craig, USA, Continuous-Flow Wilderness Therapy

I had no idea what was in store for me really. It’s not necessarily what they said to me, but more what they didn’t tell me. I’m not sure even they knew the extent of the program and what it would entail for me. What they did say was that it was a therapeutic camp, that it was a new experience for me, and that it would be interesting for me. And it was. I thought it was going to be more of a summer camp experience. But the therapy aspect was definitely downplayed in my conversations with my parents.

Nancy, USA, Continuous-Flow Wilderness Therapy

I was expecting a wilderness retreat, so to speak. Almost like a summer camp where you talk about your feelings and you do yoga, stuff like that. That’s what I was expecting, which is not what it was at all.

Connor, who was caught with marijuana, described himself as a “willing participant but under a bit of false pretences.” William voluntarily engaged in his wilderness-based therapeutic boarding school as he preferred “camping instead of sitting in a classroom.”

Ethical discussions of adventure therapy and involuntary placement are limited throughout the literature (Becker, 2010; Harper, 2017; Mitten, 1994). Becker (2010) explored issues of consent when adolescents are coerced into wilderness therapy programs, raising
questions about how the needs of the adolescent can be addressed when they have no legal grounds to leave the program or deny treatment, and also about what happens when a young person is involuntarily placed into a program by parents who pay for the treatment and these parents are also the abuser of the child. Ethical considerations such as these are presented further in the discussion of this chapter. The first type of adventure therapy program I describe are continuous-flow wilderness therapy, also known as OBH in the United States.

**Continuous-Flow Wilderness Therapy Programs**

This section describes the experiences of those who engaged in continuous-flow wilderness therapy programs (See Figure 7), which are typically longer in length with clients coming and going from the group as they graduate (Russell, Hendee, & Phillips-Miller, 2000). While the term ‘graduate’ might seem odd for practitioners, this is a term commonly used in wilderness therapy programs. These programs are synonymous with OBH in the literature (DeMille et al., 2018; Gass et al., 2019). As the previous narrative thread explored how participants arrived to their adventure therapy program, this section compares and contrasts participant experiences during their adventure therapy experiences.
Figure 7: Continuous-Flow Wilderness Therapy Programs
Strip Search

Although some were transported to their wilderness therapy program and others agreed to attend voluntarily, after insistence from parents, participants on continuous-flow programs in the United States were strip searched upon arriving. After the strip search, participants were outfitted with new clothes, which commonly consisted of a pair of blue thermals, brown pants, boots, wool socks, a rain jacket, a sun hat, and a beanie. During my participant observation of a continuous-flow wilderness therapy program, I noticed that despite wearing the same clothes, participants attempted to individualise themselves. Participants wore their blue thermals mostly, and some rolled up their sleeves. Some wore the bandana they were issued in different styles, and others preferred to wear the beanie instead of the sun hat. Emma, Craig, Laura, Michelle, and Michael described their experiences of arriving at their programs, being searched, and issued clothing and equipment by the program.

*Emma, USA, Continuous-Flow Wilderness Therapy*

We got to kind of this little town and we went into this medical clinic and they started doing a bunch of tests on us, making us do jumping jacks, breathing tests, making us answer anything medical. They tested our urine, our blood. And then, after that, they put me and [another participant named] Heath in a van and we drove about another 40 minutes through this dirt road into what I came to know as base. It was kind of this big warehouse in the middle of nowhere. So, when we got into base, they separated Heath and I, and I told Heath, “Oh, see you in 30 days,” because that’s how long I thought I was going to be in there.

I went into this room, and then this lady came up to me and she gave me this set of clothes and it was this red long-sleeved shirt and green cargo pants, this kind of
granny panty underwear, and a sports bra, and told me, “If you would please strip and change into these.” And I was like, “Oh, wow.”

I did as I was told, and I remember they told me no jewellery, no nothing because I was wearing big hoop earrings and a bracelet and a watch, and they told me so none of that. But on my ring finger, I have my grandmother’s ring. She gave it to me when I was 14, so I didn’t want to give that up. I remember I put it in the bottom of my tongue when they were coming to search me, so I could keep my ring with me. After that, they put all my things in a bag, including my iPhone. They put it in a locker, and without answering any of my questions, they loaded me in a van again and they drove me out into this desert again.

The staff put Emma’s iPhone and the rest of her belongings in a bag and into a locker. The staff refrained from “answering any of” her questions and “loaded” her into a van. After a half hour’s drive, Emma was in the desert.

*Lance, USA, Continuous-Flow Wilderness Therapy*

So, upon arrival I was put into a very small room and told to strip out of my normal clothes. Completely naked. Then I was given my supplies. I had two sets of clothing and a backpack. A couple bags of clothes. That was really intense for me. At that kind of point I knew, “Hey, this is not a normal camp. This is not really what I signed up for.” I was too anxious at that point.

*Laura, USA, Continuous-Flow Wilderness Therapy*

So, we were led down to this basement and we were strip searched. We gave them all of our stuff and yeah; we were strip searched. We had to literally squat and cough like
we were in prison, or something like that. We were given all of our clothing and then we piled into a van. They didn’t tell us where we were going or anything like that. That was one of the rules in the program. No future talk or no future speak basically. You can’t ask what you’re doing in the future, you just have to focus on what you’re doing presently in the now. I remember feeling like this is insanity.

These continuous-flow programs took away individuality, self-determination, and freedom of expression. This was a practice I was accustomed to, having worked at multiple wilderness therapy programs in the United States. Craig and Michelle described the demoralising effects of this practice.

*Craig, USA, Continuous-Flow Wilderness Therapy*

They literally stripped me of my individuality. Same clothes as everybody else, same pack as everybody else. Same everything. I get that shirt-buying in bulk might be more economical, but I think retaining that individuality is very important. Maybe give everybody a shirt or a pair of pants that’s a little bit different or a nametag or something like that.

I was just being reduced to what is essentially a number. Mine was number 7. I had a number that we had to call during roll call and if we were ever out of sight, we had to loudly count our number so that they could keep tabs on us. There was no trust at all placed in the campers at any point. They were always ready for us to escape, and they made a point of telling us right off the bat, “Look, if you run, this is what you’re wearing, this is what you look like, you will be caught, you will be brought back.” So, it was very much, in my mind, like a prison induction. That really took any aspect of individuality or freedom away from it.
Michelle, USA, Continuous-Flow Wilderness Therapy

I think it was like in a motel where my parents dropped me off and I was taken into a room and took my clothes off and was given the new army surplus gear and had all my stuff taken away from me. I very vividly remember all of my self-identifying teenage pieces, my earrings and my bracelets and my watch and everything went into Ziploc bags and was taken away. I remember feeling so metaphorically naked of all these pieces of my identity and I felt that they were trying to break me. Then it was reinforced by the “You’re not allowed to talk to each other for a week.” I was like, “Oh, you’re trying to break me.” Then I was like, “No, no, no, no. You won’t break me.”

After the participants were outfitted with their gear, they were driven to the “woods,” which is called “the field,” as I mentioned in Chapter 1. Thomas’s and Angela’s program provided a unique perspective in that all members of the new group were admitted to the program together. After each member of the group was individually searched and outfitted with new gear, they were loaded into a van, blindfolded, and driven to the field.

To provide a contrasting experience, Logan, a psychodynamic practitioner, stressed the importance of addressing power dynamics in adventure therapy settings. While Logan was completing a work placement for his psychology degree, he spent a summer on an island working with groups of young offenders. Logan described his program as “off the grid,” and every piece of equipment or gear had to be wheelbarrowed nearly “two miles from the nearest road.” The premise of the program was to provide an alternative to incarceration where young offenders could “experience the outdoors together.”
Logan, Psychologist, Wilderness Therapy

When they arrived, they got off their minibus, they were un-handcuffed from their minibus. We met them at the top of the track, and we put all our stuff in the wheelbarrows. We wheelbarrowed it down. Just after lunch, we arrived. They had some soup and bread for lunch. In the afternoon we were going to go kayaking in the little bay we were in, so we got into wet suits and they just went in the sea. They didn’t want to get in the boats. They just wanted to feel the water. They just jumped straight in the water. They just wanted to feel that, I think.

Logan felt this “helped to get the program started off on the right foot.” He argued that program participants should be allowed to interact freely with nature, even when they arrive under involuntary circumstances. He mentioned this balancing of power in relationships was an important aspect of adventure therapy practice. Shared experience and experiences of democracy and collaboration are explored throughout Chapter 7.

Logan’s first day with young offenders began with an invitation to participate instead of a strip search. This is in contrast to others, such as Connor, who described the strip search was when everything “set in.” Similarly, Frank thought to himself, “Holy shit. This is crazy.” After the initial strip searches and being outfitted with the same clothing, participants were driven to the field to meet their respective groups where the initial phases of the program began.

Conducting participant observation in four U.S. wilderness therapy programs, Russell’s (1999) doctoral dissertation still provides the most in-depth examination programming in the U.S. context, describing that the wilderness therapy process is guided by three distinct phases. First, there is an initial cleansing phase, followed by a social responsibility phase, and finally a transition or aftercare phase. Many of the programs used
Native American folklore or themes from nature to name these phases. For example, one program named phases Rabbitstick Walking Phase or Badgerstone Phase, while another used Coyote, Buffalo, or Eagle Phase. It is, again, worth linking to Skidmore’s (2017) argument about stealing wisdom and cultural appropriation, which she explained some Native Americans having described as “like stealing the ‘skin off our backs’” (para. 27).

These phases emerged from the participant interviews, as well as through my experience of observing a participant advancing to a subsequent phase of a continuous-flow wilderness therapy program, where we burn sage and students read stories about Native Americans. Below, I use Russell’s (2001) outline of the phases throughout to represent the experiences of adolescents on continuous-flow wilderness therapy programs.

**Cleansing Phase**

Russell, Hendee, and Phillips-Miller (2000) described this cleansing phase as beginning typically with:

… minimal but healthy diet, intense physical exercise, and the teaching of basic survival and self-care skills. The client is also removed from intense cultural stimuli, such as dress, music, and food. The treatment team steps back and lets natural consequences teach basic lessons of wilderness living. The cleansing process prepares the client for more in-depth work. (p. 212)

As participants were driven out to the field to join a group, they were instructed to remain in their shelter area and not interact with the participants. Below, one program’s cleansing Mouse phase is described.

New clients are brought to existing groups and given a limited amount of grain and rice and told that they are allowed only to observe the group, not to participate in any
way. It is a phase for introspection and reflection about why they are there, and a chance to cleanse the body and mind from drugs and/or alcohol . . . Some clients will remain in *Mouse* phase for weeks, staff patiently waiting for them to realize that it will be much easier on them if they complete the necessary tasks for transition. (p. 104, emphasis in original)

My inquiry provided a unique perspective of these phases as participants provided in-depth recounts of their wilderness therapy experiences to learn about what helped or hindered progress in specific cases. Interestingly, many participants detailed cleansing phases similar to the description above. While shorter in length and represented later in this chapter, Barry’s and Brady’s experiences on contained expeditions in Australia and my observations in Norway were not guided by phases but were seamless and less rigid. Phases might not be necessary for contained expeditions as program length is provided to the participant prior to their participation. Continuous-flow programs use phases as behavioural targets to process participants through the program. Below are excerpts from Emma and Craig about the initial cleansing phases.

*Emma, USA, Continuous-Flow Wilderness Therapy*

Wolf stage is usually the stage most people are in which is solitary stage. You have to eat alone outside of the camp site, and all that. To graduate that stage, you had to make fire using metal and a spark rock. They tell you how to gather the bark, or whatever, and then spark the fire and use cloth.
Craig, USA, Continuous-Flow Wilderness Therapy

So, the beginning level is called Individual stage. This basically entails that you’re not allowed to talk to the other group members, unless you’re being very closely observed by the counsellors that are with you. There were two to three staff with us while we were hiking so Individual stage starts out and you’re generally sitting in what’s called med spots, or meditation spots. They are the spaces to keep us from one another.

Angela and Thomas’s program was most unique in structure, while still resembling the rolling admissions like most continuous-flow wilderness therapy programs. The participants spent one month in the field, which was structured similarly to the other programs, and then spent a month in a base-camp setting where they continued practising primitive living skills—living in tepees and yurts, for example. After the month, this particular program offered participants a placement at their own therapeutic boarding school. Participants remained in the rural “boarding school” environment until their therapist approved their graduation. Still, during their first two weeks in the field, Angela and Thomas remained at their own campsite, away from the other participants. Hiking each day was done in silence, and they only spoke to the other participants during nightly group sessions around the fire. I experienced participants on a cleansing phase during my visit to a U.S. wilderness therapy program in November 2017. None of the participants I interviewed attended this program. Below is an excerpt taken from my journal.

United States Participant Observation

I arrived at the program’s base camp in the morning and waited with the program’s logistics manager before being driven a little more than an hour to meet the young adult group I would be staying with for the week. The clinical director of the program
preferred me to join the mix-gendered group of 18- to 22-year-olds due to their recent progress and for issues relating to consent. As the manager of the field guides, Brandon, arrived, we loaded into his pickup truck and started our drive to the field.

We arrived at the group’s scheduled camping spot before they did so we waited. After about two hours of exploring some of the ruins, finding a tarantula, and discussing the program’s philosophy for helping young people, we heard the group climbing down into the valley. We met the group. The participants knew Brandon since he facilitated a Native American sweat lodge ceremony for them the week prior. They joked with each other for a few minutes before we finished the final five minutes of the walk and arrived to an already established campsite. Brandon got in his truck and left the group.

The participants dropped their bags and the head field instructor, Suzanne, decided for us to circle up around the established fire pit to have a group session. Suzanne acknowledged that someone had camped in this spot recently and left cigarette butts and some broken glass. We talked about if particular participants felt triggered and what they could do if urges to self-harm or smoke one of the cigarettes came up. After this discussion, I introduced myself to the participants and the purpose of my research. They all seemed okay with it and not very interested in my presence. Not in a negative way, but that they were interested in getting on with their day and accustomed to people coming and going from the field.

Participants in different phases have different responsibilities. This program’s phases follow the four directions of the compass rose. Participants begin in a Gateway phase, which allows them time to reflect, complete assignments in their workbook, and begin to learn new skills. During this time, they do not interact with other members of the group. This phase lasts just a few days before a participant enters the
South phase. Graduating from the South involves completing a list of tasks, such as bow drilling a certain number of coals, completing specific journal assignments, writing letters to family, and some initiatives outlined by their therapist in an Individualised Growth Plan.

Although I arrived in late morning before lunch, the participants spent the rest of the day working on tasks. Some were bow drilling, others working on letters back home, and one participant was given an assignment, called The Mask of Solitude. Still in the South Phase, this participant was assigned by her therapist to spend time away from the group simply reflecting on her current situation. I was told this intervention is used regularly with participants that are distracting themselves from the reason they were sent to the program.

On the morning of Day 2, one of the male participants was ready to move from the South phase to the West. The participant was instructed by Michelle to build a medicine wheel out of rocks. This was a circle of tennis ball sized rocks with an X or a cross across it to symbolise the four directions. The participant advancing to the West walked away from the campsite and collected sage to make a smudge stick. He burnt the sage and smudged all the members of the group as we entered silently. The participant was asked to identify three things he did not care about that were not worthy of leaving in the medicine wheel and three things that are beautiful that he liked about himself. Everyone in the group provided the participant with an affirmation and the participant was instructed to remain in the circle until he felt ready to close the space. He sat there for what seemed like half an hour on his own and then returned to the group.
Many programs have different rituals for advancing participants in their phases. Most included mastering hard skills, which can be thought of as technical skills like fire making, self-care practices, and navigating, and soft skills, which are the more emotional skills such as working to advocate for oneself or spending time in reflection. Some programs provide workbooks, which were called *journeys* or the *curriculum*. Katy, for instance, was issued one book “for daily journaling and writing, and then another workbook where we would check off the different skills that we were learning that were contingent on advancing to the next phase.”

These initial phases held an individual focus. While participants, besides Angela and Thomas, joined an already-established group, they were not to interact with other participants until the staff felt they were ready and within earshot. The participants contributed in group sessions each night and had a therapist who visited them in the field each week. For some of the programs, receiving an *impact letter* from their parents initiated their transition from the cleansing phase to a social responsibility phase. The following section includes the experiences of receiving these letters from home.

**Impact Letter**

The impact letter was a common thread throughout the participant stories in U.S. programs, though letter writing was not a component of participant experiences on contained expeditions and in community-based adventure therapy practice outside the United States. According to Tucker et al. (2016), impact letters are used for describing how the parent’s life has been affected by the child’s behaviour, writing in direct frank language, but avoiding hostility and blaming. Family therapists may teach parents to repackage the message in a way that it is easier for their child to listen and
understand their experience . . . The child then reads the letter to his or her peers around a campfire at night. (pp. 35–36)

Katy, Andy, Connor, Nancy, and Craig shared their experiences of receiving impact letters during the first few weeks of their programs. As above, Nancy described having to “read this letter in front of the group.” Katy was in a unique situation, as the other two female participants in her small group had graduated. She remained alone with two field staff.

*Katy, USA, Continuous-Flow Wilderness Therapy*

There were letters written to my parents as part of the therapeutic process. There was one point towards the beginning, where your family members write a letter. It’s called the letter of impact; talking about what it was like to be your mom and dad with you doing all of these things. My dad’s letter reduced me to tears. I found out there were multiple nights where my dad didn’t want to come home because he knew that me and my mom would be arguing, or I’d be doing something crazy. There were nights where he would intentionally stay late at work, so he wouldn’t have to deal with it. My sisters were afraid of me. It was really tough. I think hearing my youngest sister, who was 10 at the time, telling me that she was scared of me and scared for me, that did it.

*Andy, USA, Continuous-Flow Wilderness Therapy*

Andy’s program was in the Appalachian Mountains in the United States. On Day 7, he received his first impact letter from his parents.
I communicated with my parents through letters, and one of the first things they do is, they have what’s called an impact letter, which is what your parents send you. That was basically a, “This is where you are. No, we’re not going pull you out. This is why you’re here. Learn to accept it” type of thing. It was basically one of those hard to read letters that I actually think I still have.

The impact letter was well named for Andy and Katy. It challenged them to reflect and take responsibility for their actions by exploring how their behaviours had affected their family members.

For Craig, the impact letter had a demoralising and humiliating effect. Craig did not relate to the other participants in his wilderness therapy program. He “did not have a drug problem” or difficulties at school. But when his parents opened his laptop to find “a lot of homosexual porn” and discovered he was talking and meeting up with older men, they found a wilderness therapy program for him.

_Craig, USA, Continuous-Flow Wilderness Therapy_

So, I get a letter from my parents, talking about all of the porn and all of the people I’d been talking to online. And then I was made to read that letter in front of the entire group. So, that was kind of a setback for me and I had quite a cry that day. I forget exactly what was in mine, but the addiction to masturbation was definitely a part of it and that was a little bit, obviously, embarrassing for me.

In a single-sex group of males, Craig was uncomfortable laying out all of his history in front of them. He was embarrassed and hurt. His consent was not sought prior to reading the letter. This raises important questions about gauging a participant’s readiness to receive a letter with
potential to elicit feelings of shame. Also, Craig was not provided with a choice or opportunity for consent to share his intimate details with the group. Although the participants reported different experiences of receiving their impact letter, like Connor whose parents’ letter “suggested they didn’t know who I was,” the theory behind such a practice, especially given the lack of informed consent, is worth questioning.

One of the core components of these wilderness therapy programs was preparing participants to acknowledge the issues motivating parents to send their child away. In his dissertation, Russell (1999) described one program’s cleansing phase involved creating an “inventory of destructive factors” (p. 104) to illustrate why the participants needed to be there. The intent of such therapeutic rituals is to provide a therapeutic focus for the program, which are inherently problem focused. As participants advance through their wilderness therapy experience, they graduate to a social responsibility phase. Here, they are given more responsibilities to work as a group, such as collecting firewood, cooking for the other participants, and navigating using a map and compass. The following section explores the threads linking participants’ experiences with these phases.

Social Responsibility Phase

The social responsibility phase represents the core of most U.S. wilderness therapy programs. It is usually the phase in which participants spend the most amount of time. For different participants, the social responsibility phase had different names. Again, some referred to nature’s elements such as Water or Wolf, while another was simply called Community phase. Russell (1999) explained the social responsibility phase, describing natural consequences and peer interaction are strong therapeutic influences, helping clients to learn and accept personal and social responsibility. Self-care and personal responsibility are facilitated by natural consequences in wilderness, not by authority
figures, whom troubled adolescents are prone to resist. If it rains and they choose not to set up a tarp or put on rain gear, clients get wet, and there is no one to blame but themselves. (p. 14)

Although the U.S. continuous-flow programs began with a cleansing phase, this social responsibility phase resembled most of the participants’ experiences from outside the United States; however, the U.S. programs had rules enforced by authority figures, such as not talking to other participants when instructors were not present, receiving no future information, calling your name while away from camp or going to the toilet, and not eating a hot lunch if a certain number of tasks were not completed. Resonating for me throughout the interpretation of these narratives was how little appears to have changed in U.S. wilderness therapy programming. Similarly, psychologist Matthew described after reading Ferguson's (2000) wilderness therapy book *Shouting at the Sky* that, “so much is the same.” This is a resonant thread that is discussed in this Chapter. Below, is an excerpt from Yosef who attended a wilderness therapy program in Israel.

**Yosef, Israel, Continuous-Flow Wilderness Therapy**

Yosef from Israel attended a wilderness therapy program that occurred throughout each year. Participants could attend for varying lengths of time. Yosef was an “awkward child.” His mother was worried about his weight and searched for programs to improve his self-esteem and help him to improve his social skills. She found “an advertisement” for the program and thought it would be a “good fit.” Yosef met with the director and joined 10 other participants at a base camp. In contrast to continuous-flow programs in the United States, Yosef’s group lived at a base camp while different expeditions occurred in a
mountainous area nearby. Yosef’s first expedition out of base camp was a three-night hike. Below, Yosef outlines the day-to-day structure of the program.

We would hike, usually, about two to three hours in the morning. Our general goal was about six to seven miles a day, some of it a little bit tougher terrain, some of it more challenging, but it was a lot of mountains, up and down. Often, we had at least two ascents a day, all over 500 metres, within the range. You were going up 500 metres, down 500, back up 500, and usually we did about one to two mountains a day within the range. And some days were a little bit longer, again based upon where we needed to stop. We would do lunch somewhere in the middle of the trail. We tried to end our days early to let people just relax at the end of the day. We were usually done about three to four hours before sunset. That just really gave people time to get into camp, make dinner, relax, have fun. And then, usually by the time sundown came, everybody was passed out.

In observance of the Jewish Sabbath, Friday was always a short day of hiking, and Saturday was, we were just camped out for the entire day.

Yosef did not go into more detail on how Jewish teachings influenced programming. The similarities to programs in the United States were the hiking to a new camp each day and learning survival skills, like making friction fires by using a bow drill. The relatively new program grew each year, and Yosef returned as a participant and then later as an assistant expedition leader. Yosef’s expedition leader focused on helping Yosef to believe he could accomplish the daily hikes. The rest of the time, the group focused on having fun and learning new skills in the outdoor environment. Yosef did not share specific rules for appropriate behaviour, and the program was not based on phases. This was in contrast to
continuous-flow programs based in the U.S., and which had strict rules that pertained to all participants, even those graduating in two days’ time. Below is an excerpt from my journal where I discuss these rules, such as “name bouncing.” This passage is from Day 3 of my time during the program. We had remained at the same established campsite for the previous two nights and were preparing to return to base camp where the participants were going to meet with their therapist.

United States Participant Observation

The participants have spent the day in different spots. We enjoyed breakfast together and laughed a bit. To help participants check off some of the hard skills they need to achieve, we walked a few hundred metres from camp to collect sage for their bow drills. When two or three participants are out of earshot from the wilderness instructors, they are told to Name Bounce. This means one participant calls their name out loud and then the other. For example, one participant would shout “Steve” while the next would yell “John” a few seconds later. When participants were washing their hands before breakfast, they were reminded to name bounce when the staff were away from the water. Participants also called their name whenever they were going to the toilet out of sight from the staff.

Despite literature describing natural consequences as providing much of the learning in adventure therapy practice (Gass et al., 2012; Russell, 2001), authority figures still delivered consequences to set firm boundaries for the participants. For example, participants who did not successfully bow drill a fire were not awarded hot lunch, which was most commonly an untoasted pita with long life cheese. This created a hierarchy amongst participants. I was trained in my social work degrees, at both undergraduate and postgraduate levels, to do as
much as possible to avoid anti-oppressive practice and to reduce power differences as much as possible. I was also taught while working at an Alaskan wilderness therapy program to never use food, or any other human right, as motivation. Still, some of the program participants responded positively to the social responsibility and being held accountable to follow the rules. Louis, for example, described the impact responsibility had on his experience as something he had “never really done before.” This is explored further in Chapter 8 when discussing factors unique to the outdoor adventure therapy settings.

Louis, USA, Continuous-Flow Wilderness Therapy

I was stripped down of everything that I’ve been so used to. I’m trying to think in a therapeutic sense. I have just the bare essentials. I have a metal fire starter, like a flint and rock starter, and I have to make my own fire and cook my own food, which I’ve never really done before. In terms of I guess a therapeutic sense, it seems just bare essentials.

Practitioners Evan and Mary perceived personal and social responsibility as being important to effective adventure therapy. For example, Evan, a counsellor employed by a nonprofit wilderness therapy program using experiential learning ideas to inform his work, discussed how a novel environment can work with adolescents.

Evan, Counsellor, Wilderness Therapy

Like I said, it’s an environment that challenges people in ways they’re never ready for. You could try to predict the weather. You could try to predict if I go to school, this is what’s going to happen, but at the end of the day, you know there’s going to be
rain. You know that there’s going to be a storm, and it’s just a matter of when, so why not be ready.

Like Evan, Mary, who is recently employed at a continuous-flow wilderness therapy program for adolescent women, specified how social responsibility can empower young people.

Mary, Social Worker, Wilderness Therapy

I think that it provides that sense of empowerment for kids, too. Where maybe they’re not doing it the first day, but maybe a week or two down the line, that kid is able to say, “Okay, we’re here on the map, this is how we calculate mileage, we’re this far from camp.” So, there’s that greater sense of empowerment based on the skills that we’re offering. And I think that’s ultimately what we want is for people to gain a new sense of themselves and a new sense of their confidences in the way that they access the world around them. And it’s very identifiable and straightforward in a wilderness setting.

Incorporating neuroscience into her work, Mary believed the phrase, “when they’re firing, they’re wiring.” This is a common concept in neuroplasticity and neurobiology research where new neuropathways are developed through new experiences. The more an experience is repeated, the more likely it is for the same neurons to fire. While this approach makes sense to adventure therapy, the repetitive nature of the practice requires critique, as most of the responsibility is being enforced by the participants. Consequences are hardly ‘natural’ when field staff enforce who can eat a hot lunch or not. In this case, I notice a disconnect between literature and practice.
To advance in the initial cleansing phase, many participants had a list of items they needed to check off each day to graduate the program. This included writing letters to family, completing daily journal assignments, setting traps like the Paiute Deadfall or Figure Four, which were commonly-used among Native American cultures, mastering the ability to bow drill a fire, or learning to navigate with a map and compass. David, who referred to himself as “an experiential therapist,” shared the story of a participant diagnosed with ASD. After the first few days of a wilderness therapy program, the young man broke down into tears feeling “proud of my accomplishments.” He was particularly impressed with his ability to set up a shelter and cook for himself. Program participant Tony, on the other hand, struggled to master the hard skills and described why he never advanced to the ultimate phase of the program.

Tony, USA, Continuous-Flow Wilderness Therapy

The only reason why I never made Water phase is because I was shit at the hard skills. I couldn’t bow drill to save my life, so I never made Water. And still to this day, I don’t mind not making Water. Like that never made any difference to me even slightly. But it’s like really shitty teaching to hold somebody back in their progress. They actually believed this shit.

The funniest thing to me is that my wilderness program was considered not a very hard-skills-oriented program. I know a bunch of people who went to this other program and they were like “All we did was bust embers. It was all hard skills.” I was just like okay, so what’s the point? Send me to summer camp.

This section has explored the participants’ experience of social responsibility phases in continuous-flow wilderness therapy programs. The narrative threads have demonstrated that
though holding participants accountable can help some to take responsibility for their actions, others can feel that their individuality and self-determination is at risk. While the participants were in the field, therapists worked with parents throughout each week and this work has been discussed in the OBH literature (Bettmann et al., 2013). The following section explores how parents and families were involved in the wilderness therapy programming.

**Family Involvement**

Wilderness therapy programs are promoted to incorporate family involvement as a key component to the service. Harper (2005) surveyed 10 wilderness therapy programs accredited by the OBH Research Council to assess the types of family involvement in wilderness therapy programming:

Results indicated that (a) most programs expressed mandatory parental involvement, (b) programs assess and include family goals in treatment, (c) most describe utilizing a counseling/supportive and psycho-educational approach with families, (d) remote family contact ranged from ten hours each week (40%) to thirty hours each week (60%) and (e) 90% utilize letter writing, therapist-parent phone calls and direct family participation in certain program elements (generally at client admission and discharge). Additionally, (f) family inclusion in programming includes some combination of conjoint, separate or multi-family format, (g) programs collaborate with parents in planning aftercare and the post-treatment transition, and (h) that follow-up efforts with clients and families ranged from no contact (30%) to periodic contact for more than six months (30%). (pp. 24–25)

Many programs had parents visit the group to engage in family therapy work. Angela and Thomas’s program held intensive family therapy workshops monthly during their minimum
three-month stay. Angela was struggling and would tell the field staff every day that her mother was going to come and get her during her first month in the program. Her therapist told her she was not going home, and she remembered “just shutting down completely.” She told them “it sucks out here” and that she would kill herself. The field staff put Angela on “suicide watch.” When the first family program came around after 28 days spent in the outdoors, she knew this was her “time to get out.”

Angela, USA, Continuous-Flow Wilderness Therapy

I tried to tell my parents when they visited, and the therapist pulled us aside. All the kids’ parents were there. I tried to say I was fixed. But I wasn’t. I was still lying to my therapist and she saw right through it. She sent me back to a new group in the woods. I had to not lie and start a fire every day for a week. I remember feeling defeated. I was like, “I’m never going to see my parents again.” I earned my way back to my group. It took me a week.

Angela was struggling in the woods. She was kept on “runaway and suicide watch,” which meant she remained within “arm’s reach” of a staff member at all times. Being sent back to start the program over again and earn her place back in her group left her feeling defeated. During the parent program, her parents were adamant she remained in the program. Thomas also “struggled in the wilderness.” He was not adjusting, and he believed his parents were “deceived” in not knowing where they sent him. Like Angela, when he struggled, he was removed from his group and started the program over again when a new group came. After now a month and a half in the field, he was excited to see his parents but disappointed his program had kept the letters from him.
Parent program was fine. I was never angry at my parents for sending me there. From the start, I was never angry. A lot of kids were. I was just sad that things had reached that point. I was very happy to see them and not be angry. But I found out at the parent program, that during the wilderness phase, that we were allowed to write letters to our parents. And during the parent program I asked my parents, you know, did you receive my letters? They said no. So, I found out they were never sent. That was another element of distrust. Being told that you can write to your parents and that went nowhere. It turns out, they were writing me letters, along with other family members, weekly. Those letters were being received and kept at the administrative office and they were given to me in a stack when I got to the therapeutic boarding school. So, not given to me when they were received and that was very upsetting.

Despite Angela and Thomas having unique family involvement, the majority of family programs took place as participants graduated from their programs. For Thomas, the “element of distrust” impacted his belief in the program. Real relationships and importance of transparency are explored in Chapter 7, unpacking the therapeutic relationship.

For Connor, the family program at his graduation came as a surprise. Because he had received “no future information” for the duration of his program, he recalled being startled when it was his time to graduate. Connor knew his food rations were resupplied each Wednesday, and if a participant was graduating, they were going to be picked up then to go to a family program.
These dudes would come and if you’re graduating, they would get you right there and you basically have time to pack up your stuff and then you go. There wasn’t a goodbye process with the group. No preparation. No planning. It’s you go. And that was on a Wednesday and then the actually leaving of the program I think was on Sunday.

So, parents spent one night there, on the Saturday night. The other days it’s just us and the instructors. I guess kind of a buffer period between being re-introduced to parents, which was the talk through some “Hey, what are you going to do after this? What’s going to be tough for you?” Just stuff like that.

That was a very interesting experience for sure. I was mad. I was real mad to see them because I still have that over their head of like, “You sent me here.” I don’t know what would have been a better alternative, but it almost made me more upset that they were only halfway immersed in the experience. I spent the past 60 or whatever days in a tarp and we were in these shed things. I never had a tent or anything like that. We cooked together, and we had a little stove and boiled our lentils. How modern. It bothered me so much that what we were doing there was only a taste of it.

My parents still tried to play the “Okay, we kind of experienced this, it must have been a really tough time.” Which again made me more mad I’m guessing like you have no idea what this was like. This is not even close to what it has been. But there were several activities that we were led through. I remember it was better for me to have those facilitated interactions first because I didn’t have really heart-to-heart genuine conversations with my parents after that ever.
Connor’s parent program involved spending a night with his parents to show them what he had been through, but it was only a “taste” of his experience. Having a constructed shelter, instead of the tarp, made him think they were experiencing a fake version of it. His anger about being at the program did not diminish despite eight weeks in the field. Michelle’s parents participated throughout the wilderness therapy experience, but Michelle felt “it was still very focused on me” and not the family dynamics. Laura described her parents spending the “last three days” with her in the field. For Lance, his parents’ “involvement was pretty eye opening.” For Mark, the final parent program provided the chance to connect with his adoptive parents in a way he had not before.

Mark, USA, Continuous-Flow Wilderness Therapy

I didn’t see my parents until three days before the end of my stay there. So, I didn’t see them for a month and a half, which was fairly difficult. But when they did come, we had a one-on-one session where we had to talk to each other in a format that was like, “This is what’s happening, this is how it makes me feel, this is what I want for you,” like that kind of stuff. That was really hard to hear. So, I learned more about my parents in those journeys and how their cycles have affected my cycles, and where those cycles come from.

And it was just a moment where I connected with my parents in a way that I hadn’t before then. I didn’t know much about my parents’ pasts and what they had done to raise us kids, and how that would affect me—especially being adopted and nature versus nurture, and all that different aspects. And they’ve worked really hard to figure that all out.
Many participants who graduate from a continuous-flow wilderness therapy program are referred to a therapeutic boarding school or residential treatment, which is examined further in Chapter 9. Katy felt her parent program gave her the opportunity to show the skills she had learned and spend time with her parents before being driven to a residential treatment program. She graduated on her 70th day.

*Katy, USA, Continuous-Flow Wilderness Therapy*

The final day is when you graduate. It was Halloween, and my mom, my dad, and both of my sisters came. I got to demonstrate a lot of the skills that I had learned. It was pretty legit. Everybody was crying. There was lots of crying. Everyone was happy. After the ceremony was over and I had officially graduated, I went back to the office and got to shower.

Family involvement was a component of continuous-flow wilderness therapy programming, both in the literature (Norton, Tucker, et al., 2014) and in my interviews with program participants, but only in the United States. Participants both felt excited to see their parents and held resentment on being sent to a program involuntarily.

There were other narrative threads emerging from the U.S. wilderness therapy programming, such as the solo experience where participants are provided the opportunity to remain for one to three days on their own. Although this is a core program element, I have placed this in Chapter 8 in the discussion about the adventure therapy setting as this is a practice common in outdoor therapy programs and reflects the intentional use of the outdoor setting in the therapeutic process. Additionally, many who attended these programs were referred to therapeutic boarding schools and ongoing residential treatment programs. Felicity,
a counsellor working in wilderness therapy, described how the common referral to ongoing residential treatment was communicated to her.

*Felicity, Counsellor, Wilderness Therapy*

My friend who works wilderness, said that wilderness therapy in America is really just an assessment. It's a program to do assessment. Then they go get real help at a boarding school.

I was also told during my visit to the U.S. program that wilderness therapy is focused on stabilisation and preparation for ongoing treatment. Future research may explore whether this referral is indicated, especially given participants graduate from wilderness therapy programs with wellbeing scores above clinical ranges, meaning scores are above the presumed boundary line between normal and clinical populations (Bettmann et al., 2016; DeMille et al., 2018). Further discussion about the resonant threads arising are presented in the discussion of this Chapter. The following section presents the participants’ experiences of contained expeditions.

**Contained Expeditions**

Unlike continuous-flow programs, contained expeditions are characterised by their fixed program length, having groups of participants begin and end the program together, and having a therapist in the field for the duration of the expedition. These programs are typically shorter than continuous-flow programs and make up more common practice outside the United States (Dobud, 2016; Margalit & Ben-Ari, 2014). In Australia, participants Brady and Barry took part in eight- and 10-day expeditions, respectively. Jeanne’s expedition in Canada also lasted 10 days, while Clare’s, Sarah’s, Willow’s, and Sophie’s expeditions in the United
States were either three or four weeks in length. While these expeditions did not follow phases, I represent the sequences of participation beginning with the arrival to the program.

An illustration of my coding is presented below in Figure 8.
Figure 8: Contained Expeditions
Arrival

Of the seven participants, Clare, Sarah, and Sophie were securely transported to their expeditions in the United States. Sophie and Willow were strip searched and outfitted with their gear upon arrival. Sarah explained she was given an orientation about the purpose of the program.

Sarah, USA, Contained Expedition

They went through a little orientation and then a safety thing . . . so I had never been in the wilderness before. My parents weren’t outdoorsy or anything, so this was my first camping experience. So, we went through an orientation and they told us why we were there and then probably the next four hours they taught us how to do our camp bags and gave us our equipment and things like that. Then we actually started hiking that first day.

Willow, USA, Contained Expedition

There were other kids that were flying in from other parts of the country on that same day. I just remember like, “We’ll take your bags. Here’s what you need. Put these into your backpack. This is the clothing you’re required to wear.” I was supposed to buy hiking boots for the program, and really, I needed nothing else. They supplied everything.

All of our clothing was uniform. We all wore the same type of pants, and sweaters, and socks, and everything. The only variation was the boots that we had.
Sophie, USA, Contained Expedition

Sophie’s experience was unique to all the participants in my inquiry given that, although she was transported to the 21-day expedition, her parents were waiting for her at the program when she arrived. The program did not use an impact letter, but still used the word *impact* to begin the program, and it held instead, a group session with parents to discuss why they chose this program for their child.

The first day you go into the office, bleak-looking office park, out in this small town. After getting searched, I go up the stairs and there’s just this sparse-looking room with tons of chairs and couches all in a circle. All of the girls that were going to be going on the trip were in that room, as well as their parents or whomever brought them to the thing. So, my parents showed up there as well.

It was basically just this three-hour long session of just parents talking about all of the reasons why they’re bringing their kids to this program and all of this stuff. Basically, just confrontation and impact statements to leave the kids with so that when they go into the wilderness that they have all this in their head. Looking back seven years later, that’s how I see it. It was really just leave the kids with something that was shocking to them and give them the things they need to think about on the next three weeks.

So that was very emotionally exhausting for everybody, especially hearing all of the things that my parents were worried and concerned about with me; to my face, all laid out, on top of these 10 to 12 other girls and their problems and all the crazy stuff that was going on in their life. That was probably the most emotionally draining day of my life and then to realise that I’m going out into the wilderness and I’ve never
even hiked really before in my life and being left with all of these thoughts can be really crazy stuff.

Brady, Australia, Contained Expedition

In Australia, Brady’s arrival to his eight-day expedition had some similarities to Sarah’s, but the program did not discuss why the participants were there. The individualised focus of the experiences on continuous-flow programs was different to Brady’s where his trip leader’s focus was encouraging teamwork and participation from the moment Brady and his peers arrived. Brady was the only participant to arrive to the program with a group of participants he already knew. This was due to Brady’s school nominating a group of their students, who were at risk of disengagement, to take part.

My team leader was a clinical psychologist named Kelly. When we got off the bus, we were all a bit rowdy and thinking that we were the toughest people ever. Kelly’s quite little and I towered over her. So, initially I didn’t think that she was going to be much of a problem authority-wise, if you get what I mean. I thought I’d be able to overcome but she led with respect and with a certain authority about her, so we were like, “Oh shit, we actually better listen to her.” I never had any ill will against her like I did with my teachers or any other authority figure at that stage, because I always hated authority.

So, first day, we started hiking and walking and then we’d have to cook at night time for the team. Cooking’s not something I’d ever done before. Making the fire when we got into camp [however], was something I was very happy with, very comfortable doing.
On Day 2, we did some little team-building activities, such as Charlotte’s Web where you’ve got to pass the participants through the web. We did things like that just to help build the team up. They’re all fun activities, when you’re 15, that’s all you see them as. Just a bit of fun. But it really does build the team dynamics.

Jeanne’s expedition, provided by a charitable organisation, was an outlier to other participants’ experiences. Jeanne was diagnosed with cancer at the age of 15, and after her cancer entered remission at age 17, she was offered the opportunity to engage on an expedition in Canada for those affected by cancer.

Jeanne, Canada, Contained Expedition

So, it was on the hospital wall that I went to. They had a link to the foundation on their website, so I just went to check around and I signed up not really thinking that anything would actually happen. And then I got a call from the organiser within a week. And I was like, “Oh, that was fast.” It was free. And it was just something that I have never done before, so I thought that it sounded really interesting. The pictures looked really nice. It’s just like, “Yeah, I’m going to try something new.”

Like Brady’s expedition, Jeanne’s program began with a focus on team building and engagement. Jeanne was flown to meet the rest of her group at a hostel where they stayed the night. The group went out for dinner where they “kind of got acquainted with everyone” by introducing themselves. The following morning after a three-hour car ride, Jeanne and the group “were picked up by a helicopter” and flown to arrive to where they would be camping. Although she was excited about the opportunity, her initial thoughts illustrated her apprehension.
My train of thought basically went, “Oh my god! This is really scary,” to “Oh my god! This is really cool,” to “Oh my god! There’s a moose! I’ve never seen a moose in the wild before.” They dropped us off in basically the middle of nowhere. We all had to take turns, ’cause obviously we can’t all fit on the helicopter at once.

So, they flew us in, and then they flew all our supplies in. And then once they dropped the supplies, we had to set up all of our tents. We set up a little kitchen station, as well. We established where we were going to go to the washroom, because obviously there were no washrooms. Fifteen participants, and then we left with about 10 staff, which sounds like a lot, but you needed the guides. We had a medical team because the nearest hospital was probably three hours away.

Jeanne’s expedition started with a night in a hostel with the rest of her group and expedition staff, unlike Barry’s and Brady’s experience, which began abruptly upon their arrival. Barry described handing “over your phone, your wallet and keys” and “all the shit you’re not going to need essentially.” Clare mentioned being “given all the gear I’d need.” As I observed participants arriving to a contained expedition in Norway, there was also no strip search or cleansing phase, though the participants and staff had prepared for the program on two previous occasions prior to my arrival.

One of the interesting components of providing wilderness therapy in Norway stems from Norway’s open-air lifestyle; a way of life comprising appreciation for the country’s natural spaces (Fernee et al., 2015). Though I knew of this concept prior to arriving in Norway, I found it fascinating, and drastically different than any programming I had experienced professionally, to witness how wilderness therapy programming is impacted by specific cultural contexts. The participants attending the program came almost entirely
outfitted on their own. Some needed an extra bowl for eating or a warmer sleeping bag, but upon arrival, they appeared prepared for the eight-day expedition.

The participants learned of the program after they came to the psychology department of the local hospital for concerns relating to depression and anxiety. Participants were provided with information to choose between the wilderness therapy program, or the hospital’s other therapy services. This group decided adventure therapy might be better for them. The group met the program facilitators on three occasions to discuss the purpose of the program, including logistics, and any of the participants’ fears.

*Norway Participant Observation*

The nine participants arrived at the hospital at noon with their bags packed. Many Norwegians already have their own gear, so the program provided little to the young people. We did a quick introduction and I met the six female and three male participants between the ages of 16 and 17. According to the program leaders, two psychologists and one social worker, this ratio of female to male participants represented the numbers referred to the hospital for those aged 16 to 18.

I piled in the truck with one of the psychologists, and we began the drive to ‘Setesdalen Austhei’, a mountainous region. Throughout the program, Leiv was routinely monitoring participant reported levels of anxiety each morning of the program with a short questionnaire he and his team had translated from English. During the four-hour drive, we took two stops. One stop was for a quick snack and another for a trip into a grocery store for soft drinks and ice cream. My focus was building some sort of relationship with the participants, so I could reduce the feeling of evaluation apprehension.
We arrived and unloaded the cars. The program leaders were more hands-off when it came to packing bags than I had seen in the past. Participants were given candy and chocolate and extra gear like toilet paper and matches. The scenery was lush and green, like southern Alaska and the water was rushing in river beds. I was told there was more water than usual. More than was there the week before when our resupply drop was dropped.

I worked with each participant to help with packing their bags. We made sure the group gear was distributed evenly. We were ready to go but prior to beginning our first hike, we joined in a circle and shook hands with everyone in the group wishing them a “Good Trip,” or “God Tur,” similar to ‘Bon Voyage’ in French. Another psychologist led a “Circle of Reciprocity” which included every member of the group holding a circle of rope, leaning back to hold each other up. The exercise symbolized the group was in it together.

Preparing participants for their adventures, in a similar way to what had occurred in Norway, also emerged from the practitioner interviews. Glen, a police officer working in a school setting, discussed approaching his work through a trauma-informed lens and mentioned the importance of giving participants a sense of control when the program began, which included providing future information and teaching participants some of the skills they would use during their expedition. Contained expeditions tended to differ from the programming of continuous-flow programs, which provided no future information to participants, many of whom did not know they were going to attend until that morning.

Arrival to the program is one of the drastic differences when comparing continuous-flow programs and contained expeditions. Although secure transport services are not discussed in literature outside North America, participants were still coerced or pressured to
attend their adventure therapy programs due to circumstances affecting their lives. However, except for Sophie whose program began with a family session, a difference in programming and a philosophical shift in how participants were treated upon their arrival emerged from the interviews.

**Expedition**

Like continuous-flow programs, most of the participants spent their days hiking to a new campsite. They would set up their tents, start a fire to cook dinner, and end the day with a group session around the fire. Since the programs were not guided by phases, mastering hard skills and daily journaling were not part of a curriculum but part of everyday life. Another distinction was that the therapist leading the trip remained with the group, whereas on continuous-flow programs, a therapist would meet with the group once a week. The following excerpts from participants discuss the day-to-day of their expeditions. First, Barry discusses how hiking every day and carrying a pack built his resilience.

*Bobby, Australia, Contained Expedition*

It worked out to be about 120 kilometres. In nine days. Really awesome scenery up there. Basically, we took one pair of pants, one long-sleeved shirt, one T-shirt, one jumper and a raincoat. Then a few pairs of socks, a few pairs of undies, and you just deal with what you got. Actually getting back into the station, it was a relief. It was excitement. I can take my boots off. Yeah, it was good. When you carry a pack that’s bigger than you are, it’s physically demanding, and I think it was mentally demanding enough that it changed people. We tightened up our group through being spread out
over 100 metres, to 16 of us standing [together] as we walked in, and we were all happy to be back. I dare say a few of the blokes changed out there.

Sarah, USA, Contained Expedition

We would hike anywhere from 10 to 13 miles a day. Maybe sometimes even a little bit more. So, a lot of it was just hiking to our next spot. I don’t know if they would try to wear us down physically thinking that that would break us emotionally, but at the end of the day, they have the group session. That was kind of their strategy and I don’t know if it’s changed. They would do a reflection group at the end of the night and it was really more of a structured group setting, so I think they have pre-picked topics that was not like a free-flowing situation. It was more focused on what was wrong with you.

Willow, USA, Contained Expeditions

I think the immediate effect of a wilderness camp that was beneficial was that when you’re dealing with kids who have low self-esteem, and low self-worth, you’re actively doing activities throughout every day. You get immediate verification that you have achieved something, and that you have learned something. Because of your own efforts, you are going to survive another day. You’re going to be okay. You have fed yourself, you started your fire, and cooked your food. You have kept yourself warm. All of those things add up throughout the day. At the end of the day, when you process and discuss with the counsellor, you really have a sense of accomplishment.

The structure of Clare’s and Jeanne’s expeditions differed from the others in that hiking was not the core adventurous activity. Along with “hiking and walking,” Brady’s group would
participate in “team-building activities” each day, and they learned to abseil from a cliff. Jeanne’s expedition consisted of white-water rafting, while Clare’s program took part in a different adventurous activity each week.

**Jeanne, Canada, Contained Expedition**

Every day we woke up [and] we would have to take our tents down. We took the entire campsite down. We had breakfast. Some of us would help with the cooking. Some of us would help with the cleaning and some of us would help out with the water, like getting water to wash dishes and getting water to purify it so we could drink it. After we had breakfast, we would all get in our rafts, and then we would raft down the river. We wouldn’t see that tent site again. We raft down the river for a couple hours. We would stop. We would have some lunch. And then we got back in the rafts, and we went for another couple hours. And then we got to our new campsite. We would pitch camp again. We would have the dinner team. We would have a plate-washing team [and] a water team again. And after that, we’d usually have a camp song. And then during the campfire, sometimes we’d have group sessions, sometimes we’d play games. And then we went to bed.

Clare’s contained expedition resembles Jeanne’s in that she was learning a different activity each week. She had friends who had graduated from other wilderness therapy programs, and she reported feeling lucky to have experienced the program that she attended. In the excerpt below, Clare acknowledges the importance of being able to talk during hikes, which is not common on U.S. continuous-flow wilderness therapy programs.

**Clare, USA, Contained Expeditions**
What happened is that each week, you went to a different place, and you did a different activity. Now this is the kind of wilderness therapy that I think was good. Things were much more laid back than I’ve heard from other programs. We could talk while we were hiking or doing any activity. We did different activities not just hiking all day in silence. For example, we did one week where we went on a biking trip. Another week, we did rock climbing and fishing. And then the last two weeks we did white-water kayaking.

In contrast to Clare, Sophie reported participants not being “allowed to talk while . . . hiking”, reflecting some of the experiences of participants on continuous-flow wilderness therapy programs. Being shorter in length, participants recounted getting involved in their adventures right away. Where programs beginning with an initial cleansing phase kept participants away from the group of adolescents to reflect and adapt to the novel environment, contained expeditions began with social interactions and adventurous activities. Additionally, the participants knew when their programs would end.

**Program’s End**

Many of the programs had rituals and ceremonies for ending their expeditions. Participants shared special meals together, and group sessions focused on what meaning they had constructed from their experiences and what changes they would make in the future. As Jeanne’s 10-day expedition was coming to an end, she was beginning to love white-water rafting. Where before she was nervous about falling in the water, and hid in the centre of the raft, she was now ready to embrace the adventure.
Jeanne, Canada, Contained Expedition

I think I just realised that the trip was coming to an end and other people had fallen out. My hair was a mess, so I didn’t have to worry about that getting wet anymore. And I was like, “You know what? This is ending, so let’s just make the most of it that I can.”

It was sad at the end. But they did a lot of really nice things, actually. The last night that we were actually camping, they just asked us about one word that described the trip. I picked the word “crazy.” That’s how I felt the whole time. I think everyone on that trip has a little bit of crazy in them. And then when we got back to the hostel, the leaders give us each a piece of driftwood they collected with our word on it. Which was really nice, so I still have that in my room.

We also made a stop on the way back home at the beach. And we all stood in a circle, and we held this rope, this thin rope. We said a few words about the trip. And then one of the leaders cut the rope up into bracelet size pieces, and she made us all bracelets. And I’m still wearing it. I have it on right now.

Sophie and Clare felt “excited” about going home. Brady “didn’t want to go home,” and Barry was “happy to be back” though he quickly returned to the program after a difficult return home. Barry’s experience and that of others returning home is presented in Chapter 9. Willow’s expedition ended with a “solo” where she spent a night away from the group. For more on participants’ experiences with solo, see Chapter 8.

Barry’s and Brady’s expeditions in Australia ended with ceremonies involving food. Barry’s group was greeted with a meal cooked by volunteers as his group returned to where his expedition began. Brady’s group cooked a barbeque around the fire on their final night and were awarded with a certificate and boomerang to symbolise their accomplishment. In
Norway, we spent the final night in a cabin and prepared a substantial meal for the participants.

Norway Participant Observation

Prior to the hike the group nominated two leaders for the day. Again, one the expedition leader and the other for navigating. The two organised the group to prepare for the day’s hike. It was just a short three-kilometre hike to a Den Norske Turistforening (DNT) cabin. The participants were unaware that we would be staying in the cabin and were thrilled about the opportunity.

Upon arriving, one of the therapists cooked the remaining trout for the participants to have for lunch. He told me that part of cooking for participants was about making them feel cared for. Many of the participants do not eat a family meal at home and he found it important for them to experience good hospitality.

We held another group session in the cabin discussing the time spent in nature. After the group, participants met individually with their respective therapist for about a 5 to 10-minute session.

We spent the rest of the evening playing cards, Yahtzee, and laughing at my attempts to read Norwegian fairy tales. The therapists prepared pasta for dinner, which we ate under candlelight. The mood was positive. The participants stayed up well into the early morning talking and laughing after the therapists and I went to sleep. They told the therapists that they were holding their own group discussing what changes they would like to make at home.

We woke up early at about 6:00am to get moving. The participants were tired having little sleep but were in good spirits regardless. After breakfast, we began our hike. It was a steep downhill climb to the road where the cars were parked. It was
slow going being that the trail was wet and slick. We arrived to the end of the road and picked up the vehicles to drive back to the hospital where the participants were picked up by their parents.

Like some of the continuous-flow programs, Sophie’s and Sarah’s expeditions ended with parents joining their children in the field. This was a chance to demonstrate the hard skills they had learned and, for Sophie, to make plans for referring her to ongoing residential care. Although Sophie’s expedition did not use letter writing as a ritual, she did experience an impact group where she met with her parents and heard all the reasons her parents chose the program. Sophie’s program ended in the same room.

**Sophie, USA, Contained Expedition**

There was a similar meeting to the first meeting where you go back to the offices. We had to have a similar round table but not as crazy and emotionally charged as the first one obviously, because you talked about all the things you got out of the program and all the things you’re going to change when you go home. Things like that. Parents setting boundaries for their kids rules-wise about what’s going to change when they come back. Other than the outtake meeting, there really wasn’t anything different at all, except me being really excited to go home and having really vivid dreams about actually being home before I went home and waking up and still being out in the woods.

This section has explored experiences on contained expeditions, a more common approach to wilderness therapy outside the United States. Although some programs were structured similarly to continuous-flow programs, with participants travelling and establishing a new
camp each night, there were contrasts in practice, such as letter writing, the use of phases, and not requiring the mastering of hard skills. Likewise, the therapist remained with the group for the duration of the program. Implications of these differences are discussed in the resonant threads of this Chapter. The following sections discuss community-based adventure therapy programs.

**Community-Based Adventure Therapy Practice**

Participants remaining in their local community distinguished community-based adventure therapy from the two previous modalities discussed. Community-based adventure therapy can include practitioners working in private practice, and charitable and nongovernmental organisations. Three of the practitioners interviewed, Bella, Lynn, and Nathaniel, worked in private practice, while Crystal, Grace, Kennedy, Magnus, and Robert worked in community-based organisations. Although there was a good representation of practitioners working in this context, only two of the participants I interviewed, May and Andrea from Denmark, participated in a community-based program (See Figure 9). Both were trauma survivors and had been a part of Denmark’s mental health system for years. May and Andrea were uncomfortable with conducting an interview in English, so they elected to write their responses to me by email. While providing context to this specific adventure therapy practice in Denmark, their responses do not elicit the richness and description as the others since they preferred to email their responses. Still, their contributions provide context to adventure therapy practice in Denmark. In addition, I observed a short expedition facilitated by a charitable organisation in Australia for adolescents who had lost a parent to cancer. I begin this section representing how these program participants became involved in community-based adventure therapy.
Community-Based Adventure Therapy

Initial Perceptions

Andrea
"A friend...had to ask me many times"

Community-Based Programming

Andrea
"We have made a LOT of bonfies"
"Climbed a tree, in a height of 10 metres, and sailed a boat"
"Christmas dinner"

May
"My first thought was annoyance"

Community-Based Adventure Therapy

Participants
Andrea
May

- Outpatient
- Participants were referred to as a "team" or "members", instead of clients or patients
- Less structured than wilderness therapy programs

May
"Shooting with arrows, building bonfies, day hikes...climbed trees (and everything else that can be climbed, and learned first aid)"

May
"Hoping the program will start again in the New Year"

Andrea
"I am currently seeing psychologist weekly"
"I want the program to start next year"

Figure 9: Community-Based Organisations
May, Denmark, Community-Based

I had a caseworker who sort of suggested it to me when in reality she forced me to do it. I’m not holding that against her. She suggested it to me because of my lack of positive experiences in life and friends.

My first thought was annoyance over being “left” in the forest with a couple of “old” nuts, however, that thought was short-lived, and I almost instantly enjoyed their wit and open mind and all-around fun, loving, goofy personality.

Andrea, Denmark, Community-Based

A friend of mine suggested engaging on the adventure therapy program. She was very happy with the concept, she actually had to ask me many times before I agreed to try it, but I’m happy I did. I don’t think it was something she said. It was more about the way she talked about it. I could sense that the program had helped her, since she seemed more relaxed, and she suddenly had something to do with her time, other than just stay at home. It seemed like she had changed her view on herself, so I thought, “That’s what I wanna do!” So I decided to join.

Once I agreed to come along, I was really relieved that it was so down to earth. First, I thought it would be really challenging, and I would be given tasks, that I wouldn’t be able to complete. But I almost instantly felt like I was a part of the group, which was surprising since I usually have a hard time socialising.

Andrea and May’s programs met once a week. Sailing and spending time in the nearby forest were common ways for the group to spend their time. In the excerpt below, Magnus, a psychologist, described the community-based adventure therapy program for young adolescent women struggling with social anxiety.
Magnus, Psychologist, Community-Based

The project was paid by the government for picking up kids who were lonely and at risk of going into trouble. But we studied kids who were living at home and then we discovered there was an epic group of young women. Women who had all kind of diagnoses. Schizophrenia, depression, and anxiety. These kids were very lonesome, sat in their flat alone and had no relationships to other young kids. Quite some of them, [were] brainy enough, but they were so troubled by all the mental sickness. So, I have a project for those women also.

Like the programs attended by participants May and Andrea, Magnus described a need for more engaging services for young women in the community. He stressed the importance of getting participants to build relationships with not only the practitioners, but also with other young people their age. Where continuous-flow programs began with isolation, community-based practitioners focused on engagement. The following section explores some of the commonalities in community-based programming.

Community-Based Programming

For Tucker (2009), adventurous activities can “provide an alternative way for participants to connect through shared experiences other than through revealing feelings in traditional group therapy settings” (p. 323). Since both Andrea and May were survivors of trauma and struggled with anxiety, and despite being engaged in the mental health system for years, adventure therapy provided the opportunity to engage in something different than talk therapy.
May, Denmark, Community-Based

I got some great friends who also lives close to me, but also various activities that people like me wouldn’t have had a chance to try out hadn’t it been for people like Jacob. Like in 2016, I built my own bench that you can sit on without breaking it. We have also done a lot of shooting with arrows, building bonfires, day hikes in various Danish forests, climbed trees (and everything else that can be climbed) and learned first aid and so on, the list goes on.

Andrea, Denmark, Community-Based

We have made a LOT of bonfires. That is a skill I never thought I would actually learn. It was a nicely balanced mix between talking and doing. You can easily talk about the unpleasant things in your life, while collecting wood for example, which makes it less challenging to address the tough subjects. I felt like I had a safe space to challenge myself, both my social skills, and my self-esteem. I climbed a tree, in a height of 10 metres, and sailed a boat, which are things I have never tried. I didn’t think I could do it, but I did it anyway, and that is very healing, to discover you can do more than you think you can. I found myself opening up and talking more in a matter of weeks. This is not common for me, so I definitely see that as a victory.

For Andrea, the adventurous activities helped her to build a relationship with her group and practitioners. May’s excerpt shows how she felt proud of her ability to do the activities, such as building the bench. In the examples below, Magnus and Jackie share why they believed adventure and shared experiences can be helpful for participants struggling with “social anxiety.”
Magnus, Psychologist, Community-Based

When we pick up this group of young women in the beginning, they don’t talk much; they are very hesitant. And we go out and maybe we go for a walk and to find a place where we build up a fire. They are very quiet and nervous. And after a while, they relax, and they talk. And then on the way back in the car, they talk all the time. Or around the fire, they loosen up and after a walk, instead of direct, face-to-face eye contact, you walk aside them. You look straight ahead, and something happens there. It’s very easy to get in a talk walking side by side.

Jackie, who works at a residential program in the United States, also described the preference for walking side by side when taking participants on a hike.

Jackie, Psychologist, Therapeutic Boarding School

I wouldn’t want to walk on a trail with a client where either of us are in front of or behind. I would want to walk on a trail where it’s wide enough for us to walk side by side. Maybe the client is sometimes a little ahead, and sometimes I’m a little ahead. It’s like we’re doing this together.

Understanding adolescents coming to his program may be reluctant to engage, Magnus used adventurous programming to help make participants more comfortable. Both Andrea and May remained engaged with the adventure therapy group for more than a year. They participated in my inquiry in January 2017, and the program was on a break for the Christmas holiday. Even though May had another psychologist she saw weekly, both were looking forward to the group getting back together in February. They referred to the other program participants and the psychologists facilitating the program as a “team.” Presented below,
using different terms for participants emerged during my observation of a community-based program in Australia.

**Australia Participant Observation**

The program I am observing is a non-governmental, charitable organisation that provides support for young people affected by cancer. Most of their services include case management, provided by psychologists and social workers, and a team that does fundraising for advocacy purposes. The opportunity I was given was to observe a five-day expedition with a group of ten adolescents who have lost a parent to cancer. These young people attend different schools but see each other regularly when they meet at the organisation. Adventure therapy expeditions are provided four times a year. Along with me, the program was facilitated by the clinical director of the program who is a trained social worker and another nurse.

I met with the team two weeks before the program to prepare. We spoke about some of the social worker’s concerns about the participants’ wellbeing and the purpose of the program. Interestingly, this organisation’s board of directors consists of participants. All participants were called *members*, instead of clients or kids. The social worker hoped that the program would help participants open up more about their experience of losing a parent.

The morning of the program, we met at a local community centre. The participants arrived one by one. There would be five other groups of participants, so we had more than 60 young people to get outfitted with gear and food. After two hours, everyone had arrived, and we held a large group to discuss some of the rules for the program. Although we were booked to take a ferry to an island for the
expedition, bad weather had cancelled the ferry service for the day. Instead, we went for a hike and camped at a local caravan park.

After the night at the caravan park, we ferried over to the island and completed the short backpacking trip. The social worker leading the program facilitated nightly group sessions to talk about the impact of losing a parent to cancer. The program ended with a celebration, which included a barbeque. The participants remained engaged in the program, receiving case management services, and taking part in future programs, including a day at a high ropes course.

Community-based programs can use adventure-based activities to engage participants in the therapeutic process. In this case, the group setting and outdoor activities were designed to progress the therapeutic purpose of the program. This was evident while I observed the program in Australia. While the participants had previously established individual relationships with the social worker, I did not witness much sharing during the group sessions early on.

If continuous-flow wilderness therapy programs began with the most abrupt start for adolescents, the experiences in community-based adventure therapy seemed most gentle. Participants were given the space to feel more comfortable and begin accomplishing tasks they did not know they were able to do. Tasks or initiatives may fall flat without a person feeling welcomed and cared for. For Dewey (1938), tasks and hard skills should be used for “establishing conditions that arouse curiosity, strengthen initiative, and set up desires and purposes that are sufficiently intense to carry a person over dead places in the future” (p. 38). It was December when I received responses from Andrea and May. The program was on hold for the winter and, as put by May, both were “hoping the program will start again in the New Year.”
This section has explored experiences in community-based adventure therapy settings. Excerpts from May and Andrea provided representations of community-based practice in Denmark and I presented my experiences participant observing a short program in Australia. Practitioners described how adventurous experiences can create a more democratic and engaging therapy setting, as opposed to traditional talk therapy, which can occur face to face. The following section explores William’s experience at a wilderness-based therapeutic boarding school in the United States.

**Wilderness-Based Therapeutic Boarding Schools**

A few of the participants who graduated from continuous-flow wilderness therapy programs went on to therapeutic boarding schools, incorporating some adventure therapy programming, which is presented in Chapter 9. William’s first adventure therapy experience, however, was at a wilderness-based boarding school. Although William was just one participant I interviewed who attended such a program as his first adventure therapy intervention, his experience and the structure of the program resonated with other participants in my inquiry. This section begins with a presentation of William’s experience. Figure 10 illustrates the structure of William’s program and some of William’s key reflections. This section begins with discussion about how William’s parents presented the rationale for attended the therapeutic boarding school.

William’s parents, concerned about their son’s “troubling behaviour” sat him down, and “sold it” that he would be “camping instead of sitting in a classroom.” William had grown up hunting with his grandfather, so he “was excited.”
Figure 10: Wilderness-Based Therapeutic Boarding School

Wilderness-Based Therapeutic Boarding School

Participants
William
- Living in primitive conditions
- Attend school daily
- Responsibilities increase as participants progress through the program
- Base camp model as opposed to expedition setting

Use of Phases
William
"They go by initials: Buddy, NGM, GM, AGM, RGM, DGL, SGM"
"You're supposed to complete a certain amount of goals to get off that status"
"Artificial"

Rules
William
"The group interaction is none"
"They can assign punishments at will"

Family Involvement
William
"Every month they had all the parents come for a day"

Leaving the School
William
"Tachycardia"
Wound up in hospital, went home to finish school with "straight As"
Program Structure

William referred to his school as a “wilderness survival camp” mixed with a school. He remained at the school through Years 10 and 11 and turned 17 before he returned home. He was at the school for 18 months.

William, USA, Wilderness-Based Therapeutic-Boarding School

You live as part of a group, and there’s five different groups. They’re all Indian names and stuff like that. The group interaction is none. You are literally not even allowed to look at the other groups. You can get in trouble if you looked at another group.

The reason I call it a wilderness program is that you are living in almost primitive conditions. You live on a campsite of varying distances away from the main campus. Ours was about a mile away. We were in an uninsulated cabin on basically prison cots, with no running water, no electricity, two outhouses, a campfire, and a wood-burning stove, and not even a really good kind, like a grill that you put wood in and burn and then put a grill on top come rain, snow, sleet or shine.

The phases steering William’s therapeutic boarding school, referred to as “statuses,” were designed for students to accomplish and “go through to graduate from the program”.

The first one is Buddy. The second one is New Group Member. The third one is Group Member. The fourth one is Advanced Group Member. Then Responsible Group Member Then Designated Group Leader and then Senior Group Member. They go by initials: Buddy, NGM, GM, AGM, RGM, DGL, SGM. You’re supposed
to complete a certain amount of goals to get off of that status and move up to the next, and as you go up, your privileges increase, and your responsibilities increase.

The way it works is, the buddy is assigned to a senior buddy. The senior buddy is someone of AGM or higher. That person has basically complete control over you. They can say if you can speak, they can say if you can do anything. You’re not allowed to talk to anybody else in the group. They’re the only one you’re allowed to talk to. 24/7, you must be within 10 feet of them. That means if you go to the bathroom, they’re standing outside and vice versa. That person has complete control. They can assign punishments at will. Punishments included carrying heavy things, walking, not being able to talk, standing at attention, which means basically arms down. Stuff like that, and various other punishments, including carrying a bucket of rocks. Literally carrying a bucket of rocks.

William was in the Buddy phase “for about a week and a half” and then moved to the next phase where students were instructed to never focus on themselves. During the interview, William used the example where a fellow student ate his cookie. If William complained, the staff would say Williams was focusing on himself, and there would be consequences. Where wilderness therapy literature has stressed the importance of natural consequences being responsible for most of the learning (Russell, 2001), like the continuous-flow programs in my inquiry, field staff administered most of the ‘consequences.’ Like U.S. wilderness therapy programs, I have found a troubling gap in programming appearing seemingly-different to how they are described in the literature.

As William progressed through the program, he was allowed home passes to visit his family. During these times, his mother thought he was “a new person.” For William, just being away from the school’s “toxic environment” made him feel better. Each month, the
parents would come to visit the school for a Family Day. William noticed the program did not give an accurate representation of what the program was like.

Every month they had all the parents come for a day. It was called Family Day.

“We’re gonna show off what our lives are like here. We’re gonna have the helicopter land in our field to show that your kids are safe.”

The biggest problem with that is, no matter what was wrong with us, the first things the parents did when they came to the campus for Family Day was they went to a room, before they ever saw us, and had about a two-hour session with the camp leaders and the treatment teams. It was basically a, “This is why you shouldn’t believe anything your son says that’s going on here. This is how they’re trying to get out.” They are basically inoculated against seeing us in a miserable condition, physically, our skins were terrible. We were forced to take a shower every day, which was fine, but we literally had three minutes to shower and one bottle of soap to share among six people. It was prison.

When the parents left, things would “go back to normal.” William found the phases “artificial.” He remained a New Group Member for nine months until he was “forcibly promoted” to Group Member. He did not want the additional responsibility of the Group Member, so he purposefully did not accomplish the tasks required to move up. Refusing to follow the rules, William was in trouble regularly. A usual punishment was weeding or carrying a “five-gallon water cooler in each hand”.

After spending 18 months at the school, William fell sick. He had a previous heart condition, which resulted in trips to the hospital at 13 years old. The “tachycardia” acted up, and William was “sitting there on the ground, screaming, crying, in pain for four and a half
hours.” William finally wound up in the hospital, and the school called his mother who would not visit as she was on a vacation in Florida. William’s father offered to come and spend time with his son in the hospital, and the school advised against this. William’s father came anyway and removed William from the school. William went home and lived with his father to finish high school where he “got straight As.” The practitioners I interviewed who worked in residential programs and therapeutic boarding schools echoed some of William’s experience.

Jacqueline, a trauma-informed psychologist working for a residential treatment program in the United States discussed similar programming. While the program was trying to move away from its past as a boot camp, she described this as a slow process and that not much had changed. Like Jackie, Charlotte mentioned a “militaristic” style of programming in relation to her program.

**Jackie, Psychologist, Therapeutic Boarding School**

I work at a residential treatment centre for adolescent males. It’s owned by the largest psychiatric chain in America. They have like 300 programs, and this is one of them. But it’s not like a psychiatric hospital like most of their facilities. Really, it used to be a boot camp, and way, way back in the day. It was a wilderness program, but a boot-camp-type wilderness program.

**Charlotte, Psychologist, Therapeutic Boarding School**

If a kid walks out of my office mad and walks down the hallway, there’s staff in the hallway that approach them and are like, “Stop. Get in and chill out.” And the kid has to look at a wall and keep his hands behind his back. This is why really deep down I know I’m where I’m supposed to be. There’s some purpose in me seeing the
destructive system of behaviour modification and militaristic scare-them-straight kind of shit. But I’ve come in at this time where they’re trying to make a transition, and they’re struggling so much, and the whole thing is just fascinating, but it’s also highly toxic. I have to do a lot of self-care. I don’t even want to go to work at any of the wilderness therapy programs in this country.

William, Jackie, and Charlotte provided just a few therapeutic boarding school experiences but offered some wider context to the varieties of adventure-based programming for at-risk youth. Like continuous-flow programs, William’s school used phases and enforced rules about when participants could speak and who they could speak to. Phases did not emerge in the interviews with Jackie and Charlotte. The following section discusses the resonant threads emerging from this review of adventure therapy practice and participant experiences.

**Resonant Threads**

In this Chapter, I explored the arrival of participants to their respected therapeutic programs and the varieties of adventure therapy practice; that is, continuous-flow wilderness therapy programs, contained expeditions, community-based adventure therapy practice, and wilderness-based therapeutic boarding schools. The resonant threads were (1) “Gooning,” (2) “They’re Trying to Break Me,” (3) “The Similarities in Wilderness Therapy Programming,” and (4) “Shared Experience Versus Forced Experience.” These threads emerged by discussing how programs began in relation to the ways participants were introduced and prepared, the similarities of continuous-flow wilderness therapy programs, and the various applications of shared experience. These threads point to areas of tension between practice and literature in the field of adventure therapy.
**Gooning**

The resonant thread of ‘gooning’ emerged from participant experiences of deception and being securely transported. Tucker et al. (2018) mentioned in their article about outcomes for young people transported to programs that coercive processes might be at odds to many peak bodies’ mental health standards, though may be deemed necessary to provide an adolescent with a safe environment. As mentioned, two studies (Tucker et al., 2015, 2018) have emerged recently, highlighting quantitative outcomes that are unaffected by whether or not a participant was transported. In these studies, the authors explained, “All U.S. states uphold the right to confine or isolate individuals from society for protection of its citizens from disease, criminal activity, and individuals with mental illness who pose a threat to others” (Tucker et al., 2018, p. 438). Problematic, however, is that secure transport services can be used to detain an adolescent in a wilderness therapy program prior to any clinical assessment, doctor’s order, or court mandate (Harper, 2017). That is, there are concerns for the rights of the child and whether this practice is at all ethical, based on the codes from various professional associations. Additionally, while quantitative studies found no differences in outcomes, the experiences described by these program participants provide evidence for a different narrative. Thus, quantitative findings do not tell the whole story regarding transport services.

There is a certain possibility that the use of secure transport is contradictory to a helping professional’s pledge to do no harm (NASW, 2016). This discussion is timely given the popularity of trauma-informed approaches in social work practice (Kezelman & Stavropoulos, 2012). Similarly, the United Nations commissioned an extensive report with the goal of minimising coercive and involuntary mental health treatment, concluding only life-threatening concerns should warrant seclusion or restraint, and that therapy should not be
done to people without it being a joint effort (Gooding et al., 2018). For these participants, coercion and involuntary mental health treatment were the foundation for many wilderness therapy experiences in the United States.

Carlson and Dalenberg (2000) found a lack of controllability, a negative perception, and the suddenness of certain experiences to be the elements of potentially traumatic experiences. While an individual’s subjective understanding can mediate how the experience is processed, the exposure to secure transport for Olivia, Sophie, Thomas, and Kelly could be potentially traumatising for these reasons. Olivia did report that being transported ruined her overall wilderness therapy experience and communicated, during her interview, feeling distressed to this day. The use of secure transport contains all the ingredients of a traumatic experience.

Sophie provided an interesting perspective, considering herself “lucky” that her transport did not occur in the middle of the night. Katy’s wilderness therapy program held a philosophical shift in ideology given that they did not allow secure transport services to bring participants to their programs, something she deemed as a positive. Program participants in my inquiry interpreted their transport experience as getting kidnapped, feeling lost, not knowing where they were going or if they were going to be raped, and feeling nervous that they were not to “fuck” with their escorts.

This resonant thread points to the potential adverse experiences for those sent to residential programs in the United States. Given the considerations outlined by Bettmann et al. (2017) for adapting wilderness therapy programming for young people with attachment-related issues, it seems mandatory for programs to stress to potential service users the potential effects of transporting a young person to a program. In their article, the authors argued that programs should make it their motivation to provide the opportunity for secure attachments between adolescents and their caretakers. My review of literature found no
mention of involuntary treatment or the use of transport services for adolescents outside the United States, though this could be simply a symptom of the private-pay troubled teen industry in the United States (Mooney & Leighton, 2019, Tucker et al., 2018). Likewise, recent OBH outcome studies, such as DeMille et al. (2018) and Gass et al. (2019), made no reference to the use of transport or involuntary treatment in their outcome studies.

The use of deception is troubling; reflected by parents describing the program to their child as a summer camp, or disguising the amount of time their child would be away. Given the rationale of why and how a certain therapy works elicits hope (Frank & Frank, 1991; Wampold & Imel, 2015), it seems at odds to pressure young people into therapy using falsehoods, especially so when it comes from the director of the program, such as in Michael’s experience where he was told the program would last just a month though he ended up staying for three and a half months. Emerging in Chapter 9, some of these participants held ongoing resentment towards their parents for sending them away under false pretences.

An interesting finding in this resonant thread and future ones, such as “Success and Mastery,” relates to comparable terminology used among U.S. continuous-flow wilderness therapy programs. For instance, the term ‘goon’ was used in a blog written by a former participant on a wilderness therapy program’s website (Reedy, 2016). The author described knowing “it was coming” because his “dad owned the program” and he had gotten “into enough trouble”. The ethics of gooning your child to a program you own are problematic enough, given the obvious conflict of interest. For this thread, however, it is interesting that the term goon is used throughout these programs and does not reflect a positive experience.

Using the common factor of demoralisation and literature about potential traumatising experiences (Carlson & Dalenberg, 2000), there are important questions to consider, given that the practice of gooning and outright use of deception is contrary to many ethical codes
for social workers. Moreover, the United Nations Human Rights Council (2017) defined involuntary treatment as “the administration of medical or therapeutic procedures without the consent of the individual” (p. 7). Procedures administered “on the basis of misrepresentation” (p. 7) also constitute involuntary treatment. Misrepresentation was common in the case of those referred to U.S. wilderness therapy programs. The United Nations called for mental health services “to put an end to involuntary treatment and institutionalization” (p. 1). Other researchers are beginning to explore these practices with more depth, such as Mooney and Leighton (2019), who have used the United Nations push to end such involuntary practices to inform their critique of the U.S. ‘troubled teen industry’. Based on my inquiry, researchers and practitioners must strive to mitigate coercive and involuntary practice in wilderness therapy.

**They’re Trying to Break Me**

There were stark contrasts in how participants became involved in adventure therapy. The use of coercion was common for most participants, though the more than half of continuous-flow participants were escorted to their programs by a secure transport service. Adolescents actively seeking treatment for issues relating to depression, substance abuse, and family conflict were rare, though it was interesting to explore how different programs approached the adolescents upon their arrival.

Community-based adventure therapy programs, though perhaps not comparable as an outpatient level of care, seemed to maintain a focus on engagement. Adventurous activities were used to reduce a participant’s social anxiety and make them feel like a valued member of their group. The two participants interviewed from Denmark, both survivors of trauma and many previous treatment failures, remained engaged in their adventure therapy programs for over a year and wanted them to continue.
In contrast, continuous-flow wilderness therapy programs, also known as OBH, and a selection of the contained expeditions began with a strip search, outfitting the participants in a uniform, and enforcing a rule of seclusion, which was informed by the programs’ phases. While Chapter 7 is dedicated to exploring the therapeutic alliance in adventure therapy settings, the importance of these practices could be questioned. If wilderness therapy offers a unique social environment where participants have a social responsibility to their group, and natural consequences facilitate much of the learning, I ask why these supposed essential factors are intentionally withheld upon the participants’ arrival.

Participants said their programs began with “trying to break me” and being “stripped of individual identity”. For those who came voluntarily, there was a feeling of shock and vulnerability when they were asked to remove their clothes and jewellery. Then, as they were adjusting to life in an outdoor environment, they were instructed not to talk to other participants and remained isolated from group interaction. From my observations of a continuous-flow wilderness therapy program, it seemed odd to have consenting young adults name bouncing, being instructed not to talk with other participants in their therapeutic community, and calling their name every few seconds while away from program staff. It is clear that some aspects of adventure therapy programming are degrading to participants.

There are common aspects that exist regarding wilderness therapy programs being specifically designed for field staff to control their participants. The Chapter that follows explores the relationships between adventure therapy practitioners and their program participants. The findings presented in Chapter 6 show some programs prioritised enforcing rules and discipline. This enforcement and lack of control can denigrate a person’s self-worth. My findings are support by Frank and Frank’s (1991) view that controlled, residential therapy settings can further demoralise participants.
The quality of these relationships might be influenced by the philosophical assumptions programs make about the role the participant plays in adventure therapy. Mitten (1994) presented a feminist critique of adventure therapy, raising many ethical queries of practice and implications for practice relevant to my inquiry. She argued participants need time to be with other group members for unstructured discussions. Mitten’s piece was written in response to Kimball and Bacon’s (1993) wilderness challenge model, which mentioned the level of physical and social stress and the pressure to succeed at concrete tasks tend to minimize an adolescent’s ability to maintain a false front. It is difficult to hide one’s true feelings when one is wet or hungry, and almost impossible to repress an emotion when one learns that it is necessary to hike three more miles before making camp. (p. 26)

Maslow’s (1954) *Hierarchy of Needs* is telling when revisiting in wilderness therapy experiences, and this discussion is developed further in Chapter 7. If the therapeutic relationship is our best predictor of therapeutic progress, program directors should address why having a participant wet, hungry, insecure, and unsafe, Maslow’s most basic physiological and safety needs, are perceived essential to outcomes. These strengthen power differences between leader and participant, further evoking structures of coercive practice (Mitten, 1994). This occurs when the participant’s individual needs and preferences are second to the program’s structure. Dewey (1938) felt it was the responsibility of educators to adjust their material to the unique context of the student and not rely too much on previous experiences with similar clientele. When rules and guidelines are stressed by program staff (Russell, 1999), it becomes easier for program participants to submit to a program’s methodology and practitioner’s authority, which can lead to what looks like positive engagement but may be inherently disempowering. The use of phases to structure the
wilderness therapy setting can also evoke compliance, which for Mitten (1994) reinforces the patriarchal status quo. For survivors of trauma and family conflict, as most of these adolescents were, the lack of meeting these individual needs could have been the same issue, prompting the problematic behaviour in the first place.

Like Mitten (1994), Frank and Frank (1991) reviewed some of the areas of concern for participants engaged in inpatient psychotherapy or residential treatment centres, what they referred to as controlled settings. One of their considerations is around the therapeutic norms established by the programs and coercing participants to conform to those norms. In a more recent review, Gooding et al. (2018) raised similar concerns about the ethics of coercive practice. Although program staff might see a participant’s adjustment to the norms as a positive sign of improvement, this might not equate to the participant feeling re-moralised or hopeful and might not signify how well the participant will adapt to life outside the program. Practitioners should be concerned about the depersonalising effects of institutionalisation, such as with Craig, who described being given a number, and Michelle who felt upon arriving at the program that they were “trying to break me”. For example, a participant who is resistant to conforming to the norms of the program confirms the assumption that the participant is irresponsible and may internalise the beliefs and attitudes of the program staff that the participant is not to be trusted and is in need of further intervention.

**Similarities in Wilderness Therapy Programming**

Emerging from continuous-flow programs was the similarity in language used by the program participants. All the continuous-flow wilderness therapy programs participants attended in the United States were accredited member programs of the OBH Council (Gass et al., 2014) and the participants’ narratives had similar threads, making it easier to see how similar these programs were than to find their differences. For example, participants from
different programs used similar terminology like impact letter, described similar phases in programming, and mentioned comparable hard skills, such as bow drilling and primitive traps. It was common on these programs to withhold future information from program participants and for their therapists, who visited the group once a week, to act as gatekeepers for preparing the adolescents to go home (DeMille & Montgomery, 2017). Discussion on these unique therapeutic relationships is developed in Chapter 7.

Those attending continuous-flow wilderness therapy programs described strict rules, such as providing future information to participants. I also observed these rules during my participant observation in the United States. While the intention of such practice is to help a participant focus on the present moment, the evidence indicates that the effect can leave participants further demoralised. People are more likely to cope with stress when it is well-defined and time-limited, such as a broken leg or grieving the loss of a loved one (Carlson & Dalenberg, 2000). However, when stress lacks clear meaning, for example, why a therapeutic experience is intentionally evoking stress and withholding information such as how long the stressful experience will last, participants can be left further demoralised. People tend to cope with uncomfortable situations when they feel the outcome of such an event might be a positive one. Withholding future information, such as the purpose of the program or what the lives of graduating participants look like after the program, is at odds with some of the very core factors making psychotherapy effective, namely, hope and expectancy (Norcross & Lambert, 2011; Wampold & Imel, 2015).

Although I have not worked in OBH since 2011, and the interviewed participants’ experiences occurred after 2007, it was interesting to reflect on what has changed in wilderness therapy programming. It felt familiar observing wilderness therapy in the U.S. in 2017. I had worked at similar programs and understood the terminology and the program’s philosophy. In contrast, Norway’s wilderness therapy program and the interviews I conducted
with participants from Australia, Denmark, Canada, and Israel were much more diverse in practice. No phases or hard skills required mastering to advance in the program. The roots of wilderness therapy in the United States link back to the adventure therapy program at Brigham Young University (Gass et al., 2012), and it is clear these historical roots remain. In my journal, I reflected on how U.S. wilderness therapy seems to have been “franchised.”

I noted the differences in practice during my participant observation and felt myself struggle when I reflected on my original training in wilderness therapy. Each night I took notes about the structure of the day. In Norway, we did very little. There were no hard skills to master as being in nature was viewed as time for reflection and freedom. Nature was not something people had to conquer. The participants spent time fishing and were provided the opportunity to hike if they wanted to. They could stay up late and talk around the fire while the practitioners went to sleep. In Australia, participants shared tents, so they could talk freely among themselves.

While visiting the U.S. program, I made lots of notes about the terminology used, like name bouncing or the mask of solitude. Although my adventure therapy career began in U.S. wilderness therapy, and I currently facilitate short contained expeditions, it was difficult to reflect on my original training. The power of a therapeutic relationship, though with its inherent power differences, is in engaging participants to do things they perceive as potentially helpful (Norcross & Lambert, 2011). I wondered what would change if Craig was asked if he wanted his impact letter to be read publicly, given its sensitive nature. Was the letter even necessary at all? Why was having him read it out loud and feel that shame and embarrassment important for his treatment? Why was it necessary to take Emma’s ring her grandmother had given her? These could be powerful values ripe for therapeutic discussion, and which could be missed when the program’s structure is privileged over the participant’s
experience. Many of these programs have existed for more than 20 years and I wonder if changes to this paternal programming are even possible.

Secure transport services have the possibility to traumatise participants given the suddenness, lack of control, and negative emotional associations to the experience. Upon arriving to the program, participants were instructed not to talk to each other and important information about their treatment was withheld. Although outcome studies emerging from such programs demonstrate robust outcomes (Gillis, Speelman, et al., 2016), the ethics of practice are entirely questionable and do not adhere to code of ethics from the NASW (2016). Each aspect of programming should be challenged critically to question its relationship to outcome.

**Shared Experience versus Forced Experience**

While ‘shared experience’ is a thread that emerges in Chapter 7 about therapeutic relationships, it emerged in this Chapter 6 discussion. Scholars have considered natural consequence to facilitate much of the learning in the field (Gass et al., 2012; Russell, 2001). If it rains and the participant does not put up a shelter, then they might get wet. While this is sure to provide an experience rich for reflection, it was interesting to see programs interfere with this philosophical notion by enforcing strict rules and structure.

Programs with phases added consequences to the participant’s experience well beyond Mother Nature. Upon arriving to continuous-flow programs, participants were instructed not to interact with their group. When participants showed resistance, like Thomas, William, and Angela, they were sent to restart the program or kept in a cleansing phase for longer. At William’s therapeutic boarding school, though, at the extreme edge as an exemplar, he felt the day-to-day staff were only there to enforce the rules, not build any type of supportive relationship. Controlling when people are able to speak makes for compliant
participants (Frank & Frank, 1991; Mitten, 1994). Compliance, however, is not a therapeutic outcome. Therapists, being the gatekeepers for allowing a young person to graduate from a program, invite questions of coercion and compliance (DeMille & Montgomery, 2017). Based on the findings from my inquiry, control and power differences are common in wilderness therapy practice. Participants cannot voluntarily disengage from the program and only graduate when the therapist says they can. Literature from U.S. wilderness therapy programs have praised treatment completion rates above 94% (Gass et al., 2019; Russell, 2003). The significance and scientific validity of such claims hold little value when exploring the involuntary nature of program participants’ experiences. These quantitative outcomes are not appropriate markers for efficacy, especially when most adolescents are referred to ongoing residential treatment. Therefore, no treatment is completed. Afterall, the majority of participants did not choose wilderness therapy and did not have the choice to disengage as they would in outpatient programming.

In their review of coercive practice in mental healthcare, Gooding et al. (2018) referenced The Convention on the Rights of Persons with Disabilities and United Nations bodies that have created task forces motivated to end treatment that is degrading or involves punishment. The review pushed for mental health interventions to make the self-determination of therapy participants a top priority.

Pragmatism offers a unique opportunity to interpret these findings, given no single system of thought can capture the complexity of human experiences (Borden, 2013). Adventure therapy literature has regularly demonstrated efficacy for the average participant (Bowen & Neill, 2013). Looking through this narrative lens creates friction, whereas programming that elicits robust, clinically significant outcomes can just as equally demoralise participants by withholding basic human needs. Reductionistic outcome studies are not the whole story.
Conclusion

This Chapter explored the variety of adventure therapy experiences for the participants interviewed in my inquiry. Three resonant threads emerged from the presentation of findings: (1) “They’re Trying to Break Me,” (2) “Similarities of Wilderness Therapy Experiences,” and (3) Shared Experience Versus Forced Experience.” A limitation to this section is that although private practice and outpatient settings are common, there is a lack of firsthand experiences of participants receiving adventure therapy in these situations (Koperski et al., 2015; Tucker et al., 2013). Future research could explore how participants experience outpatient adventure therapy programs, in order to provide a balanced view of all the different ways these people experienced adventure therapy.
Chapter 7: Therapeutic Relationships in Adventure Therapy Settings

We think we listen, but very rarely do we listen with real understanding, true empathy. Yet listening, of this very special kind, is one of the most potent forces for change that I know.


In Chapter 6, I explored the varieties of adventure therapy practice, using the narratives from past adventure therapy participants to illustrate the structured differences in adventure therapy programming. Building on the previous chapters and the research question “What is a therapeutic relationship in adventure therapy?” I use this chapter to explore the experiences of therapeutic relationships in adventure therapy settings. Narrative threads that emerged from experiences of the therapeutic relationship were (1) “Real Relationships” (see Figure 12), (2) “Feeling Valued,” (3) the “Positive Use of Confrontation,” (4) the “Therapeutic Community” (see Figure 13), (5) “Once in a Blue Moon,” and (6) “Inequality and Force.” Resonant threads and implications for adventure therapy practitioners are provided in towards the end of the chapter. Before exploring the findings, I position the importance of exploring the therapeutic relationship in adventure therapy settings. Table 6 is presented on the following page to present and define the threads contained within this chapter. First, I begin with defining the commonalities of therapeutic relationships across various psychotherapies and the implications for practice.

For Wampold (2007), all therapeutic practices “involve an emotionally charged and confiding relationship with a healer, a healing setting, a rationale or conceptual scheme, and procedures that both the healer and patient believe in and that involve active participation and positive expeditions for change” (pp. 860–861). It is a common misconception to refer to this relationship as the therapeutic alliance, for the alliance is just one part of a therapeutic relationship, which is broader and more inclusive. Norcross (2010) explained that the “alliance refers to the quality and strength of the collaborative relationship between client and therapist” (p. 120, emphasis in original). Historically, the alliance has been
Table 6: Narrative Resonant Threads within Chapter 7

<table>
<thead>
<tr>
<th>Narrative Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read Relationships</td>
<td>Participants described the importance of perceiving the genuineness and human side of their adventure therapy practitioners. Participants used words like human, person, and real to describe their positive relationships. Practitioners also used humour and self-disclosure to build these real relationships.</td>
</tr>
<tr>
<td>Feeling Valued</td>
<td>This narrative thread reflects how participants benefited from feeling like a valued member of their adventure therapy group. Practitioners facilitated experiences for participants to feel as though their contributions were valued.</td>
</tr>
<tr>
<td>Positive Use of Confrontation</td>
<td>Though no practitioner described instances of confrontation, some participants stressed that they valued direct feedback from their therapist. This confrontation was interpreted as a sign of genuine respect and these relationships were not void of a relationship bond.</td>
</tr>
<tr>
<td>Therapeutic Community</td>
<td>All participants engaged in a group-based adventure therapy experience. This thread emerged as participants described their interactions with other participants. Accomplishing group tasks together led to a sense of success and mastery.</td>
</tr>
<tr>
<td>Once in a Blue Moon</td>
<td>Unique to continuous-flow wilderness therapy programs is that a therapist visits the participants each week to conduct individual therapy. This therapist is also a gatekeeper for determining when participants graduate. This thread reflects the participants’ experience of working with therapists in this context.</td>
</tr>
<tr>
<td>Inequality and Force</td>
<td>Participants described aspects of programming in which their adventure therapy practitioners used rigid programming and strict rules to elicit compliance. This thread includes these experiences and describes that compliance is not a therapeutic outcome.</td>
</tr>
<tr>
<td>Resonant Thread</td>
<td>Meaning</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Efforts to Remoralise</td>
<td>Linking back to the resonant thread of “Demoralisation,” this resonant thread discusses how the therapeutic relationship can be used to elicit a sense of remoralisation.</td>
</tr>
<tr>
<td>Democracy and Collaboration</td>
<td>This resonant thread reflects Dewey’s perspective that education settings should be more democratic in which the centre of gravity is shifted to the participant. Participants should feel as though their contribution is valued and their experience is privileged over the program model. Participant feedback should be respected.</td>
</tr>
<tr>
<td>Solution-Forced</td>
<td>Solution-forced reflects how practitioners remained focused on delivering the same intervention to all participants and not tailoring the service based on the participants’ experience of care.</td>
</tr>
</tbody>
</table>
conceptualised as containing a relational bond, consensus around the goals or purpose of therapy, and agreement on the methods of the therapy, such as the therapeutic model the practitioner employs (Bordin, 1979). Practitioners normally contend they pay close attention to the quality of the therapeutic alliance, yet empirical studies, such as Hannan et al. (2005), have suggested practitioners struggle to gauge their participants’ experiences of empathy and the alliance. These factors, when lacking, can predict a lack of progress in therapy and drop outs, disregarding clinical advice. The client’s perception of the therapeutic relationship is the best predictor of positive outcomes, with more than 1,000 studies confirming this, including psychopharmacology studies (Wampold & Imel, 2015). Although beginning with an exact definition of what a strong alliance should look like could be useful in a tightly controlled clinical trial, I wanted to inductively explore experiences of therapeutic relationships in adventure therapy settings, given the potency of this essential factor.

The therapeutic relationship in adventure therapy has limited mentions in the literature (Harper, 2009), yet it has been theorised that practitioners working in the outdoors are more approachable than those in traditional settings when practising with unmotivated youth (Gass et al., 2012). Given the narratives from U.S. wilderness therapy, I struggle to see how these staff could be viewed as ‘approachable.’ The challenge for those working in adventure therapy, and particularly in expedition settings, is balancing the role of therapist and adventure guide. Practitioners work to engage participants in the program, while also monitoring safety. In essence, practitioners balance being in the role of both a therapist and an outdoor educator teaching outdoor skills and monitoring physical safety. As I discussed in Chapter 5, the road to professionalism in adventure therapy is messy. Likewise, the actual role adventure therapy practitioners play, and how their role is perceived by their participants, has yet to undergo thoughtful examination.
Another consideration in group or expedition settings is the presence of paraprofessionals. For example, in many continuous-flow wilderness therapy programs, the participants spend the majority of their time with field staff who may not hold clinical training or professional qualifications. Each week, a practitioner holding a postgraduate qualification and appropriate state licensure visits the participants to conduct sessions and present discussions had with the participants’ parents. Although a therapist is present throughout an entire contained expedition, there are also adventure guides who may contribute to the therapeutic relationship. Excerpts from the transcripts refer to both field staff and therapists, and I will indicate to whom they are referring.

**Real Relationships**

The narrative thread of *real relationships* emerged from the program participants use of words like “human,” “person,” and “real” for describing characteristics about their relationships with practitioners. I broke the narrative thread of *real relationships* into three subsections: (1) “You Felt Like a Person,” (2) the “Stereotypical Therapist,” and (3) “Shared Experience.” Again, Figure 12 is provided to illustrate these findings.

**You Felt Like a Person**

When reflecting on their experiences, program participants and practitioners mentioned the importance of transparency and equality in programming. Practitioners explained that incorporating adventurous activities into their clinical practice helped reduce the power differential between the helper and helped. That said, I presented the ways strict programming and behavioural phases could further demoralise participants in Chapter 6. Abigail, a clinical psychologist running wilderness therapy expeditions described the importance of transparency in her work.
Figure 11: The Therapeutic Relationship
Figure 12: Real Relationships
Adolescents are sort of a bit more cautious, initially. Understandably. But in three weeks, you know, how do you establish that kind of relationship, and I guess the approach that we sort of all share as people working on it, is sort of just transparency, and honesty, and obviously respect. And humour.

Because practitioners are living with participants in small groups, Abigail felt authentic relationships can be built with mutual respect. In Denmark, May felt her therapist’s approach was “born in that respect.” I discussed in Chapter 5 that practitioners with allegiance to their model of therapy, such as incorporating outdoor environments, could disclose their rationale to improve a participant’s sense of hope and expectancy. I have intentionally-used the example from Nancy below, who described an experience of one of her field staff self-disclosing to her.

I hated staff members when I got there, until I cussed out this one staff member. Her name was Britney, and I was so mad at her. I just swore at her, and she took me privately, sat me down, and was like, “Nancy, I came here as a student, I came here as a teenager,” and I immediately got so much respect for her, because I was like, “Oh my gosh. You’re just like me. You’re just older.”

I immediately got a respect for her that I was like, “You understand me. You know what I’m going through.” I really admired that. When the staff member, not like they’re crossing boundaries at all, but when they’re like, “Hey, I know what you’re going through, I’ve literally been in the exact position you are.” You trust them, because they were where you are at one point.
In Chapter 6 I linked to Frank and Frank’s (1991) conceptual framework for psychotherapy to discuss why withholding future information might be at odds to working with potent therapeutic factors, such as hope and expectancy. Britney’s self-disclosure affected Nancy’s sense of demoralisation about being in the program, which lacked constructed meaning and felt like it could last indefinitely. Instead, Nancy felt the program was a manageable and purposeful experience. Britney’s self-disclosure validated Nancy’s experience. Nancy continues below.

It’s definitely a motivation, and when you’re woken every day by a staff member that you hate. That you just want to yell at, versus someone you have a respect for person, because you know what they went through. It’s an inspiration to see how they’ve turned out in their life, and you’re just like, “Hey, that’s going to be me.” It also gives you that, kind of, “Alright, this is only temporary.” Because in rehab, and the wilderness, I never saw an end to it. It was, “This is my whole life. This is it. I’m never going to leave. I’m never going to graduate.”

The excerpt below illustrates Louis’ weekly visits with his therapist Noah. Louis reported struggling in the woods and being “shut down” until Noah used self-disclosure to improve his connection with Louis.

*Louis, USA, Continuous-Flow Wilderness Therapy*

He was a really cool guy. He even had a past as well. I think he had an opium addiction. He was there to help, and he was just a really calming guy, an aura that he’d come around you and you can be relaxed. In the woods initially, he was a guy I
really enjoyed talking to when he would come out. He helped me with opening up. Becoming vulnerable. I remember specifically the time he came over to my tent and we talked. He had told me about the issue in his past, opium. I think it’s at that moment, what triggered that was maybe me coming off or thinking like no one else had problems and then he shot back, or he responded and was like, “Hey. I have a history as well. We all do in some way.” I think over time that allowed me to open up more and say, “Oh. He’s human.”

Recognising the “human” or “person” of the therapist is a finding emerging from my inquiry and is explored further in the resonant threads of this Chapter.

After a traumatising transport to her wilderness therapy program, Olivia decided it was better to take on the advice she heard from a previous therapist and “fake it till you make it” and participate in the program. The best part of each week was when her therapist visited the field.

Olivia, USA, Continuous-Flow Wilderness Therapy

They would have actual counsellors come in once a week or something and talk to us. I remember looking forward to those sessions, because it was the only time you felt like a person during the wilderness phase. Just talking to him felt natural. He was, of course, an adult and he’s an authoritative figure there, but I felt like I was talking to a friend; like an equal. Even though, I was a 16-year-old and he’s my mentor or whatever, I never felt scared to talk to him about anything. I felt like he wasn’t going to judge me or anything like that. Because that would have made me completely shut
This excerpt from Olivia stresses the importance of practitioners maintaining a nonjudgmental stance. This is more important when working with adolescents who have had previous psychotherapy experiences. They may arrive to therapy with a belief their practitioner is not to be trusted. Participant excerpts continue below to examine how practitioners made participants “feel less alone”.

**Jeanne, Canada, Contained Expedition**

Her name is Renée. At first, she didn’t like me that much because I was loud, and I kind of don’t have a filter. I just say things. Yeah, I’m loud. I don’t hide myself, basically. So, she wasn’t so sure about me at first, which she told me later on when we had established our relationship. I was the only person on that trip who really didn’t have side effects from the [cancer] treatment. So, I was feeling really alone in that aspect. She made me feel less alone. And she also pushed me, because she was like, “Even though cancer wasn’t the same for you as it was for all these other people, you’ll get something out of this trip.” And so, I am still in touch with her. I think it’s ’cause she reminded me a lot of a friend that I have back home. She sometimes acted like she couldn’t stand me, but at the same time, I knew that she loved me. I would annoy her, and then she would pretend that she was upset. It was just this funny dynamic. And it was exactly like a friend I have back home.

**Emma, USA, Continuous-Flow Wilderness Therapy**

It was just her sense of humour. She was more of our friend than like our disciplinary. She laughed with us and there was a lot of different kinds of girls at that camp. There was girls with cuts from their wrists up to their elbows to girls that were super-pretty
cheerleaders in high school. She somehow found a way to connect with all of us at a level that like. Not many people can reach that with everyone.

While professionals in helping relationships hold a certain power over those engaged with them, and possibly more so when people are held involuntarily, the adolescents became more engaged when they experienced authentic relationships. C. R. Rogers (1961) described unconditional positive regard and congruence, which is also defined as genuineness, as two of the core conditions of change in therapeutic interactions. In Chapter 5, program participants discussed previous experiences in therapy where it felt like their practitioner was boring, inauthentic, and not working in line with their preferences. Approaching adolescents with authenticity and attempting to balance the power differential by engaging in an authentic relationship could be helpful for adolescents. As Abigail described, humour may also be a tool for practitioners working with adolescents, as this too seems to break some barriers in power. That said, humour can also be misinterpreted and should be used cautiously by practitioners.

Below, Michelle discusses her experience with different field guides. Field instructors are commonly rotated each week during U.S. continuous-flow wilderness therapy programs (DeMille & Montgomery, 2016, 2017). For Michelle, this meant some weeks were better than others as it depended on which staff were in the field with her. In the excerpt below, Michelle points out the “professional distance” she had with one team of instructors, which might be at odds with the transparency Abigail described.

Michelle, USA, Continuous-Flow Wilderness Therapy

There were two other leaders besides Ben, a man and a woman. I absolutely hated both of them because I felt like they were fairly unprofessional. I felt like they didn’t
care. I felt like I was like just another kid to them, whereas Ben, this particular leader, his MO [modus operandi] was to give me shit about my shit. But he did it in the way that it was clear that he paid attention to who I was and what I was saying and doing.

Ben did that in a way that I appreciated, not because it was mean and bullying, but it felt like he was an older sibling. I don’t have siblings so maybe I don’t really know what that’s like, but it felt like he was relating to me in that way. I felt he cared; he, at least, was trying to figure out who I was. I felt the other two leaders kept this really frosty, professional chasm of a distance, where it was like you’re a child and I’m an adult.

Michelle’s description of her relationship with Ben echoes two threads presented throughout this Chapter. First, program participants preferred to be spoken to directly, and confrontation was acceptable as long as there was an established and meaningful relationship. Practitioners need to prove their “heart was in the right place” before being confrontational. These experiences of direct confrontation are presented below. Additionally, Michelle refers to Ben as like an older sibling. He was an authority figure, but also demonstrated having Michelle’s best interest at heart. Some of the participants in the following section describe a caring and “maternal feel” when reporting on their positive relationships with their therapists; in a narrative thread presented in the section “Parental Feel.”

While these excerpts represent positive experiences of these human relationships, other participants, like Sarah, felt the adults “were not very open.” Similar to how authentic relationships can provide a perceived balancing of power between the helper and the helped, practitioners and program participants noticed the importance of having more personal interactions, which, for the participants, was lacking in previous experiences of therapy.
have labelled the following narrative thread “Stereotypical Therapist” based on the language used by the practitioners and participants.

**Stereotypical Therapist**

Although there was a diverse range of struggles leading participants to therapy, they found it “boring,” “routine,” “stereotypical,” and not aligned with their best interests. This section will begin with Magnus, Crystal, and Glen, three practitioners who were direct about challenging their professional training or perceptions of what was to be a “traditional” therapist. What this means exactly is unclear, as it may mean there is something wrong with a “traditional” therapist when outcomes are clear there is not (Baldwin & Imel, 2013). Throughout this section, practitioners described wanting to be experienced as caring individuals instead of all-knowing experts. This is a common approach in solution-focused practice, as clients are positioned as the knowing expert. Similarly, practitioners strived for their services to be more equitable. They used language like “walking side by side with participants,” which is also a metaphor used in early solution-focused literature (Ratner et al, 2012). This idea is expanded in the next section about “Shared Experience,” where practitioners described creating a therapy setting where both participant and practitioner experienced similar conditions and initiatives, such as carrying the same gear in their backpack. The discussion which follows examines how some of the practitioners approached their adventure therapy practice, while avoiding terms like therapy or therapist.

Glen is a school-based police officer with no clinical training, but while providing community-based programs he refers to as adventure therapy, he discussed being mindful about not stepping into the role of therapist. Instead, Glen uses adventure as an opportunity for adolescents selected by their school for behavioural concerns to “connect with a caring adult,” have a positive adventurous experience, and change their perception of people in
authority, such as teachers or police officers. Similarly, Magnus specified the role he played as the facilitator of the experience.

_Magnus, Psychologist, Community Based_

I call us guides. We are not outdoor guides but life guides. And that’s the way I want to get in contact with these people. Being their guide. Not a teacher. Not anyone who tells them what to do. But a person who can say, “If you want to do this, you can go that way” or “Hey, think about if you do what you do now, this will probably happen in your life. And you can change, and I will help you.” And I have training for that person. So, it’s also a way of doing the work.

Crystal mentioned her community-based organisation, which worked with people with disabilities, actively avoided labelling her work as therapy. Although clinically trained and having worked in substance abuse as well, Crystal felt using the term therapy would provide more stigma for people with disabilities who can already be stigmatised in their communities.

_Crystal, Psychologist, Community-Based_

We don’t call our work therapy, somehow intentionally as well, because I realised very quickly, I wouldn’t want to call myself a therapist. For example, I don’t want to call myself an adventure therapist, because I really believe it gets in the way. Sometimes it’s so totally unavoidable to change what you call yourself, and it’s nice that we can.
Although there may be even more of a power difference in relationships between people with disabilities and their carers than with at-risk adolescents, Crystal believed “adventure can be a great equaliser,” especially so when participants share experiences. David also said he did “not like the word therapist that much” but viewed himself more as a “life companion.” Peter described “not playing the role of therapist all the time.”

Like Magnus’s clear distinction between taking on the role of teacher or therapist, one of the participants in his young women’s group, May, had a similar experience in her relationship with her therapist Mason. She wrote the following in response to my question about the quality of her relationship with her therapist.

May

Assuming you mean people like Mason when you say “therapists” then yeah. But I must admit that, that’s a little bit too personal for me to share, but I can say that Mason and his partner have helped me finding answers to questions I’ve had for a long time. First off, and now I know it might sound stupid, but one thing I took with me was that not all grown men are “evil.” All of it was an amazing experience for me. I’m grateful that I got forced into the opportunity of being on the team.

May included the quotation marks around “therapists” in her original response, which she sent via a word document. May reported ongoing difficult relationships with adult males, which she related to her early childhood trauma. Her therapist’s ability to build an equitable relationship helped May change her perception of males. Kennedy, a youth worker, provided an example on his role as a male leader in an all-female group, similar to Mason’s approach with May. In the passage below, Kennedy explains how he used outdoor environments to
connect with disengaged young people using laughter and fun. He explained that one participant noticed that he did not yell when participants made mistakes.

_Kennedy, Youth Worker, Community-Based_

Another expression that I’ve learned recently from another facilitator is _rapport-based facilitation_, where I think I naturally employ that. Where over and above many aspects of being out there is about building that rapport. I had like me and a co-facilitator. Another male with an all-girls group. And one of the young women just sort of said, “I just didn’t really know men could just not yell when you did something wrong.” You know, I think creating spaces where you’re in challenging situations, but you can still learn enough about that young person to know what makes them laugh or to sort of make them try to feel, not necessarily take their hardship away, but just make them feel like they’re respected and safe. I think a lot of the therapeutic relationship, for me, is building that rapport, making a young person feel safe and demonstrating fun.

While in a position of authority and needing to monitor safety, program participants felt comfortable when adventure therapy practitioners were able to develop real relationships, beyond the bounds of the helper and helped. In contrast, Thomas found his therapist disingenuous, stating, “They were just lines” when referring to their discussions. In Chapter 5, I represented experiences in therapy before adventure therapy, and participants described a lack of goal consensus and relational bond, and did not find therapy meaningful. Relationship issues are the biggest factor contributing to adolescents disengaging from therapy (Garcia & Weisz, 2002). Sophie found the leaders of her expedition were able to establish a relationship.
different to her previous therapy experiences. There are implications from these findings relevant to all modes of psychotherapy, not only those adventure-based.

_Sophie, USA, Contained Expedition_

They actually had good person conversations with me instead of just treating me like the quiet type of thing. I just felt more connected to them on a people-to-people level as opposed to a therapist-to-client or abuser-to-abusee type of thing.

Possibly understanding that adolescents engaging in adventure therapy have been through numerous interventions and arrive experiencing a state of demoralisation, practitioners should focus intentionally on building authentic relationships where participants feel cared for and experience unconditional positive regard. The genuine and transparent practitioner might help participants to feel remoralised, which in turn can evoke a participant’s positive coping skills (Wampold & Imel, 2015). Youth worker Kevin felt “it was a different thing for someone to be there” when describing his approach to make adolescents feel welcome, validated, and cared for. By attempting to downplay their role as therapist, practitioners should endeavour to build the more democratic setting recommended by Dewey (Borden, 2013).

_Shared Experience_

Shared experience has been portrayed as a distinctive characteristic of adventure therapy (Newes & Bandoroff, 2004; Russell et al., 2017). Participants are viewed as active participants, not spectators, sharing their experiences with practitioners, and it is often assumed this creates a new and potentially more cooperative therapeutic relationship, which adolescents may not have experienced in previous therapeutic interventions (Gass et al., 2012). The practitioners I interviewed referenced this idea frequently. Interestingly, many of
these descriptions involved examples of weather providing a natural consequence to both the practitioner and participant. For example, psychologist Lynn described her experiences practising both talk therapy and adventure therapy. She used similar metaphors to other practitioners in using the weather or natural setting to describe shared experiences. Now a licensed counsellor, Jackson also reflects on his wilderness therapy experiences and the “power of shared adventure.”

*Lynn, Psychologist, Private Practice*

I think one of the things for me about what is different about my relationship in adventure therapy, versus when I’m doing talk therapy, is that I am a more active participant as a therapist. It’s still a shared experience when you’re doing talk therapy too though. We’re still having conversation. I’m not a blank page. But this piece that I am there with you in the boat when it’s raining on us. I am right there with you, when something’s happened, or the success is happening. And it’s happening to me, too. When we do an experience right away, and we’ve lived it together, that support and compassion, and capacity for validation and empathy shifts.

*Jackson, Counsellor, Wilderness Therapy*

I think what’s great about the therapeutic alliances in these situations is, if you’re in a rainstorm, we’re all in a rainstorm. If one kid doesn’t want to walk, then nobody’s going to walk. If somebody burns the grits, or undercooks the oatmeal, then everybody’s eating it. I guess ideally, we take a lot of intention to try and create a relatively equal relationship between counsellor and client. At least that’s my focus. And as far as the environmental circumstances in a wilderness setting, you’re in there.
This is a hill, and this hill is hard for everybody. We slip, we fall, we get blisters, just the same as you guys.

**Grace, Social Worker, Community-Based**

I think that some of the things that I really like about the wilderness setting for therapeutic relationships is that shared experience on a same plane, you know? Like it rains, you both get wet, you’ve both walked all day. The hill is the hill you’re both walking up it. It’s cold, you’re both cold. You’re sleeping in a tent, you’re both sleeping in a tent. Like there’s very much that shared experience. I mean it bonds all people right, when we share these experiences together. And so therapeutically, when you’re sharing that same experience with a client, that connects you in a stronger or different way to what it can if you’re just connecting with someone in an office. It completely mixes up that power differential.

Jackson’s and Grace’s excerpts contain interesting language. They both describe a hill as an opportunity for shared experience. Grace felt adventures in the outdoors can mix up the “power differences,” providing a more democratic setting. Bella, a social worker working in private practice, also specified the “reduction in power dynamics” because if it rains, “it rains on both of you.” In the above examples, both Jackson and Grace stressed the importance of shared adventurous experiences as conducive to building more equitable relationships. In the following thread about “Feeling Valued,” Andy describes his relationship with the wilderness instructor Christine who was willing to get her “hands dirty” with the participants. Of course, power differences are always present in therapeutic interactions, but it seems these adolescent participants preferred to engage in activities together with their practitioners.
Brady’s contained expedition in Australia was unique to other experiences represented in my inquiry in that two of his schoolteachers accompanied the group on the expedition. Brady’s mathematics teacher was someone he “hated.” Brady explained he would “kick a chair over or do something just to get . . . kicked out of his lesson.” He did not want to “deal with him.” During their eight-day expedition together, Brady was able to see a different side to his teacher.

*Brady, Australia, Contained Expedition*

Throughout the week, I was talking to him and stuff. I started to see that he wasn’t actually the bad guy that I thought him to be. I realised that he was human. We got talking. He started to see things from my side. I started to see things from his side, and we got on famously after that.

I think it was seeing each other on a different level. My only interactions before that were just, he was my teacher, I was his student. I didn’t like what he was teaching or the way he was teaching it so when we’re out there. He didn’t have anything to teach me. All we had to do was talk to each other and by doing that, I started to see well this guy actually does just want to see what’s best for us. So that helped me stop being so arrogant, I guess. Then that’s what turned that relationship around, seeing he was a human being.

Emerging from this thread of shared experiences was the importance of participating in activities and living together. Counsellor Peter described there being “nowhere to hide” when facilitating wilderness therapy programs. Logan felt it was important to be present and “there 24/7.” For Brandon, one benefit of wilderness therapy was that people “are together 24 hours a day.” Jackie said shared experiences meant, “We’re doing this together,” suggesting a
potential difference from action-oriented therapies and talking therapy. During his wilderness therapy program, program participant Craig honoured his field staff for living “with us day in and day out.” Similarly, Michelle described her field staff as being “in this together” with her.

Counsellor Nathaniel described telling his participants that “You’ve got to look after us as much as we’re going to look after you.” Nathaniel preferred sharing this responsibility with participants to allow for more of their feedback throughout their sessions together.

Social worker Robert described an experience of conducting his own participant observation on a month-long outdoor course and reflecting on wilderness therapy practice. During the expedition, Robert and the group of participants were trained in complex mountaineering skills.

**Robert, Social Worker, Community-Based**

It was feeling some of the power differential dynamics that you get when you’re on an expedition team. I was on a team that was all adults. All the students were adults. I was the oldest. I think the youngest was 18 and everyone was in their 20s and still, even with us being adults led by two adult team members. There was a big power differential between the instructors and between the people that were the students. Sometimes I got pretty frustrated with the decisions that they were making and when I perceived that they were doing things poorly. And I’m an adventure therapist in this class learning these things from these folks. I can only imagine how much worse it is when it’s a client, someone who’s been court mandated to go out or who’s been transported in the middle of the night into one of these environments, how they feel that dynamic and that lack of collaboration with their instructors. So, I think that was a good learning experience, to just see what it feels like to have some of that power
taken away and be in the learner seat and have to go on someone else’s plan, on an organisation’s plan, working on what were the goals I agreed to, but more or less their goals and their way of teaching it.

Robert described feeling frustrated about not being heard in his outdoor experience. The more Robert experienced a perpetual hierarchical divide between practitioners and participants, the more uncomfortable he became. Shared experiences have the potential for displaying to adolescents that the people caring for them are “human beings” and establishing a democratic environment. Brady described having a negative relationship with a schoolteacher until they participated in an adventure therapy expedition together. This changed Brady’s perception of his teacher, from having little connection, to seeing him as a human, a factor stressed by many of the participants. Program participants again pointed to where relationships, for the most part, were more equitable. Practitioners found adventure-based programming to provide opportunity for a more equal relationship between the helper and the helped, which can improve the relational bond. While the authenticity of the practitioner helps to reduce the perceived power differences, feeling valued also emerged as key to improving participants’ engagement in the program.

**Feeling Valued**

This section contains two subthreads contributing to participants feeling valued. The first is “validated” and welcomed to the program and the second is participants viewing the practitioner as having a “parental feel.” Brady from Australia and Laura who attended a continuous-flow wilderness therapy program in the United States provided examples of their practitioners’ approaches being influential to their experiences. During our interview, Brady
described Kelly’s approach to leading the group as important for his group obtaining the most out of the program.

*Brady, Australia, Contained Expedition*

I guess they made us all feel valuable. They treated us with a level of respect which we’d not really received before, but we’d not done anything to earn it before either. And they didn’t have that mentality of ill respect until you give me a reason not to. Because we gave them plenty of reasons not to respect us, but they still gave us respect the whole time. Which for a 15-year-old was, I guess, vital for us and our acceptance of other people. And they accepted us for who we were but definitely were comfortable in telling us that what we were doing wrong, like how we were living our lives, like going out drinking, treating school like it was just somewhere we had to go. So, I guess that was the big thing for us. Being treated as an equal, an adult.

The participants preferred program leaders who appeared approachable and demonstrated an interest in their lives. After a month in the field, Laura’s therapist resigned. Her therapist had visited her once a week and maintained contact with her parents for the previous weeks. Laura was assigned a new therapist Jason, who came out to visit her and introduce himself. Although Laura reflected negatively upon her experience in wilderness therapy, Jason was someone who left a lifelong impact on her life. From his first visit, he began with helping her to feel valued and “special.” Laura referred to Jason as her “dude” and described how he validated her experience. Validating participants’ lived experience also related to my finding about the “Distribution of Dysfunction.”
Laura, USA, Continuous-Flow Wilderness Therapy

Jason was the name of my dude. I feel like I distinctly remember the time that he told me, although I couldn’t tell you verbatim what he said. I remember that he said it in a way that made me feel like I was his equal which no one ever did in the program or outside of like I’m a teen in mental health services experience, because I felt like my impression of the whole program was exclusively like, “Oh you’re broken, how are we going to fix, you’re poor, sorry.” But in this moment, I just remember him looking at me and saying, “Between you and me, I’m not supposed to tell you this, but your family is fucked up.” I remember feeling like we were on the same level and that he was telling me something really important that it was as if nobody had ever said that before and I felt really special. I felt like he had treated me as his equal, if that makes sense. He wasn’t talking down to me.

You know what would be crazy now that we’re talking about this. I mean I got picked up in the middle of the night by some ex-marine people, right? I don’t even know how I put up with that. I mean I don’t know how to establish rapport with a disgruntled teen in 20 minutes, but what if that was my first interaction with the program was somebody who spoke to me that way was somebody who validated me. I feel like nobody except Jason really validated my experience, which is such an important thing at any age. To have somebody be like, “Wow, man, I’m so sorry that happened. I’m here for you.” How different would that experience have been?

Willow mentioned that she “didn’t feel judged,” and Olivia felt she was “talking to a friend.” Yosef honoured his expedition leader for “not giving up” on him. Michael’s relationship with his field staff let him know he “wasn’t a bad person.” The practitioners around Kelly validated her experience saying, “I know what you’re going through.” Frank
found his field staff “so helpful and understanding.” Mark was told by his therapist that he should return and “become a counsellor” at the program. This meant a lot to Mark and made him feel capable and valued.

Practitioners also described the importance of validating participants’ experiences and making them feel as valued members of the group. Felicity, a counsellor working at a wilderness therapy program, stressed that she tries “to create a relatively equal relationship” with her participants. Psychologist Magnus said practitioners should trust their adolescent participants. He stressed participants should feel “listened to” and interpret their therapist as “open-hearted.”

Adolescents involuntary placed into adventure therapy programs might begin their programs reluctant to engage; feeling valued helped participants get more out of their programs. While Laura looked back negatively on the bulk of her experience, mostly due to the way she was treated and the program’s “we’ll break you down and build you back up” philosophy, Jason helped her to realise the impact a negative family environment had on her upbringing. Dewey designated young people as the most vulnerable members in society since they are directly affected by the choices and attitudes of the adults around them (Sikandar, 2016). He was concerned their voice was missing from the education curriculum.

Interventions, like the impact letter, might be worrying given the one-sided nature of the therapy interaction. Participants described the importance of shared, democratic experiences as being essential to their adventure therapy experiences, yet these program-oriented interventions, delivered to all participants void of context and preference, seem to be at odds with the participant feedback. Although many wilderness therapy programs are branded as a family treatment (Tucker et al., 2016), I found many programs began with a focus on the adolescent as the primary client, potentially ignoring the “Distribution of Dysfunction.” Adolescents responded more favourably when their lived experiences were acknowledged
and validated. Practitioners should walk a thin line between pushing clients and aiming for them to experience hope, success, and mastery and acknowledgement.

**Parental Feel**

To illustrate this narrative thread, I have included program participant descriptions of practitioners who exhibited a ‘parental feel.’ For example, Andy described his relationship to one of his field guides while comparing her to the others, and Kelly perceived one of her field guides as “grandmotherly.” Andy’s words below resonate with the previous narrative thread of “Shared Experience” as well.

**Andy, USA, Continuous-Flow Wilderness Therapy**

What was nice about her is that she was just as down in the dirt as we are. Some of the other counsellors would not get their hands dirty as much. Christine was all about getting in, getting dirty, hiking with us. She’d run laps around the group if we weren’t going fast enough. That type of thing. She was always quick with a joke. If you ever had a problem, she had this maternal feel of you could talk to her about because you knew what you said to her didn’t go in her report if you didn’t want it to. If you were like, “Look, like can I talk to you off the record?” She was the kind of person you knew you could do that with, whereas everybody else, you knew every word you said was monitored, basically.

**Kelly, USA, Continuous-Flow Wilderness Therapy**

People were so kind, and nice. I didn’t feel judged. I didn’t feel like there were unreasonable expectations put on me. All we had to do was just follow the guidelines of the day, hike, and follow directions. The big deal was always being able to make a
fire at the end of the day and make soup, which I managed to do being a city girl. I think I was closest to this one woman, just because she seemed very sweet, not necessarily motherly, but more grandmotherly.

Solution-focused counsellor Nathaniel also cited the parental role in his work in private practice stating, “sometimes, I just feel like I’m a professional dad.” Similarly, Jeanne from Canada referred to the therapist running her program as “a total dad” who she “liked from the minute she met him.” Connor compared the relationship he had with one of his field guides, Alice, with that of Jodie, another field staff. Connor felt Alice’s “mother-like” personality made her a highly respected member in the group.

**Connor, USA, Continuous-Flow Wilderness Therapy**

Alice was recurring for my group. We had her every other week and Alice, from my perception, kind of seemed almost like a mum figure to the group. She was really highly respected. If anybody was going to be disrespectful, it wasn’t to Alice. And she wasn’t more stern with us or anything like that, it was just, I guess more calming for lack of a better word. It was like kind of a mom-ish figure for the group and I personally found it easier to converse with Alice. I felt like she was more relatable to me and I don’t think that is a female thing because there was also Jodie who we had her for every other week for three weeks straight. Jodie brought a really different vibe to that group and I think she had no shame whatsoever. Jodie would get really upset, take things personally, pull herself away from the group, and I think that really hurt the group’s ability to kind of put Jodie in that mother-like figure that Alice had.
The parental and caring feel described in this section made it easier for these program participants to engage in adventure therapy. The practitioners described by the participants portrayed a caring personality, making them approachable. For adolescents involuntarily placed into an adventure therapy program, this type of relationship is useful for increasing engagement, where participants feel cared for, listened to, and understood.

Practitioners eliciting this “maternal feel” still maintained the ability to enforce boundaries and confront participants. Participants did not describe these practitioners as having a lack of authority. They respected the practitioners’ authority who established respectful and caring relationships. This was depicted by William, who attended a wilderness-based therapeutic boarding school. Although William’s school resembled more of a “lord of the flies” mentality, William described one worker whose warmth stood out to him.

William, USA, Therapeutic Boarding School

The counsellors at the boarding school didn’t have a lot of training. For long periods of time, they were away hanging out doing their own stuff. There was no equality there. There was no reciprocation of respect. You were expected to respect them no matter what. They could treat you like shit. There was only one person there that ever gained my respect. There was a woman named Hillary who was there for my first two months. She was the sweetest woman on the planet. Anybody in our group would have done anything for her because she respected us. She held us accountable. She genuinely cared about our happiness.

Hillary was able to hold participants “accountable” through respect and a desire to be helpful. Echoing this thread, Michelle described one of her field staff, Ben, as being like “an older sibling.” So far in this Chapter, participants and practitioners have described the qualities of
relationships perceived to be the most helpful in adventure therapy settings, namely, that shared experiences, authentic relationships, and participants experiencing feeling valued were important to their time in the field. In the following section, I explore the use of confrontation and the contrasting roles adventure therapy practitioners play in different program structures.

**Positive Use of Confrontation**

Tony, Kelly, Katy, and Angela valued the qualities of their relationships with their practitioner, despite the confrontation it contained. That is, these relationships included practitioners provoking participants’ based on their perceptions or problem behaviour, but were not devoid of care or a relational bond. In the previous section, Michelle described a field guide who was able to hold her accountable, stating he maintained a role similar to an older sibling. They had fun together but had her best interests at heart. The excerpts below come from experiences on continuous-flow programs and refer to therapists visiting weekly to engage with the groups.

Although Tony struggled to master the hard skills required to progress through the program, Tony had “fond memories” of several of the field staff. In the excerpts below, Tony discusses how his primary therapist was able to hold him accountable, and Kelly, Kay, and Angela provide examples of their experience with confrontation in the therapeutic relationship.

*Tony, USA, Continuous-Flow Wilderness Therapy*

I had, at the time, and continue to have a lot of respect for my primary therapist. Simply for no other reason than he was the first therapist that actually told me I was full of shit. And that might be his style, I don’t know. I have no comparison. I did it once, I’m only doing it once. But he was the first one like, “Yeah, I don’t believe
you.” He was the first therapist I ever went to that didn’t deal with me saying nothing. He didn’t deal with me not participating, didn’t deal with me not wanting to talk. And certainly, he didn’t deal with me not telling him anything other than the answer. And I respected him for that, which is worth something. I email him every so often still. We trade messages. When I think about people who formed who I am today, he’s high on that list. That means something to me.

Kelly, USA, Continuous-Flow Wilderness Therapy

Her name was Zoey, and I absolutely hated her when I first got there. Because she told me, basically this was the reality of the situation of. This is where you are. These are your problems. You’re not going to leave. She didn’t baby me like my therapists previous to this had all done. I always pulled the, “I’m only 13” card, so they always were like, “Okay, yeah, you’re going to mature and grow up,” but I never actually did growing up. I just kept on doing consistent bad behaviours.

She basically was like, “Do you know what, I know what you’re doing is not okay, and I’m going to tell you straight up about it.” Which I came to really admire and respect because she was blunt, and I’m very blunt as a person. She came once a week and I was really, really sad when I graduated, that I didn’t get to see her anymore. Because I had finally become close with someone.

Like Tony and Kelly, Katy reported to benefit from her therapist being upfront. She credited her therapist for having “saved her life.” She acknowledged during our interview that if she “had kept going in the direction” she was going, she would have been “dead within a year;” most likely from taking her own life or “making a really shitty choice.”
**Katy, USA, Continuous-Flow Wilderness Therapy**

She realised very quickly when I had my bullshit face on. When I was trying to bullshit her and tell her that everything was fine and rainbows and unicorns. She called me on that. She’s like, “Katy, you’re lying. You need to cut that shit out and be straight with me.” There hadn’t been a therapist up until that point who had been that abrupt with me. I think she realised, and she didn’t do it right away, but I think she realised that was about the only way she was going to get through my hard head, was with getting abrupt with me, with getting a little snappy, a little bossy. I was a 15-year-old kid. I hadn’t had anybody speak to me that sternly besides my own mother. That was interesting.

In the excerpt below, Angela describes working with the clinical director of her program, a social worker, during the program’s first parent program. With all the families seated in a circle in a small room, the director began speaking to Angela directly.

**Angela, USA, Continuous-Flow Wilderness Therapy**

And, he does his magic to make you feel like, I mean in a good way, but at the time like you are a total shit and your decisions are beyond questionable. Whatever the exercise was, it’s imprinted in my brain that one of the biggest issues I had pre-wilderness therapy was the ability to control myself enough to use the word no. During my escapades, that was an issue. There were people I became physically involved with only because I didn’t say no. I didn’t know how to stand up and say no. So that was a big lesson that I learned—that I control me. I control what I do or don’t want to do. I control my thoughts. I control who I allow to be in my close circle. I control my emotions; which is still a daily struggle by the way.
Confrontation did not emerge as a narrative thread from the practitioner interviews. Confrontation however, gave participants a sense of agency. By pointing out discrepancies in a participant’s behaviour or attitude, participants built some respect for practitioners that did not “baby” them. Tony’s, Angela’s, and Katy’s relationships with their therapists had lifelong impacts, as they remained in touch with their therapists and credited them for helping. Working in wilderness therapy, Marcell described telling participants what they were doing was “not acceptable” when it came to making fun of transgender people. Kennedy’s program participants knew the “buck stops with me.” Brady mentioned that although the facilitators of his contained expedition made him feel valuable, they were also “comfortable in telling us that what we were doing was wrong.”

Duncan et al. (1997) recommended caution when using confrontation, as discrepancy between practitioner and participant can create further distance in the therapeutic relationship, which can predict impasses and therapy failures. Confrontation, in the cases presented above, may signal a participant is experiencing the practitioner’s attitude as authentic. When practitioners do not take into account a participant’s motivation, confrontation can have the opposite effect. In this narrative thread, program participants received the therapist’s positive force, which may have also displayed a level of care important to their relationship and ongoing progress.

**Therapeutic Community**

The program participants I interviewed took part in adventure therapy in a group setting with other adolescents their age, and some considered their fellow group members to be an important factor in the change process (Russell et al., 2000). This narrative thread of
“Therapeutic Community” is illustrated in Figure 13 below. First, however, I present the evidence regarding group adventure in the therapeutic context.

Using their new Adventure Therapy Experience Scale, Russell et al. (2017) found participants who reported higher scores of group adventure, mindfulness, and helpfulness demonstrated improvements in overall wellbeing throughout the course of an adventure therapy program. While feedback on the helpfulness of an intervention has been shown to predict positive outcomes across different therapies (Lambert, 2015), group adventure, which relates to encouragement and support among group members, might be an important aspect to the therapeutic relationship. That said, adventure therapy has been used in private practice settings with individuals not living in a therapeutic community (Tucker et al., 2013; Tucker & Norton, 2013). A wilderness therapy practitioner, David, said this work was centred on “the relationship between people,” and Brandon, a former field guide and now social worker, reflected on the importance of the therapeutic community.

Brandon, Social Worker, Wilderness Therapy

In a wilderness setting, you are together 24 hours a day. And so even as much as the experience is isolated to a particular setting. The fact that a 14-year-old kid who hasn’t been able to maintain any of his basic habits at home. The fact that he’s able to get up and start making breakfast with one of the staff members, and prepare that for the rest of the group. That might not have happened at the start of the week, but by Day 5 he’s getting up and doing it.

Participants Andy, Craig, Katy, and Michelle all described experiences of living in a therapeutic community during their continuous-flow wilderness therapy experiences.
Figure 13: Therapeutic Community
Andy, USA, Continuous-Flow Wilderness Therapy

Suzy, Jeff, Ryan. These names I remember from eight years ago. That's not something I do. We have wonderful stories of stupid things we did. We made cordage out of grass, and as a challenge. Our goal was to make six feet of cordage. We made like eight feet of eight-braid cordage, so probably 100 plus feet of. We would play tug-of-war with it. That was an amazing accomplishment for us. We’re like, “We’re gonna see if we can do this.”

We hiked from mountain to mountain. A couple of times, me and another student, we’re just like, “We can’t do it anymore.” Everybody else was like, “Look, we’re right there. Come on. Let’s do this. Here.” We played riddle games and stuff like that to keep each other occupied. It was a great sense of comradery, and that was what I was missing for all my socially maladjusted years before. That human connection and accomplishments are the real reward in life for doing things right.

As the effects of bullying factored in getting Andy wilderness therapy, Andy stressed that the comradery of his wilderness therapy group was like nothing he had experience before. Additionally, “human connection” was important to his experience. Another participant, Craig advanced to the Community phase of his program after two weeks; faster than other members of the group. This phase reflects the social responsibility phase described in Chapter 5. Since the others remained in Individual phase, Craig could only talk to the field staff.

Craig, USA, Continuous-Flow Wilderness Therapy

It was really irritating because the other kids in the group, while they were mostly wallowing in self-pity at being there, and they weren’t doing anything towards the
advancement of their, I guess rank? So, they weren’t moving upwards. When I got there, I kind of gave them a kick in the pants when, within the first two weeks, I graduated into the Community phase. After that, everybody started moving up quite quickly with me and moved to Community phase in about 4 weeks after that. So that would be about Week 6 in the program. We were all at Community phase and we could talk and eat our meals together; things of that nature. Of course, still under very close supervision.

Craig’s group became “close-knit,” and he took on the role of being a “leader per se.” Craig believed it was because he had done scouts before that he was able to use his previous experience to start advancing through the program. Katy’s experience was unique in that after one week in a female group, the two other participants graduated. She spent the majority of her program alone with two field instructors.

*Katy, USA, Continuous-Flow Wilderness Therapy*

I had two staff with me at all times, but they’d switch out usually once every other week. It was a lot of the same staff members over and over again. You got to know them and build relationships with them. I will say this. The guides were fantastic. It wasn’t a negative experience at all. Not from that. I was having a very negative time in my own head, but a lot of the staff members were working on degrees I psychology, sociology. Things like that. They had some context on which to talk to people about it.
It was Katy’s 42nd day on the wilderness therapy program before another adolescent joined the group. Katy reflected on the experience of being able to mentor the other participants, but she wished she had had adolescents in her group to help her master some of the hard skills.

It was cool to have other girls come to the program because I remembered what I was like when I had first gotten there and how much more comfortable and happy I felt then. I was trying to teach them the way that I didn’t have the opportunity to be taught. It was cool. Amanda came first, then Amy, then Cindy, then Carolina, then Hannah. It was six girls altogether. I loved it. It was like having my training wheels taken off. I had gotten to a point where, by about Day 50 or so, I didn’t need the map anymore to get us from campsite to campsite, because I knew where I was going. It’s a safe forest. I got to help teach the other girls, at least some of the skills stuff. I got to have people there my age too, which was really nice.

Like Andy, Katy listed the names of others in her groups to demonstrate their importance to her experience. In the excerpt below, Michelle reports on benefiting more from her therapeutic community than she did the program structure. Although she was just trying to “work the program” to “get out,” she found the unstructured time with other participants and specific field guides to be more useful as they “understood” her.

Michelle, USA, Continuous-Flow Wilderness Therapy

It was like “You’re a young person and you’re an idiot.” You have to follow our rules. There are so many spaces in which young people are told that explicitly and metaphorically that it was like did this really need to be another one of those spaces? I think that there were people and there were moments along the way where I felt like I
got to be the queen of my own experience, but that was definitely not the overall. I think it came explicitly from social connections of other people because I felt like they trusted me, or they were my peers and they understood me and looked after me.

May and Andrea in Denmark experienced similar programming, referring to the group they interacted with as “their team.” Michael credited the other people in his group as having “changed my life.” Mark had a positive experience, finding it “really nice to become a part of a group.” Angela, however, was moved by her therapist into another group for a week to try and engage her in the program. For Angela, this contributed to her having “never felt the connection to my group.” Sophie described feeling as though she was in the wrong group, given that she did not struggle with substance abuse as the other participants in her group did.

**Sophie, USA, Contained Expedition**

I think the thing that separates me the from a lot of other people is I didn't have drug and alcohol problems. I wasn't going out and getting arrested. I was misdiagnosed with the wrong mental illness and put on the wrong medication. That really made me feel very separated psychologically and with my experiences from the rest of my peers. I really didn’t feel like I had anybody to relate to when I was there. And then I think also therapists were trying to get things out of me that I couldn't give them because it was all tied to my mental illness and poor coping skills, as opposed to actual drug and alcohol and violence problems, which, I would say, all of the other girls were there for. A lot of the program was tailored towards drug and alcohol abuse and that just wasn't something I was doing. So, I felt alone. I would want it to be more therapeutically based as opposed to just drugs and alcohol based because people have
all different kinds of problems. Just because you're a bad teenager doesn't mean you're doing drugs.

The use of therapeutic community living and shared experiences between participants and practitioners echoes some of the common practices in *milieu therapy* (Frank & Frank, 1991). Emerging as an alternative to patients living in mental hospitals, milieu therapy provides an environment that demands social responsibility and using well-defined norms to improve socialisation. Milieu therapy typically involves larger groups of participants and involves a hierarchy so newer members can be held accountable for their actions by more experienced participants.

This narrative thread of the therapeutic community relates to the group environment in which adventure therapy experiences take place. Included in this interaction is the peer group and practitioners or field staff. The following sections explores the unique role of the therapist on continuous-flow wilderness therapy programs, and in particular, the practitioners who visit their respective group once per week.

**Once in a Blue Moon**

A major difference between continuous-flow programs and contained expeditions lies in the role of the therapist. While the lead therapist remains with the group for the duration of a contained expedition, the therapist in continuous-flow programs visits weekly to his or her respective group. During my visit to a U.S. continuous-flow program, I witnessed what was a unique style of programming, where the group actually returned to a base camp once a week to meet with their therapist who would spend the day conducting individual sessions.
Today was my final day in the field. Two participants are graduating today, so we drove back to base, so they could begin their preparations for graduating. We piled in the van, strapping all of our gear to the roof. No one wanted the job of handling everyone’s “poo bags.” Because we have to pack out our excrements, all of our “stuff” was double bagged and put into a large trash bag. Everyone avoided the task, so I decided to take on that responsibility.

We eventually arrived at base camp, a flat location with a large tepee and surrounding shelters. I was told the tepees were fairly new and we actually sat through an interesting lesson on how to have a fire in the tepee and use the roof flaps to draw the smoke out.

The therapist arrived. He offered me the opportunity to sit in on his sessions with the participants, but I declined. I did not want to impose on the participants, and I was not there to capture their personal struggles, just the program structure. The head field guide, Michelle, went with the therapist and the first client for a discussion about the previous week and to process some new letters the participant received from home. I remained at camp and helped chop firewood, cook lunch, and bow drilled with the participants.

After about an hour, the participant returned alone and asked to “bust an I Feel statement.” When a participant is feeling emotional, they are instructed to “bust an I Feel,” which entails having all the participants gather in a circle. The participant uses the following script:

1) I feel ____________

2) I imagine I feel this way because ____________
3) In the future, I hope/request ____________

The participant then asks another member of the group to repeat what he or she has said, to ensure the participant felt heard. A participant repeated what he said, the circle broke, and the participants went on with completing their daily tasks. One of these tasks is to write a weekly report, which they discuss with their therapist at their weekly session.

Tony’s program also had a “regimented check in process,” which felt like “bureaucratic bullshit.” The program participants mentioned the role of their therapists, who visited the field once a week. Participants Olivia, Katy, Michelle, Connor, Oliver, Craig, and Thomas all reported having their therapists visit their programs weekly. For example, Katy’s therapist would “drive out to the campsite, sit and do therapy with us,” and then they would head back home. For Katy, these discussions helped her to begin engaging productively in therapy.

*Katy, USA, Continuous-Flow Wilderness Therapy*

For me, it was exhausting because I was very resistant. I had very much gotten into the mentality of “I’m bipolar. I’m on the right kind of meds now, so get the fuck out of my life.” Realising that number one, the way that I was feeling was not normal, and that it wasn’t my fault that I felt that way. A lot of it was me coming to terms with the fact that I wasn’t going to be able to fix it myself. I’ve always been very independent and needed to acknowledge there was something to fix in the first place.

Although Katy and Olivia described positive relationships with their therapists, other participants described the relationship as “fake” and “having no impact at all.” Despite Olivia
mentioning her time with her therapist was the only time she “felt like a person,” Olivia ended her interview saying having more time with her therapist was “the first thing I would change.” Matthew, a social worker, discussed his experience of working at a wilderness therapy program where it may, depending on the day participants were admitted, take four days before they saw a therapist.

Matthew, Social Worker, Wilderness Therapy

Students come in and there’s no trust with guides or therapists, at least at that program. Students may arrive on a Thursday afternoon, so they won’t see their therapist and then the therapist doesn’t come in until the following Monday. So, it’s like four solid days of just being in this program and not knowing what the fuck is going on.

Situations like this might further demoralise participants. Howard et al. (1996) urged therapists to symbolically package therapeutic interventions early on in therapy to elicit feelings of hope to improve the subjective wellbeing of the client. When participants are left without future information or hope as to how the service could help improve their future, it can be further discouraging.

Distinctive to the role of a therapist on continuous-flow wilderness therapy programs, is the final decision-making process for when a participant graduates from a program. DeMille and Montgomery (2017), in their piece about incorporating narrative therapy into outdoor programming, acknowledged this role can interfere with creating a collaborative relationship:

. . . a therapist in this OBH program has an evaluative and gate-keeping role with the student that makes an egalitarian relationship in therapy unrealistic. The therapist is
the gate-keeper of the decision about when the student is ready to transition to a less restrictive treatment environment, and students are aware of this dynamic. Thus, initially in therapy, the goal is to minimize the impact of that dynamic on the treatment process and to create a safe therapeutic environment. (p. 39)

Craig experienced his group’s therapist as a gatekeeper, which interfered with their ability to establish a collaborative relationship.

_Craig, USA, Continuous-Flow Wilderness Therapy_

We would have weekly check-ins with our therapist, and it was made abundantly clear that she would be the one to ultimately decide when we were ready to leave. It definitely irritated me. Especially as the weeks went on. And it was made clear that I was definitely going to be staying longer and longer and that the only person in the way of my leaving was her. It really got at me. And I think it really chafed the other people in the group as well.

We did not get along. Not at all. And many of the other group members will attest to the fact that I, on multiple occasions when she was not there, I insulted her ruthlessly because she was just, she seemed to really enjoy lording it over people. They were not getting out until she decided that they got out. So, it was almost like she was on a power trip and she held your destiny in her hands. It was made abundantly clear to you by her on multiple occasions every time she came out, that you were not getting out until she decided. I don’t know if I got a bad therapist or just that’s the way it is, but that was definitely what I went through.
Craig felt his field instructors knew more about his current situation than his therapist. When asked about what he would change about the quality of the program, Craig said he would rather have spoken to his favourite field instructor, who exhibited “mum-like” qualities. Michelle said, “everybody was there to make me crack,” and this comment represented her perception of the philosophy of her wilderness therapy program. Although Thomas described his experience in the field as a “very negative experience of my life,” Thomas pointed to his therapist making little impact, truly evidenced by not remembering his name. Oliver also described having little relationship with his therapist.

*Thomas, USA, Continuous-Flow Wilderness Therapy*

I remember there was a guy. Don’t remember his name, but he was one of the therapists that would come out there to the woods once a week and talk to people. And I just felt like he was a complete phoney. The things he would say, they were just lines, you know? Lines you could learn online.

*Oliver, USA, Continuous-Flow Wilderness Therapy*

They had a therapist that came once in a blue moon. It was probably every week or so, once or twice a week or something like that. It didn’t really stand out as like a person. No big impact at all. You’re there. You’re just like, “Oh shit. I’m going to be here for a while.”

The role of the therapist in continuous-flow wilderness therapy requires balancing. Although an equitable and meaningful relationship is preferred, the therapist can often miss out on the impact of having more-shared adventurous experiences, because of entrenched practices of holding power over the participants; making uninformed decisions about when they are to
leave the field. Moreover, the therapists create individualised treatment plans and goals for participants and coordinate psychological testing, which can possibly end in the diagnosis of mental disorder. Practitioners should take care when adhering to rigid adventure therapy programming as this may be at odds to participants’ preferences of the therapeutic experience and relationship.

Zach provided a cautionary tale for this process as he witnessed therapists in wilderness therapy who “came up” with individualised treatment plans “on their own.” He said clients would be shocked when they discovered their treatment goals. For Emma, this was a concern for her when she was taken in for testing.

*Emma, USA, Continuous-Flow Wilderness Therapy*

They would talk to us about how we were feeling. And my therapist’s name was Suzy and the way that it kind of worked is just like by talking to us she would kind of diagnose where we were. During the second week, because week to week you were allowed to go back to base to take a shower. My first time going to the shower, they set me apart from the group and they made me take an IQ test, a personality test; just a bunch of psychological tests. It was very intimidating. Because a lot of the girls are very good liars, a lot of them are diagnosed with having sociopathic tendencies, stuff like that. So, they do treat everybody as a potential danger to themselves and to the rest of the girls. I felt like a criminal. I really didn’t have anything to feel too guilty about, but I just felt very cornered. In a sense, I was afraid that I might say or do something that will make these people think I was crazy or a dangerous person or something like that just because it happens. A lot of the girls would get diagnosed with x, y, and z thing. Then they were stripped of privileges like shoes or talking.
Mary, a social worker working in wilderness therapy, discussed why she helped to create a program where “two therapists and two mountain guides” lived with “the group the whole time for three weeks.” She made comparisons to typical continuous-flow wilderness therapy programs and said remaining in the field with her adolescent participants helped her to “build the relationship in a different way” than she could if she were just visiting once a week. The role of a therapist on continuous-flow wilderness therapy programs is unique to adventure therapy, as many of the practitioners I interviewed stressed the importance of shared adventure and the reducing of power struggles. Program participants pointed to authentic relationships, feeling valued, and shared experiences as important to the quality of their relationships with practitioners on their adventure therapy programs.

**Inequality and Force**

Outdoor settings provide a unique responsibility for adventure therapy practitioners. In continuous-flow wilderness therapy programs, the therapist determines when the participant is ready to advance to a subsequent phase of programming and ready to leave the program. In other adventure therapy settings, practitioners balance the role of teacher, such as instructing hard skills, monitoring physical and psychological safety, and creating a therapeutic climate, ripe with positive regard and empathy (Walsh & Golins, 1976). Program participants, like Craig, described their therapists as gatekeepers, holding power above the participants, something the field instructors also recognised. In this section, I present experiences of relationships with inequality and force. Excerpts are provided by Sarah, Tony, and Thomas.
**Sarah, USA, Contained Expedition**

I didn’t feel like they were very open. They were more of a disciplinary person. They weren’t very good at being double-sided as far as being, you know, you need to follow all the rules and then also being empathetic as well. I passed out the first day and fell down because I kept telling them I needed to stop, and they told me I was whining so that made me mad. I think they were just used to the kids whining and weren’t very open to listening. It wasn’t taken seriously.

I don’t think at the beginning they had a really good balance. I think sometimes they thought they had to be so strict that you would follow the rules without being strict with empathy. Empathy-guided strictness is what I would have hoped for. That’s I guess what I would call it. They didn’t really have that balance.

---

**Tony, USA, Continuous-Flow Wilderness Therapy**

They like to fuck with us in that group. So, I was reasonably new. And they had told a guy because he had fucked up so badly, he wasn’t leaving when they said he was going to leave. And he believed that, right up until the moment that his parents showed up to the group. Yep, straight up lied to him. There is another guy that they told . . . I don’t know how familiar you are with my wilderness therapy program . . . but it was Earth, Fire, Water, Air were the phases. They told a guy that he’d need to make Air [phase] before he left. He didn’t do well at it, and then they told him, “Oh we were just kidding. but you fucked up so badly.” My therapists were dicks.

---

**Thomas, USA, Continuous-Flow Wilderness Therapy**

And then, borderline physically abusive. If I didn’t want to get out of my sleeping bag in the morning, he and another instructor would pick up my sleeping bag with me in
it, there was snow on the ground, and they would just dump me out into the snow in my underwear. Then walk away with my sleeping bag and just leave me there. So, stuff like that. Psychologically manipulative, in the sense of when I refused to hike, they forced the other kids to build a stretcher of sorts and carry me. Which, you know, turns the kids against me. And then they hate me for making them do work. So, yeah, the first two weeks sucked pretty bad. I did not react too well. But at that point I realised I needed to change my behaviour if I wanted to progress. I was trying a little harder. My heart wasn’t in it. I was faking it in some degree.

Frank also described being “pushed . . . down the hill in the sleeping bags” by the field staff. In the section on shared experiences, counsellor Jackson described that “if one kid doesn’t want to walk, then nobody’s going to walk.” In this case, the natural consequence occurs when one member of the group does not want to engage. The group works through this experience together. Sophie, however, described her program wanting “to take away all control” from participants.

The narrative thread of “Inequality and Force” demonstrates a contradictory experience to the participants’ preference for authenticity and shared experience. Field staff and therapists withheld future information, used disruptive techniques, and created more stressful environments for participants. Where it was a natural consequence for the group to turn against Thomas for refusing to hike, it was the authority’s suggestion to craft a stretcher and make his fellow participants carry him that may have made the situation worse. In Chapter 6, participants discussed how practitioners enforced rules, such as not talking when out of earshot and how programs waited for participants to complete certain sets of tasks, rather than engaging the participant in the purpose of the program.
Resonant Threads

In this Chapter, I set out to explore and represent experiences of the therapeutic relationship in adventure therapy settings. Program participants and practitioners both described the value of shared experience, which helped to equalise power differences and establish an initial working relationship. Practitioners assumed roles unlike helping professionals the young people had worked with previously. Some, such as Magnus, Glen, and Crystal, intentionally distanced themselves from the term ‘therapy’ altogether. In some sense, these relationships mimicked that of a caregiver providing warmth, positive regard, and upholding boundaries or confronting negative behaviours. The final narrative threads revealed relationships lacking congruency, where the practitioners used their power to leverage compliant behaviour and determine the outcome for the client. In this discussion, the resonant threads rising from these findings were (1) “Efforts to Remoralise,” (2) “Democracy and Collaboration,” and (3) “Solution-Forced.”

Efforts to Remoralise

I have found many adolescents engaging in adventure therapy experienced a state of demoralisation, supporting Frank and Frank's (1991) hypothesis that after consistent attempts to solve a particular problem themselves, people feel demoralised and seek external help. I linked to other literature, such as Barish (2009), who provided case vignettes of what demoralisation looks like in clinical practice. In the case of most adolescents in my inquiry, the decision to try adventure therapy was made by their parents, who may have been demoralised in their own right after various failed therapeutic interventions.

Participants arrived under a variety of circumstances. Some were deceived by their parents, being told it would be like summer camp, and others were transported in the middle of the night to the program. These experiences elicited more feelings of demoralisation and
created relational distance between the parents and the young person. In contrast, in Australia, parents and schools worked to motivate Barry and Brady to engage, which led to their willing participation. Although different wilderness therapy programs operate across the United States, a cleansing phase was used through the majority of them to prime adolescents for their experiences. However, potentially traumatic transport experiences, the strip search, and being ordered not to talk with other adolescents on the program worked to further demoralise participants.

On the contrary, program participants described a narrative thread of feeling valued and engaging in authentic relationships, which helped to remoralise the participants. In his writings on educational reform, Dewey (1910) argued for education to ‘shift the centre of gravity’ to the student. The subject matter, in the case of an adventure therapy program’s structure or theoretical orientation, does not work in isolation. There must first be connection, because as Dewey (1981) argued, young people are the most vulnerable in society. Duncan et al. (2007) raised similar concerns in psychotherapy stating that “Therapists can begin to cast their youthful clients in the role of the primary agents of change” (p. 36).

Forcing program structure onto adventure therapy participants is designed for control and compliance. The problem with this approach to practice is the assumption that each participant will respond similarly to the same program structure. Sikandar (2016) interpreted Dewey’s philosophical view of education that teachers “should observe the interest of the students, observe the direction they naturally take, and then help them develop problem-solving skills. The teachers’ primary purpose is to increase freedom of the children to enable them to explore their environments” (p. 197). In Chapter 6, participants, such as Mark, Andy, and Kelly, described how their wilderness therapy programs taught hard skills as a specific factor designed to improve self-esteem and self-concept. This is a common aspect of adventure therapy programming in the available literature and my inquiry supported findings
that adventure-based hard skills can be used to help participants construct meaning of being capable and competent. For Frank and Frank (1991), experiences of success and mastery should occur early in therapy to invoke hope in the notion that the participants’ continuing efforts will lead to a positive outcome.

Relationships perceived as significant made them feel safe and valued. Practitioners also used self-disclosure from their own healing journey, which further showed their “human” side and congruence to the participants. These are communication skills that practitioners could use to help engage with adolescent participants who may have previous therapy experiences. The practitioner should attend to the participant experience over the program’s structure (Mitten, 1994). If an adolescent has been transported, a decision likely made to get them to a safe environment, it is worrying to think they felt “lost,” “scared,” and “lonely” during the initial phases of their experiences. In his impact letter from home, Connor’s parents said they felt like they “lived with a stranger” they did not know anymore. Connor, having smoked marijuana on one occasion, was sent to a program where he felt alone again. In his words, he was “a stranger at home and in wilderness therapy.”

While outpatient settings provided a less restrictive environment, emphasis seemed to be placed on establishing an experience where participants felt safe. The power of a therapeutic relationship, in this case, can work as a remoralising factor. Participants, such as Olivia, Nancy, Laura, Brady, and Willow, described the importance of practitioners validating their concerns or struggles. Laura, for example, described feeling “special,” on the “same level,” “validated,” and “equal.” Emma, on the other hand, “felt like a criminal.” Frank and Frank (1991) argued that any therapeutic relationship must recognise a person’s _wounded humanity_, while affirming his or her moral worth. Practitioners able to form authentic relationships made participants feel valued, thus producing better relationships.
Participants used terms such as “person,” “human,” and “equal” when referring to the way they felt about their caring professionals.

A recent meta-analysis by Gelso, Kivlighan, and Markin’ (2018) explored how real relationships, like the thread emerging from my inquiry, in psychotherapy affect outcomes. The authors defined the real relationship as

the personal relationship between patient and therapist marked by the extent to which it is genuine with the other and perceives/experiences the other in ways that are realistic. The strength of the real relationship is determined by both the extent to which it exists and the degree to which it is positive and favourable. (p. 434)

Based on their findings, which are similar to mine, the authors suggested practitioners empathically can help participants feel valued and understood, manage countertransference, use self-disclosure in well-timed situations to demonstrate genuineness, describe situations when the practitioner chooses not to share, and remain consistent and constant. These findings are similarly reflected in my inquiry.

Withholding future information and using trickery, as in Thomas’s and Tony’s cases, could also be further demoralising. The lack of explanation of the purpose of the program, its length, and freedom is problematic and at odds to social workers’ codes of ethics (AASW, 2010; NASW, 2016). My findings are especially troubling given how readily the importance of social interaction is referenced in adventure therapy literature (Paquette & Vitaro, 2014; Russell, 1999; Russell & Gillis, 2017). Trauma-informed guidelines (Kezelman & Stavropoulos, 2012) and professional bodies’ codes of ethics or best practice guidelines (AASW, 2010) call for practice to incorporate participants’ preferences and consent by describing the purpose and context of the service. Participants, such as Frank, described “not knowing what the fuck is going on,” which might raise an important ethical dilemma about
removing someone from their home, against their will, and then waiting for them, the child, to partner with the adult.

If participants attending adventure therapy programs are likely experiencing a state of demoralisation, it will be beneficial for programs to accent their efforts to remoralise (Collins, 2015; Howard et al., 1993; Norcross, Bike, & Evans, 2009). Hope is a future-focused paradigm in which participants believe their efforts, or the efforts of those around them, are likely to help. In this case, the stress they are feeling at the time, likely due to being involuntarily placed in a new environment, becomes manageable due to the hope it could help. A focus on establishing success and mastery, whether through hard skills or soft skills, early on in the program might tap into what the literature has shown to be the most effective therapy. This might begin by establishing a more democratic and egalitarian environment.

**Democracy and Collaboration**

The second resonant thread that emerged from the representations shared in this Chapter relating to therapeutic relationships, is “Democracy and Collaboration.” Following Dewey’s stressing of the importance of collaboration, Borden (2013) argued for a “recalibration of the authority of the practitioner” (p. 264). The author goes on to describe how this looks in the helping professions:

Pragmatic approaches reaffirm notions of egalitarianism and participation, emphasizing the fundamental importance of dialogue and an open-minded, deliberative process between the practitioner and the client as they consider alternative approaches to care and work to determine what works best in any given situation. Clinical formulations are provisional, shaped by experiential learning and outcomes over the course of the intervention. (p. 264)
For Dewey (1938), practitioners should avoid using the same interventions for all people and instead think about the context and preferences of a particular participant. In this case, programming should change as a participant progresses through different stages. These adjustments might be based on feedback from participants and an exploration of what is working and what is not.

The practitioners used examples relating to the adventure therapy setting, such as the rain or terrain, to describe shared, democratic experiences in the field. Participants described practitioners using humour to relate, self-disclosure, and being just as “down in the dirt” as they were. These practitioners were also able to step outside the role of all-knowing expert to build more equitable relationships. Participants from wilderness therapy programs, who work with rotating paraprofessionals, noted the differences in field staff, showing who provided a more collaborative environment made for better engagement.

A relational bond, consensus on the purpose of therapy, and the tasks or rituals to achieve that purpose are the three components included in the original and enduring conceptualisation of the therapeutic alliance (Bordin, 1979). Empirical evidence exists to suggest that when these factors are absent, therapy participants are likely to disengage from therapy or deteriorate (Miller et al., 2013; Wampold & Imel, 2015). More evidence encourages practitioners to collaborate with their participants’ preferred future and purposes of therapy, perceiving therapy consumers as active participants (Lambert, 2013). In reviewing 50 years of process-outcome research in psychotherapy, Orlinsky, Ronnestad, and Willutski (2004) described the ‘quality of participation’ as the most important factor determining positive outcomes. Empirical findings suggest positive therapeutic relationships, as perceived by the participant, can improve participation. Based on my inquiry, this relationship includes a participant’s perception of empathy, experiencing a genuine relationship with a therapist, and seeing the “human” side of the practitioner. Withholding
this participation, or creating professional distance between the helper and the helped, may interfere with this collaboration, creating a less than democratic environment.

Citing meta-analytic data about the impact of the alliance in psychotherapy (Asay & Lambert, 1999; Norcross et al., 2009), Duncan et al. (2007) mentioned that “therapy works if clients (youth and parents) experience the relationship positively, perceive therapy to be relevant to their concerns and goals, and are active participants” (p. 39). To achieve this, practitioners should begin by validating the participant’s experiences and co-constructing goals for the therapy (Tilsen & McNamee, 2015). For participant Laura, it was not until her third month in wilderness therapy that her newly assigned therapist Jason validated the complicated nature of her family. Interestingly, when participants experienced feeling valued, they were able to handle confrontation and boundaries enforced by their practitioner. Nancy became hopeful about her program only after Britney, a field guide, self-disclosed that she, too, was a former participant. When these conditions were missing, the participants experienced feeling more demoralised. Participants, like William and Craig, described practitioners they respected because of their caring and empathetic nature were able to maintain their position in authority. Although practitioners in adventure therapy settings working with adolescents need to monitor safety and teach general outdoor skills, relationship seems to be the prerequisite to healthy boundaries and keeping groups safe.

Participants used the word “human” to describe their practitioners. Brady provided an example of engaging on an expedition with his teacher from school. He described their original relationship as “student/teacher,” but as they engaged in more democratic and shared experiences, he found the person within his teacher. Their relationship improved. Because participants described therapy as “boring” and “stereotypical,” a humanised approach seems important for building the essential important relational bond.
Solution- Forced Therapy

The resonant thread of “solution-forced therapy” emerged from participants’ experiences of coercive and gatekeeping practice. Nylund and Corsiglia (1994) described that a solution-forced therapist may minimalise the participant’s experience of the problem, while waiting “at the finishing line attending to solutions while the client is back at the starting gate feeling invalidated” (p. 6). While this occurred in the participant narratives, Russell’s (1999) dissertation also described practitioners waiting comfortably for participants to buy into the program. Solution-forced interventions occur when goals are established without a therapy participant’s input and when the program structure is privileged over their experience. This occurred for Craig, who was forced to read his impact letter in front of his group, which included information he would have wished remained confidential. This intervention, described throughout adventure therapy literature (DeMille, 2018; Gass et al., 2019), left Craig embarrassed and further demoralised. In Tony’s program, participants were tricked about their graduation dates in order to elicit better behaviour. For psychologist Shaun, “an unhealthy relationship wouldn’t be therapeutic and actually more damaging.” Based on the findings from my inquiry, the role of continuous-flow field staff and therapists as gatekeepers, can further demoralise participants.

One argument against establishing a democratic environment in outdoor settings could relate to maintaining physical safety for people in adventure and outdoor settings. Participants who have self-harmed, run away, or exhibited histories of violence may need firm boundaries in place. Additionally, outdoor settings provide their own inherent risks participants interact with. Walsh and Golins (1976) described the Outward Bound facilitator as requiring the “ability to be empathic, genuine, concrete, and confrontational when necessary” (p. 11). Some of the participants described experiences of confrontation as useful when delivered in a caring and compassionate framework. Sarah, who worked with juveniles
in a detention centre, said she would have preferred an “empathy-guided strictness” from her wilderness therapy program, instead of a “tough love” or “break you down to build you up” mentality. Olivia felt her therapist made her feel like a “human” though still maintained his role as an “authoritative figure.” These experiences can raise questions about whether theoretical perspectives of why the outdoors is used, such as to provide participants with shared experiences (Tucker, 2009), are incomplete given the amount of control that can be exercised over participants.

**Conclusion**

In this Chapter I explored participants’ experiences of the therapeutic relationship based on the research question “What is a therapeutic relationship in adventure therapy?” Resonant threads emerged within the discussion regarding (1) “Efforts to Remoralise,” (2) “Democracy and Collaboration,” and (3) “Solution-Forced.” The therapeutic relationship is a potent variable in psychotherapy outcomes across a range of models. These findings stress the importance of practitioners exhibiting genuineness and providing transparency in programming. A participant’s experience of empathy and their self-determination should be privileged over the structure and therapeutic orientation of the program.
Chapter 8: The Adventure Therapy Setting

Special settings have at least two functions. First, they heighten the therapist’s prestige and strengthen the patient’s expectation of help by symbolizing the therapist’s role as a healer . . . Second, the setting provides safety. Within its protective walls patients know they can freely express feelings, dare to reveal aspects of themselves that they have concealed from others, and do whatever else the therapy prescribes. —Frank & Frank (1991, p. 41)

Frank and Frank (1991) argued that one of the many roles of the therapist and the setting in which therapy occurs is to strengthen a person’s expectation of help. The intentional use of outdoor settings in adventure therapy is a factor worthy of this examination based on my ontological commitment to the experience of people interacting with these settings. The outdoors has been considered an important ingredient for adventure therapy (Gabrielsen & Harper, 2017; Harper et al., 2017). Studies which have focused on the potential remediating effects of time in nature, such as Kaplan and Kaplan (1989) and Roberts, Hinds, and Camic (2019), have found time in natural environments to improve restoration, self-esteem, stress reduction, and resilience. These studies, however, were not conducted in psychotherapy settings and the available evidence does not suggest psychotherapy conducted in the outdoors elicits better outcomes. Though potentially damning to the outdoor therapy literature, which claims that outdoor environments improve therapy outcomes, this finding is similar to other fields of therapy (Miller et al., 2013; Wampold & Imel, 2015), and suggests that change in therapy occurs as the result of meaning that is co-constructed during the therapy experience, no matter the model delivered. Additionally, the previous chapters have shown that despite being in an outdoor setting, the program structure and actions of the field staff can further demoralise or traumatising the participants. In this case, I avoid blanket statements, such as ‘nature is healing,’ as nature can be healing for one person, while simultaneously injuring, scaring, and traumatising the next.

By focusing on the personal experience of practitioners and participants in adventure therapy, my inquiry provided space to explore how the settings in which their adventure
therapy experiences took place, impacted specific experiences. Included in this chapter are experiences and initiatives unique to adventure therapy settings, such as hiking, fire making, and solo experiences. The narrative threads that emerged were (1) a “Novel Environment,” (2) “Success and Mastery,” (3) the “Solo,” and (4) “Disenchanted,” which signify experiences in nature that leave participants demoralised further. These threads are illustrated in Figure 14 below. On the following page, Table 7 is presented to describe the narrative and resonant threads contained within this chapter.

**Novel Environment**

One of the reasons parents access adventure therapy programs, especially longer residential programs, is to provide their adolescent with a safe and controlled environment, where they may be at risk of harm should they remain among the public (Tucker et al., 2018). That said, it is worth mentioning that based on the experiences studied thus far, some participants were at risk of harm during the program. Some programs participants valued the time away from home, which provided space for reflection to gain perspective about their life outside the program. Chapter 7 presented experiences of living and interacting in a therapeutic community. This chapter explores the impact of novel outdoor environments for particular participants, such as those expressed by Andrea, Craig, Willow, and Michael.

Andrea’s excerpt presents her experience of feeling herself “healing” during her weekly group therapy sessions in Denmark, while Craig, Willow, and Michael described their wilderness therapy experiences in the United States.
Table 7: Narrative and Resonant Threads in Chapter 8

<table>
<thead>
<tr>
<th>Narrative Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novel Environment</td>
<td>Participants described their experiences of adapting to the new environment as important to their experiencing of success and mastery. Similarly, the novel environment providing time for reflection.</td>
</tr>
<tr>
<td>Success and Mastery</td>
<td>Participants described how experiences of success and mastery were important to their improving their engagement. Practitioners should aim to elicit experiences of success and mastery early on in therapy.</td>
</tr>
<tr>
<td>Solo</td>
<td>A solo is characterised by participants remaining at a campsite on their own for one to three days. This narrative thread explores the range of solo experiences and how participants constructed meaning during the experience.</td>
</tr>
<tr>
<td>Disenchanted</td>
<td>Despite evidence that outdoor settings can improve wellbeing, some participants described the outdoor setting their adventure therapy took place to lead to further demoralisation. Rigid programming and the use of behaviour modification led to this sense of disenchantment more often than less structured models of adventure therapy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resonant Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking Therapy Outdoors</td>
<td>Informed by the narrative threads embedded in this chapter, this resonant thread presents how meaning and change is constructed in outdoor settings. Implications for outdoor practitioners are provided with considerations for taking therapy participants to outdoor settings.</td>
</tr>
</tbody>
</table>
Figure 14: The Adventure Therapy Setting
Andrea, Denmark, Community-Based

My self-esteem has grown a mile, which makes a lot of things easier in my everyday life. What stood out the most was the little moments, when we were out in the woods or sailing, where I could feel myself healing. When living a turbulent life, that kind of peace is a rarity, and it is difficult to see yourself. Being surrounded by nature, I think, is one of the best things you can do for your mental pain, and I wouldn’t have thought that before entering the program.

Craig, USA, Continuous-Flow Wilderness Therapy

I didn’t really heal any behaviours that had gotten me there. However, I did come out of the program feeling a lot more relaxed. A lot more, I guess, rejuvenated and more open to things. Because, I don’t know if it’s just me, but being in the wilderness is always a very therapeutic experience for me. Whether I’m being forced to be there or not. You know, it’s obviously slightly less therapeutic when I’m being forced to be there, but it’s always been relaxing for me and it definitely takes the edge off of me.

Being in the forest for nine weeks was kind of a hard reset for me. All I had to do was focus on day-to-day survival, brushing my teeth, getting up and focusing on only that and no distractions was really good for me. Well, I had physical responses going into it, I had a lot of nervous tics. I don’t think I’ve dealt with them for years. They’re starting to come back now, as I go through college, get a job, and all that.

Both Michael and Willow used terms like “so far removed” and “different light” to describe the impact of being in a new and remote environment. For Nancy, the novel outdoor environment provided “step-by-step feedback” as to what she was doing well and what needed improvement. In the case of these adolescents, the new environment provided a space
where these participants could see their life through a different lens. These perceptions are similar to those expressed in a qualitative study by Hinds (2011), who found women to describe the solitude and simplicity, challenge and accomplishment, and changing perspectives and priorities, to be the key themes after a short wilderness program in Scotland. Kelly also described her new environment provided space for natural consequences.

*Kelly, USA, Continuous-Flow Wilderness Therapy*

Well, I think just the entire environment that you’re in with, you are forced to take care of yourself, you are forced to learn how to grow up and be proactive every second of the day. If you want to stay warm, you’re going to have to learn all right, then you’re going to need to work hard, get all the stuff to make a fire, and make your fire, and you’re going to have to practice it until you’ll be able to do it.

During my interviews, however, participants perceived the new environment as important to their therapeutic experience. Frank and Louis, for example, discussed how time in nature required them to become more accountable for their actions.

*Frank, USA, Continuous-Flow Wilderness Therapy*

It’s weird because I don’t feel like I necessarily learned a lot from the people that I was there with, which maybe I just don’t remember if I did. But I think that it was more like, I learned how to be accountable for myself and how to be more responsible and just less shitty all around because I had responsibilities and people were counting on me to do certain things.
The novel tasks of learning to take care of himself in the outdoor setting led Frank to feeling more accountable. Providing opportunities for adolescents to feel that their contributions were essential, was important to many of the adolescents in my inquiry. They benefited from experiences where their contribution was essential to wellbeing and the operations of the program.

Practitioners varied more in their descriptions of nature. It is common for past therapy goers to describe the qualities of their therapist, not the setting, as most impactful (Norcross, 2010). Considering the intentional use of the outdoors in adventure therapy, it is interesting to consider how practitioners can facilitate more beneficial experiences, given the supposition that time in nature is a healing ingredient unique to outdoor therapy (Dobud & Harper, 2018). Practitioners, such as Logan and Charlotte, also mentioned the role nature can play as a novel environment for participants.

*Logan, Psychologist, Wilderness Therapy*

Instead of holding all of that within yourself, as [the] therapist, you maybe offer it out into nature, and say, “Okay. So, what is nature doing for you today?” instead of “What am I doing for you today?” You have that kind of immediate feedback, real feelings towards “it,” “the other,” “nature,” that are just absorbed into it and accepted by it. It won’t ever judge you for what you felt, and it won’t ever expect a justification of that feeling, you know? So, there’s something about transferring that transference relationship onto nature, instead of onto the therapist. That’s kind of an idea that has been forming. Instead of transference being with the client/therapist, transference is with the client and nature.
Logan’s psychodynamic training is clear in this description. Describing instances of transference, whether between participant and practitioner or participant and nature, is unique to his context. Future research could explore the notion of a transferential relationship with nature to further examine the impact of outdoor settings in therapeutic interactions.

Charlotte, a psychologist working in a residential facility, on the other hand, described the feeling of being isolated in nature as important to her work.

*Charlotte, Psychologist, Therapeutic Boarding School*

> I think being in a very isolated place, so suddenly feeling, I think feeling small, having an awareness of, in relation to nature, so feeling a bit impotent, but also having a sense of, having the space and the time to sort of just see things with a slightly different perspective. Or perhaps a bit more perspective.

In contrast to this perspective, there were participants who had previously positive experiences in the outdoors who did not benefit from the wilderness therapy setting. Thomas explained that summer camp was a reprieve and led to “a lift” in his depression. His parents, thinking an outdoor setting might tap into the same feelings he had at summer camp, decided to have him transported. Thomas described his overall experience as one of the worst of his life.

> The outdoor environment places the participant in a novel setting that, maybe, should not be compared to situations in which adolescents have spent their lives before adventure therapy. However, compared to other therapies, wilderness therapy may provide more time for reflection in the therapeutic setting. Interesting for my inquiry was whether the setting factored in as an active ingredient for improving wellbeing as described in previous research.
As Craig pointed out, it might not be the people in the program who helped him as much as the time he was provided to gain a perspective and reflect on life at home.

The findings in this section suggest that each participant experienced their time in the outdoors uniquely: some honoured the time for reflection in a novel environment, and others the helping professionals who offered care. Others also preferred the opportunity to contribute successfully to their group. This process is presented in the following section about success and mastery.

**Success and Mastery**

Although success and mastery have been used in psychotherapy literature (Frank & Frank, 1991; Howard et al., 1996), adventure therapy and experiential education have been incorporating these terms as well, for almost half a century (Gass et al., 2012; Walsh & Golins, 1976). For Kimball and Bacon (1993), wilderness therapy programming should set up an environment where success and mastery are not only possible, but probable. This requires scaffolding different initiatives so participants believe mastering a new skill, such as making survival tools, for example a hunting trap, is both useful and probable (Dewey, 1938; Walsh & Golins, 1976). That is, participants should experience some doubt about their abilities, but achieve success in the end.

Exploring experiences of success through social construction is useful, as each program participant freely and individually constructs meaning about mastery (Bacon, 2018; Dobud, 2017). Some participants describe an experience that evoked accountability and mastery, whereas others described the engagement as being unhelpful or demoralising. This comparison strengthens the notion that people freely construct their own meaning based on their experiences, regardless of the type of therapy they receive. Participants can experience success or mastery in outdoor settings by learning different hard skills or having a positive
social interaction with a group, such as problem-solving an issue at camp. Katy, Barry, and Clare described the experience of learning new hard skills during their programs.

For example, bow drilling a fire is a common initiative in continuous-flow wilderness therapy programs. For Russell and Farnum (2004), participants will typically see the skill as an impossible task, which they eventually master. In the excerpt below, Katy describes bow drilling her first coal; one of the final items on her checklist that led to her graduation. Katy’s description also reinforces the gatekeeping role that therapists play in OBH programs.

*Katy, USA, Continuous-Flow Wilderness Therapy*

I was having issues with one of the skills and I tried to learn how to bow drill. I hadn’t made my first coal yet. Going on three weeks I’d been trying to figure this out. I was getting so angry and it was the last requirement that I had to meet before I could get into the final phase. I’m sitting there and I’m staring at my bow drill because I know that my therapist is coming that morning. If I hadn’t made my first coal by the time she got there, I wasn’t going to graduate. I was going to have to wait until after Thanksgiving.

It’s like 5.00 a.m. maybe. I got up and I bow drilled almost straight through, stopping for breakfast, and to get some water and pee, but I bow drilled and I bow drilled and I bow drilled, and her truck crested the ridge where she was going to park. I was like, “Shit.” I started going even harder, which was what I needed to push me over the edge, and I made my first coal. I actually cried I was so happy and tired. My arm hurt a lot. My therapist hugged me.

Katy related the hard skills to the program’s phases. To graduate, she was required to bow drill successfully. This accomplishment gave her a sense of improved wellbeing and self-
esteem. Whether this was related to the goals of her therapy or simply to get out of the program was unsure to me. Using checklists to graduate elicits compliance, rather than consensus on therapeutic outcomes, and might be explored further (Mitten, 1994). As a solution-focused and feedback-informed practitioner, I approach each client from a position of ‘non-knowing’ where our therapeutic interactions will take us. Finding consensus between participant and practitioners maintains nearly four times the variance in outcomes to the specific models of the therapy being delivered (Miller et al., 2013). In this case, program participants should not have specific structures and goals forced onto them. Based on my examination of adventure therapy experiences, some providers met their clients with specific goals and milestones already set out.

Though many continuous-flow participants wished to do everything they could in order to graduate, Brady described the end of his program, emerging and feeling as though he wished it could continue. Brady also stressed the importance of feeling accomplished. In the excerpt from Clare’s interview, she describes mastering white-water kayaking and the thought process that came from learning a new skill. She described “something changed” in her.

Brady, Australia, Contained Expedition

I loved being out of my comfort zone. I’d never really accomplished anything before. Soon as something was a bit difficult, I’d just back out, I didn’t want anything to do with that. If I couldn’t do it, or be the best at it, I wasn’t interested. This is the first experience I had where I was actually starting to do well at something and enjoy myself. Just being out there with my group, it was just fantastic. I didn’t want to go home.
Clare, USA, Contained Expedition

I think the moment that . . . was really special to me was the first week that we went white-water kayaking. I just discovered that I was good at it, which was kind of exhilarating. I was off on my own doing all these rapids, big rapids. I’m not a very adventurous person, so when I found out that we were white-water kayaking, I felt an extreme fear. I was terrified to do it.

I remember the first day I was thrown out of my kayak and I thought I was going to drown. That was definitely something that I got really good at it and I was excited to wake up every morning and go white-water kayaking. So that really, it changed something in me that week. Just that I knew that I could do this really cool, badass activity just by myself, not even with anybody helping me. That was just really cool for me.

Clare reported feeling “badass” after a moment of success and mastery. These experiences emphasise that adolescent therapy participants, who can arrive with a sense of demoralisation, will benefit from experiencing a sense of mastery as early on in therapy, as possible.

Practitioners described experiences where they gave their participants positive peak experiences. Lynn also described taking a group of survivors of sexual assault paddle boarding. By working on balancing on the water, Lynn described facilitating an experience where participants were able to “experience their body in a position of power.” Marcell described teaching participants how to use a map and compass to navigate to camp. Below, Magnus shares about experiences of taking participants sailing and their reactions when he lets them steer the boat. Following, Kennedy describes an experience of working with a
“nonparticipatory” participant who engaged in an initiative where participants were required to start a fire with only one match.

Magnus, Denmark, Psychologist

We have . . . very important themes. One was how can we build self-confidence and how do we use nature to make better relations? In between the young kids and between the young kids and us. And how can we use nature to lower the feeling of stress, their feeling of stress? So, if I take the first one, self-confidence. The young kids who don’t believe they are very good at anything, or don’t believe much in themselves, when we go out sailing, I give them the rudder and say “Hey, now you can steer this boat” and I’ll just wait. It doesn’t take long before they get the feeling of steering a boat. We have a small sailboat and a rubber boat speedboat. In a few minutes they know how to do it and also quite safe. When I can go down in the cabin and just have a look at them, they think they are in control. To see the faces when they do that. Maybe next time we’re sailing, and they say, “Hey, let me do that. I can sail a boat. I can steer it into the harbour.” “Oh yeah, you can!”

Kennedy, Youth Worker, Community-Based

Literally, that fire was her taking into the program. She just started talking that day. It’s not often that in these programs a young person doesn’t miss a week out of the 10. I’m pretty sure she made all 10 weeks. She really struggled, physically was quite unfit, a bit overweight, but pushed herself to incredible physical limits and felt good about. And could also just stop back every now and then and just look out and go, “This is really beautiful,” when she was doing a task.
Kennedy went on to describe that this young woman would offer to help him with preparations for their adventure outings. She asked if she could carry extra gear when he facilitated a canyoning expedition. Creating a fire in a difficult situation, and with just one match, she believed she could do more, and her participation improved. Matthew described how wilderness therapy experiences allow young participants “to have a different experience and a different interaction with people who don’t see them as behavioural problems and issues and diagnosis.”

Experiences of success and mastery elicit the participant’s hope that they are able to accomplish the tasks of adventure therapy (Frank & Frank, 1991). Hard skills did not elicit positive experiences of mastery for all adventure therapy participants. Tony asked, “What’s the point?” He hated learning to bow drill and never mastered it. It held no therapeutic meaning. While some practitioners would explore Tony’s resistance, I question why the program was not tailored to Tony’s feedback about what was helpful and important. Adventure therapy literature has regularly cited the importance of ‘individualised’ treatment plans (for example, Gass et al., 2019), but these experiences suggest that participants were required to adapt to the program’s specific structure and rituals.

This narrative thread of “Success and Mastery” has demonstrated that practitioners should monitor how participants’ engagement when prescribing adventure-based initiatives. On one level, one person achieves a sense of mastery, but another leaves feeling demoralised. Below is an emerging narrative thread based on the experience of a solo; an experience where participants spend time alone away from the group. This may also be an experience capable of eliciting feelings of hope and mastery, while providing ample time for reflection.
Solo

The solo experience is most common in wilderness therapy, and originated from Outward Bound (Gass et al., 2012). Here, a participant spends “up to 3 days on their own with just daily checks by staff for safety reasons” (Conlon et al., 2018, p. 354). Russell and Phillips-Miller (2002) described that the solo experience is facilitated to allow participants “to gain a different perspective on their problems and gain new experience for the things that they had in their life” (p. 427). Olivia, Craig, Frank, Willow, Michelle, Angela, and Michael described their solo experience during our interviews. Practitioners in Australia described conducting a solo experience, though no participant outside the United States described such an initiative. Practitioners Evan and Peter described how they facilitated solos on their respective programs. Evan, in particular, invites participants to engage in a solo by attempting to validate their experience, calling it a “really cool opportunity.”

Evan, Counsellor, Wilderness Therapy

I have to frame it for my team and the clients. I tend to do it like that in the terms of this is a really cool opportunity. It’s not something a lot of people get to do. It may seem a little ridiculous, or why would we ask you to do this, and for the most part, it’s just all about the perspective or the frame that we offer it to the clients. Hearing the difference between something that could freak them out versus something that almost alleviates any stress because it validates them, right? That’s the biggest piece.

Peter, Counsellor, Wilderness Therapy

We combine [our program] with a 24-hour solo, where we ask them to create a reflective art piece. So all they get on a solo is, obviously something to sleep on, and sleep under, and ask them to create a reflective art piece, as something about
themselves or the environment, or their situation that they’ve laughed at themselves, and they create a painting, or they draw something. Then, they come back on that last night, and actually present that to the group. It’s part of that sharing, that experience, and feeling psyched to do that. I always ask the participants what happens.

Peter also carved out time each day for the participants to spend time on their own for reflection. Evan’s program provided time for reflection, but participants remained in a small group rather than being isolated as is common on U.S. wilderness therapy programs. Different programs and practitioners facilitated solo in different ways. During my visit to Norway, we did an overnight solo experience on the penultimate night of the contained expedition.

Below is a description from my journal about my experience of participating in and observing an expedition in Norway.

**Norway Participant Observation**

I woke up again at 830 and enjoyed a coffee with the therapists. We decided again to split the group into those that wished to go for a day hike and those hoping to stay at camp. This time, I chose to stay at camp. Before the hikers left, one of the psychologists introduced the idea of solo, a common wilderness therapy activity inviting participants to spend a night on their own. He mentioned that everyone would be having the night on their own. Some of the participants were frustrated by the idea.

Three participants left with two of the psychologists while I stayed with the others and the social worker. We enjoyed a morning swim in the cold lake and challenged ourselves to swim to the other side and back, about 20 metres distance each way. We spent the afternoon journaling and telling stories to each other. Some of
the participants asked me about the purpose of doing a solo and voiced their own
trepidations about the idea. I simply encouraged them to give it a try as it would be a
new experience.

The hiking group returned around 4:30 and we began preparing for solo. The
leaders facilitated an introductory group and attended to the young people’s
apprehensions. Eventually the participants began to head out on their own in different
directions to find their camping spots. Some became more anxious. We encouraged
them to stay closer to our location. I took the time to visit each participant and helped
them to start and maintain a fire. My aim was to make sure participants had
something to keep them warm while they reflected. One of the psychologists visited
each participant and gave them a reflection piece to write in their journal. He asked 1)
where will you be in 5 years in the areas of school/work, family, friends, and leisure
time; 2) what can you do to get there; 3) what can you do when you get home to reach
your goals.

One of the participants spent the solo activity on a rock that stretched out into
the lake. We built her a fire on the rock and she sat fishing near the fire for most of
the evening. She enjoyed fishing but despite hours of trying had yet to catch anything.
During solo, she managed to catch the largest trout of the trip.

I did not observe a solo experience in the United States or Australia, but the U.S. program did
run it for some participants. Unique to the experience in Norway was that participants could
visually see each other and engage with the staff. They could ask for help whenever they
wanted. In many continuous-flow wilderness therapy programs, participants are placed in a
spot out of sight for two to three days. Norway’s experience was just an overnight. Excerpts
from Olivia, Frank, Lance, and Willow are provided below.
Olivia, USA, Continuous-Flow Wilderness Therapy

The solo part was definitely interesting, where they stuck you in that little, it looked like an outhouse, with no bathroom in there. I went there in January, I think, and it was in the mountains. There was snow. It was really cold. They took our bootlaces. I guess, because they had had some incidents where people were trying to hurt themselves. If you’d have to go to the bathroom, you didn’t have bootlaces, [so] I would put my plastic bag things over my feet, so the snow wouldn’t get in them and tuck them in my socks. I don’t want to say it was traumatising, because that’s way too dramatic, but that was rough.

Frank, USA, Continuous-Flow Wilderness Therapy

They would make us do like these solos, so you’d pretty much have to go away for 24 hours by yourself and not die, but it wasn’t that hard. I was a 13-year-old or whatever, it was really weird because it’s like, I’d never spent 24 hours by myself. You know? And especially not like, feeding myself and stoking a fire for myself and all of that kind of shit. Yeah, it’s really weird. I remember being really bored, but it was cool. The area that we were in was really, really pretty. There was an area that actually had some super-old paintings from the Native Americans on the walls and stuff.

Like Frank, Sarah felt she was too young to get benefit fully from the reflection time. She mentioned there was “only so much self-reflection” an adolescent could do. During her solo, she enjoyed practising the hard skills, such as keeping a fire going, but did not see the purpose in writing more letters to family and completing a therapeutic workbook. For Sarah, she just “wrote it because you have to sometimes.” She was still “angry” and sorting through
her “parent’s betrayal.” Lance, however, loved his adventure therapy expedition. Not fitting in with school and being an alternative adolescent in his own right, the nights he spent on solo were “the best three days ever.”

*Lance, USA, Continuous-Flow Wilderness Therapy*

It was so awesome. I’ve done that a lot of times since, where I’ve gone camping by myself for a couple days, and it’s just always the greatest thing in the world. I loved it. Somebody had given me a book about Zen Buddhism with a lot of guided meditations in it, so I spent a lot of time doing that and that was great. I was stretching and meditating.

As Lance was beginning to learn about Zen traditions, meditation, and yoga, his experience began to add some spiritual and existential meaning to his wilderness therapy experience. Likewise, Willow found solo to be a spiritual experience.

*Willow, USA, Contained Expedition*

Each one of us were kind of put there, given an area to remain at, and we had to stay there, by ourselves, and thrive. And kind of just be with our thoughts. And be comfortable, getting alone. That was a big challenge. That solo was just really incredible for me. It was spiritually, very powerful, emotionally and mentally very powerful, and physically very challenging, because you don’t have anyone you can rely on. You have to do everything yourself. That peace is quite powerful.

Experiences of solo elicited mixed results for the participants. For some, it was a difficult challenge, which had a rationale that clashed with their perspectives of what could be helpful.
Others found it “spiritual” and “powerful,” and some thought they might be too young to get as much out of the experience as possible. Craig was told by his program staff that solo was a time to be a “ghost.” He enjoyed the experience so much he asked to do it “twice.” Michelle also remembered “really liking the solo experience.”

From these participant experiences, it is possible solo experiences can be both enriching and disenchanting, depending on the particular context of each program participant. Because no future information is provided to participants on many continuous-flow wilderness therapy programs, it might be further demoralising by removing creature comforts during the experience. Contrasting with other adventure therapy services, the program I visited in Norway stressed that nature is not something to be seen as a challenge or obstacle. The program was facilitated as such. I expand on this in the following section, where practitioners and participants discuss how the adventure therapy setting caused more harm to the participants. Some reported preferring not to go outside as they felt ‘triggered’, due to their adventure therapy experience.

**Disenchanted**

As many practitioners are driven to adventure-based therapies because of their own healing experiences in nature, it stood out that some participant experiences were anything but that. This narrative thread presents participants’ experiences that ruined the idea of nature as a healing setting. Practitioners discussed the importance of monitoring participants’ anxiety and comfort during different adventurous initiatives. Likewise, participants depicted experiences both during and after their programs where they experienced negative interactions in outdoor settings. In the excerpt below, Robert describes an experience working with a young person in private practice, and how important it is not to push people too far out of their comfort zone.
Robert, Social Worker, Community-Based

I can also think of a time when I was hiking in a gorge with one of my clients and we were going up to an exposed bluff. He was also a kid on the spectrum. And he was also a kid with some pretty high levels of anxiety. And he expressed a lot of anxiety about higher heights and just any high-up areas. We went up there because it was pretty protected, but it was also a large vista and that way he could kind of push himself a little bit but do it within his comfort zone. And he was talking a lot, post-processing about how he’d never done anything like that and how he felt prepared to move on to the next step. And how he challenged and beat this one fear and he was ready to beat other fears. And this was coming from a kid on the spectrum with a huge, deep amount of insight. And I was like, “Whoa, this is phenomenal and not what I expected at all.”

In the excerpt below, Nathaniel describes a scenario where he was invited to consult with an agency in his local area. The agency provided outdoor education services, but asked Nathaniel to come and observe one of their new adventure therapy programs.

Nathaniel, Counsellor, Private Practice

She told me they were out walking on a hill in the rain and it was the second day. She asked the client, “How’re you feeling now?” The client said, “I’m fucking cold, I’m hungry, I’m really miserable, and I want to go home.” Then they admitted to me that taking people for a walk in the hills was actually a bit more involved than they’d ever imagined. I just thought, where’s the basics? Like Maslow. No one’s going to have a
conversation about anything meaningful when they’re cold, hungry, tired, and just
completely pissed off, and they’re swearing at you.

Using his background in trauma-informed practice, Kevin shared how he responded to
participants who ask if there are dangerous animals in the environment their expedition is
taking place. Kevin used to joke with participants saying things like “Only small ones.” Now,
Kevin explained to participants, even before going rock climbing, “no one has the right to
scare you.”

*Kevin, Youth Worker, Wilderness Therapy*

That’s not developing their sense that, “I’m a good adult that’s going to keep you
100% safe all the time.” So, I think the more this therapy is about that “this person is
100% safe and I cannot be worried about things.” I’m not leaving them. Then they
can go out and enjoy the experience and make of it what they will but if they don’t
trust you to keep them safe then they’re not going to buy into the experience. Yeah,
not only do I need to be helpful to help them but if I can remove fear from their
environment then that’s liberating and allows them to heal.

According to Davis-Berman and Berman (2002), adventure therapy practitioners should
monitor participants’ anxiety levels and perceived risk when practising in outdoor settings
and assess how far participants are pushed out of their comfort zone. Warning against
pushing participants who may be survivors of trauma in their own right, the authors urged
practitioners to ensure the basic needs of the participants are met, which Nathaniel also
described, citing Maslow’s hierarchy of needs. Below, excerpts are presented from
participant reflections on their time spent in the outdoors.
Sophie’s 21-day contained-expedition enforced strict rules and policies, such as scheduled drinking water times and silent hikes. As a result, Sophie described her aversion to going on walks in nature.

_Sophie, USA, Contained Expeditions_

Ever since I went to wilderness therapy I look back and I think I have this aversion to hiking in general. I don’t like going on strenuous hikes at all. I don’t like walking places where I don’t know where I’m going or what the terrain is going to be like. It’s not that I wouldn’t do it, it’s just that if somebody asked me to go on a hike, I would probably say no unless I intensely studied the route and what we were doing and stuff like that. I just find it “emotionally triggering,” I guess [this] would be the right phrase to put it as. Ever since wilderness therapy, even though I had good experiences while hiking there, I just feel this general aversion to hiking and I don’t do it at all. I think that’s an important thing that I took away from it and I want to change it, I just haven’t really at all done it.

Like Sophie, Laura described feeling all her program did was “push.” She wished for more “verbal and metaphorical support” rather than a break you down to build you up. The language of “break you down” and “push” echoes throughout my thesis.

_Laura, USA, Continuous-Flow Wilderness Therapy_

Maybe it worked that way because we had been broken or whatever had the crap kicked out of us in the wilderness and then we were like ready to do the hard work because that’s really the narrative that I swallowed, right? That was like we’ll break
you down and build you back up and then you’ll feel like this safe, warm, happy space.

I think you can very easily restructure it to be an invitation and there obviously have to be things in place where if someone doesn’t want to join you in whatever it is, they can go do another thing. For that going to do another thing to not be punishment, yeah. If I want to go sit in the tree and write in my journal, I’m not breaking the rules. Maybe I just want to go sit in the tree and write in my journal. Yeah. I think I would just end up talking around circles and I think the best way to say it if it makes sense to you is like don’t push me, just like follow me around and support me.

Reflecting on his experience, Tony described the “brutal” nature of his experience. He explained he would just wake up “in the same place every day”, and “go on this punishing, punishing hike.” It was July and “really fucking hot” in the desert. He would return to camp, set up his shelter again, eat a “cold dinner,” and wake up to do it all over again. Tony had a daily checklist he would have to complete, which included bow drilling, setting traps, or completing a journal.

Tony, USA, Continuous-Flow Wilderness Therapy

I never really bought into the idea that hiking was going to make me contemplate my sins. I didn’t really think when I was hiking. It was one foot in front of the other; switched off my brain and kept moving.

The second thing that I’d say about that is stop with the fucking rubric and checkboxes. That was a physical problem. I didn’t have the physical strength to bow drill. How did that make me less of a leader in the group? And to the credit of my
group, it didn’t. It did hold me back from stuff. The staff was so heavily invested in bringing up my hard skills. I think my soft skills tended to fail. I had to fade to the back. I wasn’t there for being physically weak.

I didn’t even mind, necessarily, the hard skills. As bullshit as they are therapeutically, like I said when I left, I didn’t really feel like I valued anything until I actually saw the light at the end of the tunnel. It always gives you something to look forward to. There’s something in that. The greater understanding that the list is in everything, the whole list.

Just as Nancy described having little hope of ever being able to leave her program, Tony did not see “light at the end of the tunnel.” Both participants, in one sense, were feeling left in the dark. Tony felt the list of hard skills he was required to complete held no therapeutic value. Like Tony, Oliver described the pressure he felt to complete hard skills listed during his daily checklist.

**Oliver, USA, Continuous-Flow Wilderness Therapy**

I don’t know if I missed some grand flyer that said, “Hey, don’t worry about the checklist, worry about building yourself up,” but that’s really what it felt like to me, was a focus on the checklist or anything.

Sophie’s desire to study the routes she would take might point to a symptom of posttraumatic stress (Kezelman & Stavropoulos, 2012). Laura and Tony both described their programs’ focus on hard skills and hiking long distances made them feel pushed. Because many participants enter adventure therapy experiencing a state of demoralisation, practitioners should be mindful that failures to live up to the expectations of the program might further
demoralise participants, denying them experiences of hope, success, and mastery. As described by Tony and other program participants, it was when they found hope for the future, or simply the possibility of leaving their programs, they were able to feel more positive. As described throughout the discussion about limiting the amount of future information provided to participants, practitioners may be removing a key factor for improving participants’ subjective wellbeing.

**Resonant Threads**

In this chapter, I examined experiences in adventure therapy settings. Emerging from people’s time spent in the outdoors, narrative threads portrayed the outdoor therapy setting as a novel environment, described unique experiences of success and mastery, and explained their solo experiences and feelings of disenchantment. In this discussion, I present the resonant thread of the role of the (1) “Taking Therapy to the Outdoors.”

**Taking Therapy to the Outdoors**

Unique to my inquiry is using a constructionist lens to explore adventure therapy (Bacon, 2018). Because of equivalent outcomes in different outdoor therapy settings (Dobud & Harper, 2018), it is more appropriate to view the therapeutic setting as fluid. The purpose or usefulness of each therapeutic environment is co-constructed by the participant and practitioner. Some people may benefit from the outdoor setting, attaching meaning to their therapeutic progress as a result from their interaction with the environment. Towers and Loynes (2018) described similar theories of co-constructed experiences in outdoor education. The role of the environment in which therapy takes place plays a role in establishing a sense of safety for participants and helps to establish an expectation of help, often through symbolising a practitioner’s role as being helpful (Collins, 2015). For example, a
psychotherapist’s office may have multiple degrees or awards on the wall, an extensive bookshelf, or diagrams of the brain to create an aura of science or signify the therapist is equipped with knowledge capable of alleviating the participant’s concerns.

As explored in Chapter 7, the therapeutic relationships that elicited hope and expectancy included some level of authenticity and provided the prospect of an improved future while attending to the participant’s wounded humanity, in which a practitioner validates the seemingly negative chain of events that brought a person to therapy while also recognising and affirming the participant’s moral worth (Frank & Frank, 1991). Practitioners should work to package the program in relation to the particular context bringing the participant to therapy. Tony’s program focused on learning hard skills, which was challenging for him. In our interview, Tony said learning hard skills was not the reason he was sent to wilderness therapy. In this case, it is possible Tony did not understand the purpose of the program and instead worked through the phases simply to graduate and move on with his life. He described the desire of wanting to be anywhere else, even a boarding school, which gave him hope. For Bacon (2018), without the presence of a rationale for why the prescribed interventions are established, the therapy is likely to fall flat.

The program participants described the time in nature as relaxing and effective in providing time for reflection. Craig, for example, described the outdoor environment as a “hard reset” with “no distractions.” Both Willow and Michael found the time away helped them to see things “in a different light.” Practitioners also described the benefits of working closely with participants in a new environment.

Many of the wilderness therapy participants took part in a solo, spending one to three nights camping on their own. They provided different reflections on the experience. Because many wilderness therapy programs are guided by a curriculum of phases, it is interesting to wonder how the rationale for the solo is packaged for participants, given each of their unique
circumstances. Olivia described a “full-on” solo experience on the verge of traumatising, while Craig asked to do the experience again. Sarah and Frank mentioned they did not benefit fully from the experience as they were “too young” to get as much out of it as older participants.

While success and mastery are described through adventure therapy and outdoor education literature (Gass et al., 2012; Walsh & Golins, 1976), program participants had different relationships to the hard skills taught by their programs. Experiences of success and mastery gave them a sense of accomplishment, yet programs held different philosophies about how these came about. For Clare, experiences of white-water rafting and becoming skilled at a new activity stood out to her. She overcame fear and was able to transfer the meaning of the experiential learning to her life outside the program. Tony, on the other hand, was given a list of items to check off each day and did not see therapeutic value in learning to bow drill or go hiking every day. Like he said, he was not sent to wilderness therapy for being “physically weak,” and he was unable to accomplish some of his hard skills.

Success and mastery have been linked in both adventure therapy and the broad psychotherapy literature with the locus of control, or the belief people have control of their immediate experience and their lives (Bettmann et al., 2016). It is hypothesised that completing tasks can improve one’s self-concept and locus of control (Hill, 2007; Hoag et al., 2013; Russell, 2008). As I have shown throughout my inquiry, this was not the case with all participants. Frank and Frank (1991) found that although antidepressants worked just as well for treating depression as talk therapy did, there were different outcomes when locus of control was taken into account. Those reporting an external locus of control, or a low sense of mastery, achieved better outcomes in directive therapies and with medications. Those with a higher sense of mastery, an internal locus of control, improved with nondirective and unstructured therapies. As emphasised by Dewey (1910), when the adventure therapy
participant is repositioned at the ‘centre of gravity,’ practitioners aim to adapt the program’s structure to meet the young person’s needs. Taking into account a participant’s sense of success and mastery from the start of a program might help to improve how they experience outdoor settings, whether attributing their success to their own efforts, to the therapist, or the environment. In Chapter 7, a few participants reported their therapist’s confrontations were appropriate. This may be related to their locus of control from the beginning, thus taking into account the context of each participant’s presence in adventure therapy.

Scholars have used publications and studies about the healing power of nature and credited these effects to adventure therapy outcome research (Dobud & Harper, 2018). While studies have found time in nature capable of reducing stress and improving one’s attention (for example, S. Kaplan, 1995), these studies were not conducted in clinical psychotherapy settings. In therapy settings, time in nature has not been found to evoke better outcomes than therapy taking place in the indoors (Dobud & Harper, 2018). Thus, it is necessary to revisit the meaning of the outdoor setting and reconsider how practitioners describe the purpose of outdoor therapies to their participants. Craig described that although he “did not heal any behaviours” causing him to attend the program, he enjoyed his time in nature and felt more relaxed. In my observations in Norway, participants were presented with the rationale the solo experience, continuous-flow wilderness therapy programs did not. The initiative may risk falling flat or harming the adolescent participants if not carefully prebriefed for the adolescent.

In their study using the new Adventure Therapy Experience Scale, Russell et al. (2017) found participant reports of the benefits of time in nature did not correlate with outcome measures. Instead, experiences of helpfulness, mindfulness, and group adventure were associated with improvements in subjective wellbeing. As shown in the narrative thread of “Disenchanted,” experiences where clients feel they are not in the right program or are
pushed too far out of their comfort zone might lead to further demoralisation or even posttraumatic stress, as in Sophie’s experience who was apprehensive about spending time in the outdoors or going on a walk. Additionally, Laura wanted her program staff to “support me” and not “push me.”

The intentional use of outdoor settings in psychotherapy was worthy of examination. The Reggio Emilia approach to education described “Environment as the Third Teacher” (Robson, 2017, p. 35). The outdoor setting, then, becomes an additional ‘facilitator’ of the adventure therapy experience. Here, mastering certain hard skills and becoming self-sufficient with survival skills can help improve a person’s self-efficacy. Brady and Katy described how experiences made them feel accomplished, which they had not yet experienced at school or in the therapist’s office. However, learning hard skills did not work in isolation of a participant’s preferences. Tony, for example, described not being sent to wilderness therapy for “being physically weak,” which was highlighted by his continued failure to bow drill. Although Tony felt more demoralised during the program, it was not until he saw a “light at the end of the tunnel” that he started working harder at mastering the skills. Still, this motivation came from wanting to disengage from the program, not to improve his wellbeing.

Practitioners Kennedy and Magnus described fashioning experiences, such as successfully sailing a boat or starting a fire, to arouse a sense of mastery. While practitioners helped facilitate these successes, participants described the feeling of mastery in accomplishing tasks on their own. Frank and Frank (1991) suggested, “Performances attributed to their own efforts enhance self-esteem more strongly than those they attribute to such external factors as medication or outside help” (p. 49). If participants are arriving reporting levels of subjective wellbeing well below clinical cut-offs (Bettmann et al., 2016),
experiences of self-efficacy could elicit a participant’s self-empowerment for problem-solving.

**Conclusion**

In this Chapter, I explored the outdoor setting in which adventure therapy experiences take place, discussing the emerging resonant thread of the “Taking Therapy to the Outdoors.” Viewing therapy through a pragmatic lens allowed a unique opportunity to explore the outdoor therapy setting from a standpoint considering that time in nature can be inherently healing, but must have constructed meaning attached to it. As with the theoretical assumptions used in my inquiry, the therapeutic environment becomes meaningful when it is experienced in such a way. In addition, the outdoor setting can become part of the rationale for this type of therapy by providing opportunities for adolescents to experience success and mastery, which can evoke feelings of hope that this particular therapy can help improve their subjective wellbeing.

For my inquiry, the outdoor setting was another therapeutic element contributing to people’s adventure therapy experiences. Some experiences left participants disenchanted when practitioners did not provide a sense of safety, one of the core conditions required in healing settings (Frank & Frank, 1991; C. R. Rogers, 1957). In Chapter 9, I explore the lives of participants after their adventure therapy experiences.
Chapter 9: The Road Back

*Arriving at one goal is the starting point to another.* —Dewey

I use this chapter to examine what happened after the participants’ adventure therapy experiences. All participants, except May and Andrea in Denmark, engaged in programs away from their hometown. Distinctively, May and Andrea remained engaged with their program, which they hoped to continue attending at the time of our interview. The narrative threads surfacing related to experiences of being referred to ongoing (1) “Aftercare: You’re Sending Me Away Again,” (2) the “Trials and Tribulations” of life post adventure therapy, (3) “Becoming a Wounded Healer,” and (4) “Reflections on Adventure Therapy Experiences” (See Figure 15). Table 8 illustrates the narrative and resonant threads contain within this chapter on the following page.

**Aftercare: You’re Sending Me Away Again**

In their study, Bettmann et al. (2013) found 76.9% of the participants they surveyed were in an out-of-home aftercare facility eight weeks after their U.S. wilderness therapy experiences. Of the 20 participants who attended similarly structured U.S. continuous-flow wilderness therapy programs in my inquiry, 13 were referred to a residential treatment centre or a therapeutic boarding school. The remaining participants engaged in individual and family therapy or attended a new, smaller alternative school back in their home community. I have witnessed this common referral first hand as a wilderness therapy field guide. I find it troubling that studies, such as the cost/benefit analysis by Gass et al. (2019), have used OBH completion rates to argue the societal benefit of wilderness therapy, without disclosing that the majority of participants are referred to ongoing residential treatment, and where participants cannot leave voluntarily from their program. I do not know what ‘treatment’ per se they are ‘completing’ since they remain in treatment post-wilderness therapy participation.
### Table 8: Narrative and Resonant Threads within Chapter 9

<table>
<thead>
<tr>
<th>Narrative Thread</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare: You’re Sending Me Away Again</td>
<td>In the United States, most participants were referred to ongoing residential treatment upon graduating from their wilderness therapy program. This narrative thread explores their experiences and meaning constructed from this referral.</td>
</tr>
<tr>
<td>Trials and Tribulations</td>
<td>This narrative thread reflects the outcomes and setbacks participants experienced upon returning home. These findings resonate with Draper et al.’s (2013) previous work about adolescents returning to unchanged environments. Many participants benefitted from enrolment in a new, smaller, and alternative school.</td>
</tr>
<tr>
<td>Becoming a Wounded Healer</td>
<td>Many of the participants interviewed went on to become helping professionals, some studying social and psychology. This narrative thread describes their motivation and desire to enter these fields.</td>
</tr>
<tr>
<td>Reflections of Adventure Therapy Experiences</td>
<td>Participants and practitioners described speaking out against demoralising and traumatising wilderness therapy practice and issues relating to the cost of adventure therapy services in the United States.</td>
</tr>
<tr>
<td>Resonant Thread</td>
<td>Meaning</td>
</tr>
<tr>
<td>Back to Square One</td>
<td>The resonant thread emerging from this chapter relates to the participants returning home from their adventure therapy experience. Many reported struggling to transition after having a successful and meaningful experience away from home.</td>
</tr>
</tbody>
</table>
Figure 15: The Road Back
In this case, the term ‘aftercare’ is misleading and should be changed.

Excerpts from Kelly, Michelle, and Tony detail their experiences of being placed in another program. An excerpt from Connor is also presented; he returned home but was referred to family therapy. Angela’s and Sophie’s parents elected not to follow the program’s recommendations and did not participate in any aftercare services. Two days before Kelly graduated from her continuous-flow wilderness therapy program, her therapist told her she would be attending “another all-girls rehab in Texas.”

Kelly, USA, Continuous-Flow Wilderness Therapy

I was so mad. I was furious, because in my head I had just worked my butt off for three months in the woods, proving to my parents that “I have changed. I can come home, I’ll be better, I’ll be good, I won’t do bad things anymore.” I was absolutely horrified. I was so mad. I saw my parents and it was a horrible transition, just because I had so much anger, I wouldn’t let go of the fact of “Oh you’re sending me away again. Okay.” I made it very hard and I ran away. I relapsed with old behaviours, just on the one-day transition from Texas.

I was just so mad, because I hadn’t talked to my parents for three months, so I was like, “Well, how can you judge me, saying that I need to go to a long-term place if you haven’t talked to me in three months?” They threw that back at me, “Exactly, that’s why we need to send you away, we don’t know that you’ve changed. You haven’t proven to us you’ve changed.” Yeah, so I got transported just from the airport to the program.

Kelly went to her wilderness therapy program in year seven and did not graduate from this residential treatment centre until year 12. She described benefiting from the experience,
declaring that it “probably saved my life.” The program staff wanted Kelly to stay, but her parents decided, against the recommendations from her therapist, to get her home before the final year of high school. Kelly felt she and her parents “were complete strangers to each other.” They were “just people” she lived with, and she “did not view them as authority anymore.” For the past five years, “they were just people” she spoke to “on the phone every couple of weeks.” Upon returning home, Kelly “started doing drugs again, being promiscuous, sneaking out” and partying, which she attributed to her “anxiety and depression.”

Most OBH studies have employed a pre/post program evaluation design. The average adolescent participant arrives to a program, completes the Youth Outcome Questionnaire, and does so again on the day they leave the program. Quantitative outcomes may not capture the return home and only small percentages of participants have completed follow-up studies. For example, in DeMille et al. (2018), it was not clear if participants were at home with their parents, typical referrer to the program in the first place, when capturing follow-up data. Outcome measures collected on the day of graduation should be interpreted cautiously. As a solution-focused worker, I am much more interested in what happens after therapy or between sessions than what occurs during the program. The outcomes and meaning people build can only be measured appropriately when they are home, and able to enact the so-called changes from the participant’s treatment plan. Only then can we determine if their situation is improved as a result of participation. For example, almost all the participants reported issues of family conflict and to determine if this problem had been resolved, it would be important to have the family living harmoniously together.

Very few participants were provided the option of going home. Michelle, however, was presented with options by her therapist and in a letter from her parents. During the final days of the program, Michelle discussed her options with a fellow participant. She was
offered the chance to go to a therapeutic boarding school or return to her all-girls school she attended previously. The friend said, “I don’t think you want to go back to the all-girl school because it’s like you’re just going to be going back to where you were before”. Agreeing with her friend, Michelle decided to go to the therapeutic boarding school.

*Michelle, USA, Continuous-Flow Wilderness Therapy*

I went up and visited and interviewed and they said, “yes.” I went off to boarding school and that was the best thing that ever happened to me. It was so great. I had a rough time at first because I didn’t know anyone. I’d also just come off of this wilderness experience, which is very atypical, I think, in the way that you’re taught and expected to interact with your peers.

Michelle reported struggling to build social relationships. She had spent more than three months in the outdoor setting and had adapted to their terminology and rules, such as the specific procedures around taking medications. For example, on some wilderness therapy programs, field staff will carry participant medications. Each morning or evening in front of the field staff, participants will put a pill on their tongue, show the staff the pill, and then swallow. They might then cough or open their mouth again to prove they are not hiding the pill for later use. I reflect on these common processes, those I have been trained to deliver, and wonder how they transfer to life at home when these adolescents or young adults become responsible for their own medications.

From the field, Tony was referred to a strict boarding school. Every “minute of the day was scheduled,” including the “six hours of sleep” he had each night. The philosophy of the school was to make students “100% accountable to everything.” While Tony appreciated
the positive confrontation from his wilderness therapy practitioner, he did not adjust well to the new setting.

*Tony, USA, Continuous-Flow Wilderness Therapy*

It was like silence oriented. You weren’t allowed to talk. You weren’t allowed to talk in class, you weren’t allowed to talk to other people. You could not communicate, unless you were on an appointment with another student or you were directly addressed by the teacher, in class. You weren’t allowed to speak.

There was sitting in the chair. Way more fucked up. Where you spent all your time either sitting in a chair at a desk like journaling, or you were sitting on a marble floor in the great hall. No padding, nothing, journaling for 18 hours a day. And the program was [air quotes] “volunteer.” So, the way that they got away with it by saying well you can leave whenever you want.

The silence enforced by the boarding school staff does mimic many of the participants’ experiences in the cleansing phase of continuous-flow wilderness therapy programs. This practice seems to exist in order to control the adolescent participants, removing their right to self-determination and choice. After seven months in the program, Tony got in trouble and was put back on the sitting chair. He then decided he wanted to leave. Tony’s parents arranged for him to attend another therapeutic boarding school outside the United States. In the excerpt below, Tony depicts the environment and the democratic “judicial process” that occurred if someone got into trouble at the new school. This process mimicked being at home, which Tony preferred, in comparison to the controlling environment in which he was originally placed.
They call it milieu . . . Go live your life and we have staff that will tell you what you’re doing wrong. They were student oriented. It was a judicial process, where you went over what happened, and the honour counsel would determine what the consequence would be.

Tony graduated from the school and was accepted to a rural university in the United States. He stopped taking medications, moved to a large city, made “six figures,” and considered himself “one of the lucky ones” who went to wilderness therapy. He felt lucky given that he was able to move on with his life after the experience. Linking back to the narrative thread “Distribution of Dysfunction,” I wonder who deemed Tony’s behaviour to be problematic. He was consistently placed in controlling and maladaptive environments; he was never placed in environments where he felt competent. However, when out of residential treatment, Tony thrived.

Most of the participants who did return home were given a contract to follow. These contracts included the acceptable behaviours and rules for living at home, as well as being mandated to re-engage with some sort of therapist. Connor was referred to a family therapist, which would include sessions with his parents who agreed to the plan during Connor’s graduation.

Connor, USA, Continuous-Flow Wilderness Therapy

So, I had two individual sessions with him. I felt good about it. It was a positive experience for me. And then in one of our family sessions, he alluded to that this is probably going to take a full family effort of accountability here to move forward, and that was the end of it. My parents never took me back to an individual session. Never took me back to the family session. It was like “Nope, it’s all his fault.” We never
went back, but he was a nice guy. I’m laughing at it now, obviously it was not a laughing matter then. He didn’t even say it in a direct way. It failed so quickly. It was like, wow, 180, all right we’re leaving. That’s enough.

Despite Connor’s wilderness therapy program “marketing itself as a family program,” Connor’s parents never committed to participating fully. Connor began “partying” and skipping school. Like Connor, Craig returned to complete his final year of high school in “public school.” Lance returned home and engaged with a therapist weekly by phone.

Mark was referred “to an all-boys therapeutic boarding school,” and Michael “went to a school in Michigan.” Katy was “sent to Utah for nine months.” Frank was sent to a therapeutic boarding school, which incorporated farming and adventure-based programming. Frank referred to this school as “the coolest, most life-altering experience I’ve had.”

According to the literature, referring participants to ongoing residential treatment is an essential component of wilderness therapy programming (Becker, 2010; Bolt, 2016; Tucker et al., 2018). Education consultants can have a role in finding a placement for an adolescent, or the program may have established relationships with different boarding schools and treatment centres. In Chapter 6, I discussed the experiences of deception and being transported to wilderness therapy programs. Because a referral to ongoing residential treatment has been branded best practice in wilderness therapy, it may be worth asking whether this referral can diminish the progress and improvements people make to their locus of control. For example, Andy struggled at his therapeutic boarding school. He said, “I had just come out of this huge peaceful resolution of, ‘Holy crap, I can be my own person out here, and I was put into this hellhole’.” Oliver, too, was “sent to another boarding school.” Additionally, I considered whether involuntarily placing a participant in an ongoing residential programming was designed to consolidate the gains of the wilderness therapy or to
continue providing a substance-free, controlled environment, which is mistakenly referred to as ‘aftercare.’ If wilderness therapy programming uses phases to structure their programs, do participants arrive at a therapeutic boarding school or residential treatment centre at phase one? Additionally, it would be worth discussing the implications of the referral given the majority of participants are graduating from wilderness therapy programs with scores on outcome measures above the clinical cut-off (DeMille et al., 2018; Gillis, Speelman, et al., 2016). Discussed below, transitioning from the role of the helped to someone who had overcome obstacles and was capable of helping others was important for some. Ongoing care may perpetuate the participant’s experience of needing help, rather than experiencing success because of one’s own efforts.

Some parents elected not to follow the advice of the program and had their child return home. Thomas was referred to an “alternative school” at home, but he dropped out after a few months and began working full time. Sophie felt “grateful” her parents found a small alternative school in her hometown for her to attend. Angela was also referred to a therapeutic boarding school, but after pleading with her parents, they found a small school in her local community. A theme emerging from these narratives, as illustrated by Sophie, Angela, and Frank, is their description of their schools as “small”. The majority of program participants were enrolled in wilderness therapy due to academic issues, and though some returned home after their graduation, many did not return to the same school. Instead, they engage in smaller, alternative schools outside of the mainstream education system.

Transitioning from wilderness therapy to a small, more intimate school setting might help program participants to build stronger social networks and improve engagement in their education. Program participants described academic issues, which led to psychiatric assessments and diagnoses, such as ADHD or ASD. They also felt distant from their families. Connor, for example, reported feeling like a “stranger” at home. Others, like Andy and Tony,
were bullied in school and reported not having many close friends. Below, I have provided excerpts to illustrate the experiences of enrolling in an alternative school; one with less students and smaller class sizes.

**Sophie, USA, Contained Expedition**

They were trying to push residential treatment on my parents for me to go to afterwards. And I’m thankful that my parents did not listen to them, unbelievably thankful because the high school I went to changed my life completely. That’s what I credit with making me the person I am today.

**Angela, USA, Continuous-Flow Wilderness Therapy**

My parents weren’t initially going to move but they knew that the environment at school was not going to allow me to continue on the path that the program had allowed me to pave for myself. So, originally, they flew me to a boarding school. I wasn’t having it. I went right back to Ms. Sassy Pants and I went right in there and said, “I don’t want anything to do with you” and “I’m going home, I don’t want to go to school here.” I was really rude. I was really disrespectful. I was a total brat. And they go, “You’re exactly what this school needs.” I remember being like, “Oh my god, my entire plan just fell apart.”

But I didn’t go. And my parents, they said the reason they didn’t send me was because it was too far away. So, they found an alternative school near our home, a private school. And, that school was surprisingly a very good fit for me. It was very small.
Referring participants to ongoing residential treatment is a double-edged sword, and should be used cautiously. In one sense, participants reported similar struggles when adapting to life back at home, no matter if they attended an out-of-home aftercare program or not. Second, although therapeutic boarding schools and residential treatment centres can provide a physically safe and substance-free environment, adolescents finding out they are going to further intensive treatment can be discouraging to the progress they have already made. Programs outside the United States did not refer participants to ongoing residential treatment, and these programs were generally shorter in length and did not involve involuntary placement. This might be due to the fact that other countries are actively working to reduce the involuntary treatments for mental health concerns. For example, mental healthcare policy in Germany makes it illegal to hold any person against their will unless it a life-threatening emergency (Gooding et al., 2018). There were ups and downs when returning from involuntary experience, which I have labelled “Trials and Tribulations.” No matter the type of aftercare a participant engaged with, participants were challenged on their return to their home community. I noticed through my inquiry that a serious concern in sending a young person to residential settings is that no matter what meaning they construct from their experience away from home, the home environment becomes a whole other environment people are required to re-adapt to. The following narrative thread examines the experience of life after adventure therapy and the reported outcomes from participants.

**Trials and Tribulations**

Transitioning from out-of-home adventure therapy settings is a difficult task, which has been reported by both parents and adolescents (Russell, 2005). This narrative thread resonates with the consequences of participation in adventure therapy, echoing Draper et al.’s (2013) findings. Program participants described steps both backwards and forwards. Positive
outcomes included the ability to stand up for yourself, a new thirst for life, improved self-esteem, becoming more open-minded, better relationships with family, school improvement, and gratitude. They discussed hurdles, such as ongoing substance abuse, anxiety, depression, negative romantic relationships, anger, and residual resentment of their parents for sending them to a program.

After his first expedition in Israel, Yosef returned to mainstream school. Although he was “a bit overweight” and “awkward,” Yosef did not feel as targeted by bullies at school. After graduating high school, Yosef went to university and eventually became a high school teacher.

Yosef, Israel, Continuous-Flow Wilderness Therapy

It’s the ability to accept a new challenge. . . You learn to get over it and being able to accept the challenge of knowing that the person on the other end of the line is not going to tear your head off. Trust that they’re going to treat you like a person. And a lot of that, I credit to just building up that character through this camp, and it really made me who I am, a self-confident person, of knowing that I am who I am, and no one can ever take that. I’m not defined by what other people think about me. I am who I am because that’s of the challenges I can overcome, of my abilities, and no one else is really in charge of defining it.

Yosef’s mother wanted him to attend the camp to improve his self-esteem. During our interview, he found participation in his program led to him feeling capable of overcoming adversity. In the excerpt, Yosef is referring to how his wilderness therapy experience influenced the way he interacts with others in the real world. He described outcomes of self-
confidence and resilience in his abilities to overcome difficulties. Louis also linked his experience to resilience, describing being able to “recover pretty quickly” when things went wrong in his life, which might be related to improved resilience as a result of participation in adventure therapy.

Willow, an American living in the Netherlands, attended a contained expedition in the United States and wished her program could have been longer than just two weeks. Although the program helped improve her self-confidence, her father did not feel positive about Willow’s empowerment.

*Willow, USA, Contained Expeditions*

I think it had the opposite effect for my father. He wanted me to come back and be some sex-obedient kid, and I came back, actually having self-esteem, and confidence in myself, knowing my self-worth, and being able to stand up, and look at him and say, “You know what? You’re full of shit. I need to not be around you anymore.” I stepped away from him, and I went to boarding school my last year of high school, and then just clearly didn’t speak to him, after that.

That’s a good thing, because he was an alcoholic, and a paedophile, and was a very damaging human being. I needed to be able to have the strength to protect myself. When I think about [the] camp, it was really a catalyst.

For Willow, being able to stand up to her father was important. Although he referred her to the program, he did not expect Willow to leave feeling as though she needed to protect herself from him and his abusive behaviours. Willow remained living with her mother and did not have contact with her father at the time of the interview. Other program participants described improvements in their self-esteem. Katy’s experience was “very much life
changing.” Clare felt like “I’m becoming a stronger person.” Nancy became “more comfortable” with her identity. Craig had “roadblocks” upon coming home, but life became “quiet” and things went back to normal. Oliver said the “wilderness inevitably helped me out later” in life.

For Angela, Mark, and Louis who were multiculturally-adopted, an interesting outcome emerged. Each decided as a result of wilderness therapy to refer to themselves by their birth names. Angela described a tattoo she had to represent her wilderness therapy experience.

Angela, USA, Continuous-Flow Wilderness Therapy

I have a tattoo that I got for the program. It’s the original program’s logo. It says the program’s name. It’s the exact logo and I had my tattoo artist design some flowers for it. And what I did, there’s a specific part at the bottom where the roses are growing from and as they come up it looks like they pierce the body, you know, to symbolize trials and tribulations. And they come out and they bloom. And I had them do pink roses because pink roses specifically, the meaning behind them is gratitude and appreciation. It’s open to interpretation obviously but it’s supposed to represent, you know, birth and your trials and still overcoming. This program had a substantial impact on my life.

Mark, USA, Continuous-Flow Wilderness Therapy

I went to an all-boys therapeutic boarding school. And boy that changed everything. I changed my name. I changed my name because I wanted to be closer to my Korean heritage.
Emma described becoming “very religious” after her adventure therapy experience. After the program, she went to “a Catholic prep school” and began enjoying theology classes. This pleased her parents as they too were quite religious and “strict.”

**Emma, USA, Continuous-Flow Wilderness Therapy**

I started going to church a lot. I still go to church three times a week after camp. I just lived life appreciating everything about it so much more. The fact that you can flick up a light switch or, you know, hear music. It was just you become a lot more humble, you become a lot more appreciative. You really learned to just love the people around you. And it gives you so much self-confidence.

It’s been five years. I feel like it’s been a while personally. I think what that gave me the most is ambition and a good sense of morality. And having ambition and having morality to accompany that ambition is a very good guide for everything you want to pursue in your life.

Lance and Craig described positive changes to their behaviour and better performance at school. Katy and Laura mentioned that despite ups and downs during their college years, things had gone well for them, and they were both employed full time and married with children. Katy, for example, dealt with an abusive relationship with a partner she referred to as “just straight pure evil.” Laura also experienced a “mentally abusive relationship.”

May and Andrea, though still hoping to continue in their outpatient programs in Denmark, reported having improvements. Andrea’s “self-esteem has grown a mile.” May’s relationship with her therapist helped her learn that “not all grown men are evil.” Both said they isolated themselves less and spend more time in the outdoors as a result of their adventure therapy experiences.
As mentioned above, the return home from any residential treatment can be challenging, and lapses in progress occurred. Excerpts from Olivia, Louis, and Sophie are provided below. After three months, Olivia graduated from her wilderness therapy program and obtained a high school diploma through an online platform.

*Olivia, USA, Continuous-Flow Wilderness Therapy*

It was really weird being in that atmosphere and then going home. It was probably a different kind of weird situation for me. I met somebody in the program that was in a group behind me and we ended up dating for a couple of years. I think that kind of hindered me. Not to say that I went back to everything I was doing. I got a full-time job. I was doing really good and I wasn’t partying or anything, but emotionally it wasn’t good for him and I to do that, you know, start a relationship at that point in our lives. Because, I think we were very co-dependent on each other, because we had each other in the program. He lived like an hour from me. We weren’t long distance. We saw each other all the time. I think that we weren’t meant to be together, but we were clinging onto each other, because we went through such an important part of our lives at the program. I think that was a mistake, but I don’t regret it. Whatever, but I think that hindered my progress.

Louis was the last participant to graduate his wilderness therapy program before it closed down. He spent a few weeks alone with field staff before his parents came to take him home. At the time of our interview, Louis was taking medication for a bipolar diagnosis, and completing a degree in business.

*Louis, USA, Continuous-Flow Wilderness Therapy*
I describe my life as a rollercoaster, sometimes. Been good years and then the wilderness therapy program years where it’s getting lower. Then the rally or coming up to 18, 19 with a little market dip with a second little encounter with the law and being in shock almost because I thought my life wouldn’t have that peak or it wouldn’t have that second encounter. When it happened again, I felt some of the wilderness therapy program things helped me through that, to handle it very practically, to be upfront, honest and genuine, to just be truthful. I was able to quickly pass over it. Sometimes when I look back at it, I find, “oh, does that mean that wilderness didn’t work, or does that mean that that was inevitable to happen or something?” I look at some of my friends that went through wilderness and see that they still have some ups and downs as well afterwards, but it seems like they’re on a solid track now still even after. They recovered pretty quickly from a life event.

Sophie previously described the side effects she experienced from taking antidepressants.

After a challenging and disheartening wilderness therapy experience. She returned home to be re-diagnosed with depression, and was prescribed antidepressants. In this case, the wilderness therapy program she attended did not attend to the issue of medication, or diagnosis effectively.

*Sophie, USA, Contained Expeditions*

When I got home, I again had been misdiagnosed with depression instead of bipolar disorder, and I was medicated for that. When I got home, I totally needed therapy. Things were okay but I was also scared into being good. Nothing in terms of my therapy or medication was in the right place. So, I got home, and I still would have bouts of rage and stuff like that, which terrified me because I was like, “I’m just going
to get sent back to wilderness therapy.” Then my psychiatrist prescribed me the right medication for bipolar disorder and I just got so much better within a month or so and haven’t really gone back to that angry person that I was before since that.

Sophie’s description of being “scared into being good” relates to the ‘scared straight and tough love approach for which wilderness therapy has been criticised for in the past (Anderson, 2014). For some, adventure therapy was a positive, life-changing experience, and for others, like Thomas, it was “something they would not wish” on an enemy. Sophie left her program with a “really big passion for speaking out against the abusive, troubled teen industry.” For Sophie, she has been vocal on social media and has written her local politicians requesting added regulations to the troubled teen industry. For Sophie, participation in my inquiry could be perceived as another form of “speaking out” about her wilderness therapy experience. For adolescents who have been involuntarily placed in long-term residential treatment, outcomes may have been difficult to determine as they were forced to adjust to life at home for a second time, after already adapting to life in the outdoors or treatment centre.

In their qualitative inquiry of what factors led to lapses in progress after residential programming, Draper et al. (2013) found that among ongoing substance use or negative peer relationships, an unchanged family environment was another factor. As Connor depicts in an excerpt above, he returned home willing to engage in family therapy, but his parents were not. Barry, who struggled with being bullied, described returning home to a school environment that had not changed despite his positive experience. Excerpts from Sarah and Frank follow.

*Barry, Australia, Contained Expedition*
I got to school just before the end of the second period, so pretty much around the
recess, and I signed in on the late book and went to my first class, I opened the door
and the first words said to me were, “Hey fat shit’s back.” I’ve closed the door and
I’ve gone home. That was my realisation, I’d just spent the last four weeks busting my
arse and actually getting somewhere and coming straight back into the same shit hole
that I was in before.

Barry’s principal rang him and asked if he was coming back. Barry was on a train back to his
program’s office. School continued like this for Barry. There were fights “every other day,”
and after feeling pushed to his limit, Barry climbed to the roof of the school and
contemplated jumping. The “lead bully” of the school had seen him and snuck up behind him
to say, “Dude, what the fuck are you doing?” The two sat and talked. The bully apologised
for “three years of terror.” The bully stopped harassing Barry, but fights continued to occur at
school. One fight ended with multiple injuries and ambulances, and Barry decided it was time
to leave school. He continued to visit his adventure therapy program every week, which
provided ongoing support and a base-camp-style experience. Barry went on to get a job as a
tradesman and has since married. Like Barry, other participants struggled with their
reintegration to their community.

In Chapter 8, Sarah felt she was too young to benefit from the solo experience. In the
excerpt below, Sarah describes feeling too immature to benefit from her contained
expedition.

Sarah, USA, Contained Expeditions

They didn’t really set you up for going home. They could have done a better job at
preparing what goals for school and goals to find different hobbies and things like
that. My goals were pretty much to just go back and hang out with my friends. They didn’t really have anything put together for things like that. I don’t think that there was anything better about going home in my case. I think it took me a while to realise that it probably did help in some way, but I just wasn’t mature enough to process that at that age.

Things got worse for Sarah after the program. Her relationship with her parents deteriorated, and she began “acting like a little shit.” She skipped school and treated her parents with more disrespect. This went on until she was 17 and returned to therapy.

After two months on a continuous-flow wilderness therapy program, Frank attended a rural therapeutic boarding school. The school was “essentially a self-sustainable farm.” It was a small community, and everyone was “accountable for something.” Below, Frank describes returning to mainstream school after leaving his therapeutic boarding school.

Frank, USA, Continuous-Flow Wilderness Therapy

It was weird, it was really weird because going back and seeing people that I had gone to middle school and elementary school with and stuff, they were all like, what happened to you and explaining that story in high school is just like a lot. But I missed boarding school. I missed the type of people that I had grown accustomed to being around who were just really down to earth, good people.

In high school, everyone is so interested in being popular and materialistic stuff and just being cool and making friends who think that you’re cool and shit. It was weird, I wanted to go back to boarding school, but my mom wanted me to be home, I guess she missed me or something.
My relationship with my mother was not great because I think at that time, I felt like I had a lot of abandonment issues and so I was still kind of pissed off at her for that. It didn’t really get better until I was in college, but I mean now we’re like best friends. Me and my mom have a great relationship now.

Adjusting back into mainstream school was a challenge for Frank. As his relationship with his mother became fractured, the two re-engaged in family therapy.

Becker (2010) asked why a parent should choose wilderness therapy, which is expensive and far removed from their child’s everyday life, instead of a different type of treatment, even a residential one, closer to home. The author cited multiple papers arguing it could be “counterproductive to remove an adolescent from his or her daily environment, as treatment gains are lost once the youth returns to their home, school, and community environments” (p. 57). From my inquiry, returning home to an unchanged environment made for challenges. Like Sarah’s experience, questions arise about how well participants are prepared for returning home and whether ongoing residential treatment does better prepare participants. My findings are supported by Bettmann et al. (2013), who found that even though 76.9% of their sample were enrolled in an out-of-home aftercare program, they found no differences in outcomes for those electing to return to their home community and deny ongoing residential treatment. These findings should be interpreted cautiously given non-equivocal group sizes. Practitioners should be cautious of referring participants to ongoing residential treatment as this can demoralise participants and hinder the therapeutic progress.

**Becoming a Wounded Healer**

Program participants Angela, Sarah, and Jeanne shared that their experiences in therapy as motivating them to join the field. Yosef from Israel and Brady in Australia were
provided the opportunity to undertake their programs again as a mentor for first-time participants. In the excerpt below, Angela describes going to university and wanting to help adopted children, like herself. Angela’s career was put on hold as she remained at home with her young children.

*Angela, USA, Continuous-Flow Wilderness Therapy*

I got my bachelor’s degree in social work. My intention was to really work in foster care and adoption. I don’t know if I want to be a therapist, but I want to work with children who are in foster care or have been adopted who struggle with issues, so they don’t become, I think the statistic, is that 73% of children in foster care in the United States wind up in jail at some point. I want to work with them to prevent that. I want to give back like what was provided for me.

A week following our interview, Jeanne travelled to Sri Lanka to volunteer “in a mental health clinic, shadowing professionals,” and “learning a non-Western perspective on mental health.” Jeanne said she would never have travelled alone prior to her adventure therapy experience.
Jeanne, Canada, Contained Expedition

I’ve always wanted to pursue something in psychology. So, I did my undergrad in psychology, and then I just applied to grad school. And then I’m hoping this Sri Lanka thing will look really good on my application. I would really like to be a clinical psychologist, specifically a clinical health psychologist. So, working with people to help them modify their lifestyle, so that they can live with less stress and less chronic illness. Ideally, I would like to work with young adults, like adolescents.

Angela and Jeanne wanted to help others who have been in similar situations they had. In some respect, the meaning they attached to the concerns leading them to adventure therapy had changed. Instead of feeling demoralised, in need of external help, they felt equipped to become helping professionals themselves.

At the time of our interview, Brady had completed eight contained expeditions with his adventure therapy program in Australia. The organisation provided leadership training for their graduates interested in returning as a mentor. Brady mentioned benefiting from these experiences as well.

Brady, Australia, Contained Expedition

The thing that sticks with me is just the idea that I’m in control of my future and that I am valuable, and I am smart. They’re the core. They are the underlying things that I took away from the expedition. From when I went as a participant and that’s reinforced with every expedition I’ve ever done. So, while I haven’t done as many expeditions as I would have liked to, you know how it is, life gets in the way sometimes. Even just doing training weekends is where I seem to spend most of my time with the organisation.
Realising that I can contribute and be a positive influence. Just like Kelly and Laura were for me when I went as a participant and I respected them so much for being able to do that. And that’s what I wanted to do.

Brady described feeling as though he wanted to help others since he was young. However, he was “never an academic” and did poorly in school. The program gave him “the chance to believe” in himself, and Brady described himself as much more confident. After three unsuccessful attempts at becoming a police officer, Brady was finally successful on his fourth attempt and had worked as a metropolitan police officer for two years. He planned to continue leading expeditions for the program he attended.

Like Brady, Yosef was encouraged to return to his program to help with first-time participants. These experiences helped him while he was becoming a teacher. During his first teaching experience, Yosef described not having an “I can’t do it” attitude, but instead thought, “Go back and learn from that experience rather than just give up.” Experiences of working with first-time participants helped Yosef to work with high school students. At the time of our interview, Yosef had remained in touch with the leader of his program and hoped to return.

School-based police officer Glen described an experience in working with a high school student who wanted to help others and encouraging this willingness to help. The young female participant was invited to attend a contained expedition with Glen as the last chance before being expelled from school. She excelled in the outdoors and wanted to return. With permission from the school, Glen allowed the participant to keep coming back and help facilitate the expeditions. She taught others how to navigate and other hard skills during the programs. For Glen, this provided the participant with a sense of purpose and connection she did not have at school.
Becoming a helping professional, while not necessarily representative of a positive outcome, might show how these program participants changed their perceptions of the problem getting them to therapy in the first place. Angela previously described how her adoption led to her having issues with her identity. As she worked through these issues during her adventure therapy experience, she became motivated to help others who were struggling with similar adoption-related issues. The meaning attached to her concerns had shifted from demoralisation to capability.

**Reflections on Adventure Therapy Experiences**

In this section, I explore how these program participants and practitioners reflected on their adventure therapy experiences. This section addresses the second question informing my inquiry: If these past participants could change anything about adventure therapy experience that would have made it more beneficial, what would it be?

During my interviews, I asked each program participant what they would change if they could go back and change anything about their adventure therapy experience. I asked practitioners where they would like to see the field headed in the future. I separated this thread into two subsections: (1) a “Strong Opinion,” and (2) the “Cost/Benefit of Adventure Therapy.” These threads are illustrated in Figure 16 below.
Figure 16: Adventure Therapy: A Reflection
Strong Opinion

This section relates to the adolescents who left their adventure therapy experiences with negative outlooks. In Chapter 8, Sophie described not wanting to go into the outdoors anymore due to the emotional stress that occurred during her wilderness therapy program. Since then, she described becoming an advocate against the for-profit troubled teen industry in the United States, of which wilderness therapy and outdoor behavioural healthcare are included. Michelle described hoping her program was “more of an invitation” than having therapy forced on her.

Sophie, USA, Contained Expedition

It gave me a really big passion towards speaking out against the abusive, troubled teen industry. I actually connected with the mother of the girl who passed away in my program before me and we’re actually really good friends and update each other on our lives and stuff like that. I took away just the personal impact from that. I never would have done that otherwise.

The program that I went to was, for all intents and purposes, a little bit abusive. We couldn’t drink water whenever we wanted to during the first three weeks of our program. I was outfitted with shoes that were three sizes too big. I had a medical emergency; they didn’t take me to the hospital. Just things like that.

There exist many social media groups for wilderness therapy participants to which they can connect. For example, there are groups called Wilderness Program Graduates and Troubled Teen Industry Memes on Facebook which have tens of thousands of followers. Sophie described being vocal about her wilderness therapy experience, which she described as “abusive.” Those who have endured a demoralising therapy experience, such as Sophie and
Thomas, described the benefits of connecting with others who have been through similar experiences. This could explain why Sophie reached out to the mother of a previous program participant who died on Sophie’s program. Similar to Sophie, when I asked Thomas what he would change about his wilderness therapy experience, he described his experience as something he would not wish upon an enemy.

**Thomas, USA, Continuous-Flow Wilderness Therapy**

The wilderness phase was a big contributor to this overall impression and that impression was that this program was perhaps the worst experience of my life. And I wouldn’t wish it upon anyone ‘cause of the emotional trauma that it caused. However, looking back on myself at that point of my life, I don’t know what other option there was. I think this was the last resort. And I wish there was another option. Because as I said, I wouldn’t wish this upon anyone. I wouldn’t wish this on myself or my 15-year-old me.

So, my changes would be that basically any aspects of the program, the negative aspects which are most of everything I’ve just said to you. I would say that all needs to be eliminated. If you’re a kid who’s in trouble, and you’re sent there, then this program can’t be doing any further harm to you. That’s counterproductive. And everything from being shipped away with strangers to having your possessions and clothing taken away from you to being blindfolded and driven into the forest to borderline abusive instructors. None of that is productive to helping someone that’s in trouble. So, there were good aspects of the program. But there were a lot of negatives too. So, I think if there were a way to remove the negatives and strip the program down and leave only the positives then that would be ideal. But I understand that
perhaps for some customers who are in such a bad place that they perhaps need that tough love. But I’m not a tough love person.

Similar to Thomas, Sarah also described not benefiting from the tough love approach. Sarah now works with young survivors of trauma, and mentioned that the lack of a trauma-informed approach bothered her when she reflected on the way she was treated. Similar to my discussion about the therapeutic relationship, Sarah uses the word “human” to describe the approach she would have preferred. In the excerpt below, she describes how she wished she had been dealt with when she asked to stop during a hike.

*Sarah, USA, Contained Expedition*

For me, I would have taken something away from it had it been that way. Even when I was saying, “I can’t go any further, I feel like I’m going to pass out,” if somebody would’ve just stopped and say “I’m sorry, I understand you’ve never done anything like this before. Do you need to stop? Do you need to rest?” And then taken the time to sit down and actually speak to me like a human, because teenagers. They’re still human. That would have been very different for me.

Practitioners described similar concerns to participants and worried wilderness therapy programming had not changed or addressed its ethical concerns as much as the field has claimed (Norton et al., 2014). Practitioner Jackie described her program trying to establish new policies to stop the “boot camp” mentality of her program. Because wilderness therapy programs have endured since ongoing reports of abuse, it would be worth exploring how program modalities and procedures have changed since then. Based on my findings, the interventions, language, and frameworks of U.S. wilderness therapy programs have changed
little in the last 20 years. Because of the extensive cost of many adventure therapy programs, it is worth exploring the relationship between cost and benefit.

**Cost/Benefit of Adventure Therapy**

While participants outside the United States participated in adventure therapy at no cost to them or their families, wilderness therapy programs in the United States run at a cost. According to Scott and Duerson (2010), wilderness therapy programs can cost families anywhere from USD $12,000 to USD $30,000 and the whole process becomes more expensive when a young person is referred to ongoing residential treatment. As of November 2018, Gass et al. (2019) reported OBH member programs charged an average USD “$561 per day with the average length of treatment being 90 days” (p. 4). The question about whether these costs can be reimbursed is also difficult to answer. These studies, such as Gass et al.’s (2019), are used to seek third party reimbursement, such as private health insurance, but most programs will not help paying families seek coverage. Gass et al. (2019) claimed treatment completion rates of 94% for OBH programs justified these costs, yet do not acknowledge once in their paper that OBH is an involuntary treatment where participants cannot freely disengage. After the program, parents will have to reach out to their private health insurance provider to receive all or partial reimbursement. Social workers Oscar and Robert described some of their desires for adventure therapy to be available to a more diverse demographic of participants.

**Oscar, Social Worker, Wilderness Therapy**

I don’t know the research all that well, but two to three months and [USD] $30,000 to [USD] $50,000 just seems like a lot of money and time for stabilisation assessment and it just seems like, in the United States, that is wilderness therapy. I think that if I
had to choose one thing that I’m really interested about right now is just like access to programming. Right now, this is so confined to really affluent, white families and so I’d like to see the access changed.

Robert, Social Worker, Community-Based

I think a big one as a social worker and as someone who’s always worked with poor and underprivileged populations, having access to adventure therapy for poor and underprivileged populations because as most of us know in the field of adventure therapy, it’s talked about in the literature, it’s talked about in the journals, it’s talked about in the conferences, we have a problem in this field that is built for clients of privilege, clients who have access to sufficient monetary resources. So, a lot of the really cool breakthrough interventions, you have to be able to spend [USD] $5,000 or [USD] $10,000 to be able to go on these expeditions and to be able to have access to these treatments.

The cost of healthcare in general is a problem, but that is just absolutely 110% cost prohibitive and there is just no way that some of the kids who might benefit from adventure therapy the most and might need adventure therapy the most. There’s no way that they’ll have access to it. So, I think that’s a huge problem. It’s an intervention that’s catered to higher socioeconomic status folks.

Like social workers Oscar and Robert, participants also brought up cost. When Angela met her birth parents and siblings, she learned of a brother who had been in and out of prison. Rightfully concerned for her brother’s future, Angela tried to find an appropriate wilderness therapy program with available grants to cover the cost. None were available.
Angela, USA, Continuous-Flow Wilderness Therapy

I think wilderness therapy has become very selective, as it is only an option for those coming from wealthy families. I think it’s very selective and you’re basically saying that the only people that are worth saving are the ones that can pay for it. Looking from the outside now, it can really easily be seen as a financial, corporate thing. I think that wilderness therapy programs, like I said, are brilliant. As long as they are run appropriately and as long as you have the legitimate care to have the understanding that you have to have that you are dealing with vulnerable youth. Regardless of their vulnerabilities. But I think its selective because of the cost and this contributes to a very poor cycle where those that are not as financially set, or sound, they’re not going to have the ability to change their children’s lives. And I don’t think that’s fair. I think that youth, as a whole, has to be valued, not about the depth of the parents’ pockets. It has to be available to all.

Louis, who attended a continuous-flow wilderness therapy program, mentioned he would like to see if adventure therapy could be delivered to inner city young people. Michael, though having a positive experience, described the program as a “business” with “business interests” that might benefit from more regulation.

Interestingly, practitioners also discussed a lack of diversity in adventure therapy scholarship and practice. Robert described activities, such as camping, rock climbing and snowboarding, as “traditionally more white activities.” Adventure therapy could “do a better job of opening ourselves up to different socioeconomic statuses, to be more inclusive and diverse.” Shaun agreed there is a need for more inclusive practice.

Shaun, Psychologist, Wilderness Therapy
So, when you talk about using the wilderness, camping, rock climbing, summiting mountains, snowboarding, mountain biking, those are all traditionally more white activities and we need to be able to expand to integrate experiential activities that might be more directly from black culture, from Latino culture, from different people of colour, that are more catered to a female perspective. So, we need to do a better job of opening ourselves up to different socioeconomic status but also people from different backgrounds and making adventure therapy as a field more inclusive and diverse. So that is a huge, huge area that we need to grow.

Given the admission rates for adventure therapy programs in the United States, there have been calls in the literature for cost/benefit analyses (Norton, Tucker, et al., 2014; Scott & Duerson, 2010). Gass et al. (2019) conducted such an analysis, but neglected to describe OBH as an involuntary treatment for at-risk youth. The authors also omitted to mention that most USA wilderness therapy participants are referred to ongoing residential treatment upon their graduation. Future research should explore these concerns.

This section explored some of the reflections of those who had been involved in adventure therapy. Some of the program participants left with strong opinions about the way they were treated during their experiences. This section also presented some of the economic questions the field might address in the future.

**Resonant Threads**

In this Chapter, I explored the life of participants after their adventure therapy experiences. Program participants shared experiences of being involuntarily referred to ongoing residential treatment and the peaks and valleys of returning home. This section presents the resonant thread (1) “Back to Square One,” which represents the difficulties for
participants to integrate what occurred during their adventure therapy experiences with life at home.

**Back to Square One**

Returning home from residential programming is challenging. This supports findings from previous research (Draper et al., 2013; Russell, 2005). What emerged from these narratives was that no matter if one returned home immediately following their adventure therapy experiences, or after a longer term stay in residential treatment, there were challenges adjusting to life in their communities. Some participants, such as Angela, returned home but switched schools. A small number of the participants, like Frank, reported this placement in a small, alternative school to be positive. Sophie felt it was not the “woods that helped her” but her experience of getting the correct diagnosis and treatment after the program. Still, she feared “getting sent back.”

Similar to Draper et al.’s (2013) findings and those from my inquiry, Nickerson et al. (2007) found those leaving residential treatment centres reported struggled to get along with family, not having friends, struggling with school work, having run-ins with the police, and returning to ongoing residential treatment. Program participants described returning home to unchanged environments at home and school. Barry from Australia, for example, described returning home to the “same shit hole that I was in before.” In the Nickerson et al. (2007) study, parents and adolescents felt more home visits, education, and tools for supporting the adolescent’s transition would have improved the move home. In my inquiry, participants reported returning to previous behaviours that got them involved in adventure therapy, such as promiscuity, negative peer relationships, and substance abuse. Quay (2015) reported similar concerns for students returning from outdoor education programs in school settings.
Additionally, the difficulty of getting along with parents was an echoing plot line for Willow, Connor, Kelly, and Frank.

Researchers, practitioners, and potential service users should use caution when interpreting quantitative outcomes from out-of-home residential programs. Future research should provide more follow-up data to the lives of adventure therapy participants when they are out of the therapy, and not just on graduation day. Likewise, to refer them to a second residential program might come with similar caveats when exploring the decision-making process in relation to evidence related to dose effect. Mee-Lee, McLellan, and Miller (2010) described that for many years, the perceived correct intervention for substance abusers “involved a hospital-based detoxification followed by a stay in a 28-day residential facility, lifelong commitment to abstinence, and continuing participation in some form of mutual help group” (p. 396), such as Alcoholics or Narcotics Anonymous. Wilderness therapy programs have taken a similar path with many advocating that a 28-day minimum in the outdoors as best practice. In fact, many program participants in my inquiry were told they would stay for one month, not knowing the average stay was closer to two or three months in the outdoors. Researchers such as Bein, Miller, and Tonigan (1992), however, found the available evidence could not demonstrate any superiority from long-term, expensive residential treatment when outcomes were compared to targeted, brief interventions, or even a single visit to a family doctor for advice. This is not to say brief interventions or the family doctor are more effective, but there is simply no evidence to advocate for one over the other.

Findings such as these stress how important it is to tailor therapeutic interventions based on each person’s previous life experiences and their feedback. We cannot rely on one therapeutic model to do the work for us and expect, as many continuous-flow wilderness therapy programs have in my inquiry, each participant to react in the same way to each similar intervention. Change is co-constructed throughout the therapeutic experience and the
interactions between the practitioner and participant. Based on my theoretical perspectives of humanism and pragmatism, the participants have the self-determination to create meaning no matter the experience they receive. Whether it is one day in a doctor’s office or three months in a wilderness therapy program, change cannot be predicted until the contextual factors of the therapeutic interaction are taken into account, and taken seriously.

Frank and Frank (1991) warned long periods of residential treatment could erode social support from home and “adjustment to a particular therapeutic culture may not transfer easily to the outside world” (p. 279). Scott and Duerson (2010) found the current research “suggests to keep the youth close to home to enable parent involvement, increase treatment success and reduce the disruption of removing a child from their community” (p. 64). Harper (2017) raised similar ethical considerations given the distance some participants travel to wilderness therapy; some crossing multiple state lines in the United States.

For those capable of affording wilderness therapy in the United States, admission to a continuous-flow program is most likely going to end with a referral to ongoing care, as 85% of participants engage in some type of aftercare programming. Future research might explore in more detail the effectiveness of a participant returning to their community versus ongoing residential treatment. What could be considered the most important concern for out-of-home adventure therapy services is how well program participants re-integrate their gains to life independent of therapy services. This stance, however, also relates to those receiving outpatient therapy. Practitioners should explore the changes that occur in between sessions to consolidate potential progress as a result of extratherapeutic factors not relating to the therapy, in particular (Selekman, 2005). In essence, my inquiry has found that effective therapy should be judged by the participant’s construction of their life post-therapy. The referral away from the participant’s home is considered best practice in the literature, due to historical, anecdotal decisions, but not substantial evidence.
The caution is about what participants internalise as they are involuntarily moved from one intensive therapeutic setting to the next. For example, Gelso et al.’s (2018) findings from a meta-analysis of how ‘real’ relationships affect psychotherapy outcomes found therapists who choose to withhold specific information should present to participants why they are doing so. Mastery is an important component of successful psychotherapy, yet adventure therapy participants reported feeling demoralised when their success was rewarded with further inpatient care. Participants, such as Kelly, described feeling furious when learning she was being sent to another program. If adolescents present to adventure therapy with little hope the intervention is likely to help, programs might revisit how telling a participant of their next placement, just a few days before the end of the program, can create the unequivocal relationships my inquiry has found detrimental to adventure therapy practice.

While the literature describes wilderness therapy as a family intervention, some participants, like Connor and Frank, reported continuing resentment from being deceived by their parents. Kelly also reported having no relationship with her parents after being institutionalised for five years. Policy outside the United States would make it difficult for such a troubled teen industry to endure (Gooding et al., 2018). For example, the trauma-informed policies from the Blue Knot Foundation in Australia described that healing occurs within relationships (Kezelman & Stavropoulos, 2012). Participants must feel safe to exercise control and choice of their treatment preferences. People can only be held involuntarily or restrained in Australia for three days if they are deemed at risk of hurting themselves or others.

Future research should explore further the transition to ongoing residential programs. Do participants arrive in ongoing residential programming experience the same sense of demoralisation they had when they arrived to adventure therapy? Is the residential program a more or less controlled environment than the wilderness therapy program? Focusing on these
questions will undoubtably lead to can continue efforts to reconcile lived experience with quantitative outcomes.

**Conclusion**

In this final Chapter of findings, I represented program participants’ experiences of leaving adventure therapy and the practitioners’ and participants’ final reflections on their adventure therapy experiences. The resonant thread emerging from this presentation of findings was (1) “Back to Square One.” Program participants described being referred to ongoing therapy and residential treatment, the peaks and valleys of adjusting to life at home, and joining the helping professions. When asked what they would change about their experiences or where they would like to see the field headed, practitioners and participants pointed to the expensive nature of wilderness therapy, speaking out against the troubled teen industry, and becoming more inclusive. In the discussion, I addressed the rationale for referring participants to ongoing residential treatment as this can further demoralise adolescents and they can internalise a further sense of hopelessness. In the following final chapter, Chapter 10, I present an overview of my inquiry and provide final implications for future research and the helping professions.
Chapter 10: Contextual Understanding of Adventure Therapy

Experience is, for me, the highest authority. The touchstone of validity is my own experience. No other person's ideas, and none of my own ideas, are as authoritative as my experience. It is to experience that I must return again and again, to discover a closer approximation to truth as it is in the process of becoming me. –Carl Rogers

Two participants with seemingly similar concerns can have drastically different, and at times traumatising, experiences when therapy is taken to the outdoors; even with the same program. While outcomes studies and meta-analyses demonstrated the effectiveness of adventure therapy, knowledge is minimal around what it is like to be an adventure therapy participant. Chapters 5 through to 9 unpacked practitioner and participant stories, providing narrative threads, or plot marks, to compare and contrast varieties of experience. These were organised to address the initial research questions.

1) What are people’s experiences in adventure therapy?
   i. What were past participants’ adolescent experiences in adventure therapy?
   ii. What are practitioners’ experiences in adventure therapy?
   iii. What is a therapeutic relationship in adventure therapy?
   iv. What would program participants and practitioners change about their adventure therapy experiences?

This final Chapter provides a summary of my findings presented. I also revisit my methodology and research processes, restating the aims and objectives informing my inquiry. Implications for helping professionals and future research are made at the end of the chapter.

Revisiting the Research Process

The aim of my inquiry, as stated in Chapter 4, was to build knowledge and meaning around varieties of participant and practitioner experiences in adventure therapy. My primary
objective was to inform helping professionals, which includes social workers, counsellors, psychologists, and paraprofessionals, about adventure therapy experiences by presenting narratives of those involved. I have been involved in adventure therapy for more than a decade and was interested in how program participants constructed meaning from their adventure therapy experiences over time. I was also interested in building knowledge of what the therapeutic relationship can look like in adventure therapy settings and giving people the opportunity to narrate what worked (or did not) during their adventure therapy experiences. A secondary objective was to explore the diversity of adventure therapy practice. I observed adventure therapy programs in Norway, the United States, and Australia. I also discussed with participants and practitioners how adventure therapy was incorporated into their experiences. My inquiry was important as it builds knowledge around adventure therapy experiences, where most adventure therapy literature is dominated by quantitative outcome studies that, despite providing a substantial evidence base for adventure therapy, have provided little meaning as to what occurs in practice.

To do so, I used a qualitative framework informed by pragmatism, social constructionism, and narrative ways of knowing. A strength to my inquiry’s qualitative design was its space for rich representations of these adventure therapy experiences.

**Summary of Findings**

I organised the findings in narrative threads, which compared and contrasted people’s adventure therapy experiences. I concluded each chapter with a presentation of the resonant threads, which were “threads that echoed and reverberated across the accounts” (Clandinin, 2012, p. 14). My major findings are presented under the following headings: (1) “Who Conducts Adventure Therapy?,” (2) “Who Receives Adventure Therapy?,” (3) “Varieties of Adventure Therapy Experiences,” (4) “Therapeutic Relationship in Adventure Therapy”
“Settings,” (5) “Success and Mastery,” (6) “Re-Entry,” and (7) “Adventure Therapy: A Reflection.” “Who Conducts Adventure Therapy?” discusses the variety of practitioners and how they began incorporating the outdoors to their practice. “Who Receives Adventure Therapy?” refers to the common experiences of program participants prior to coming to adventure therapy and discusses their arrival to an adventure therapy program. “Varieties of Adventure Therapy Experiences” examines the differences in adventure therapy programming. The “Therapeutic Relationship in Adventure Therapy Settings” refers to the qualities of therapeutic relationships in adventure therapy settings important to participants. “Success and Mastery” signifies some of the components at work distinctive to adventure therapy, such as the role of outdoor settings and specific hard skills participants learned. “Re-Entry” refers to the participants’ experiences of life after therapy. “Adventure Therapy: A Reflection” is a presentation of how practitioners and participants reflected on their adventure therapy experiences.

**Who Conducts Adventure Therapy?**

The first findings chapter, Chapter 5, illustrated the diversity of 26 practitioners from eight different countries. Most practitioners were trained in social work, psychology, counselling, or youth work. One practitioner was a school-based police officer who provided contained adventure therapy expeditions for at-risk students, and one psychologist provided adventure-based services for people with disabilities. The practitioners also varied in their theoretical orientation. They reported approaching their adventure therapy practice from trauma-informed, experiential, solution-focused, psychodynamic, mindfulness, art therapy, psychodynamic, and attachment-based orientations. They worked in a variety of settings such as private practice, wilderness therapy, residential treatment centres, therapeutic boarding schools, and community-based organisations. Practitioners described a diversity of pathways
towards adventure therapy. With no consensus on what defines an adventure therapist, practitioners recounted a range of routes towards incorporating adventure therapy in various settings.

One finding emerging from practitioners was their personal healing experiences in nature. This had led many of them to become oriented towards therapy in the outdoors. Along with findings in other fields of therapy (Wampold & Imel, 2015), practitioners became oriented to different modalities based on personal preference, not because of the therapy’s efficacy. This could help improve the charisma and personal influence of the therapist, as allegiance to a certain type of therapy has been shown to improve outcomes (Frank & Frank, 1991). On the contrary, it could pose a threat to participants as they are likely to receive the type of therapy the practitioner believes in, regardless of whether the participant is improving or not. If a young participant is referred to an adventure-oriented practitioner or organisation, this is likely the therapy they are going to receive, regardless of their feedback or treatment preferences.

Another concern with the diversity of pathways towards adventure therapy is the lack of consensus as to what adventure therapy is or how it works. Quantitative studies have struggled to isolate factors unique to adventure therapy’s effectiveness (Dobud & Harper, 2018), and adventure therapy has been criticised for operating as an alternative and unorthodox therapy. Young participants have been hurt or killed in the field. Because different practitioners are going to elicit different outcomes and have varying levels of interpersonal skills, focusing on the qualities of the practitioner is most likely going to be more important than defining and redefining adventure therapy. However, we live in evidence-based times, and this pathway will likely not lead to recognition of adventure therapy as a bona fide, empirically supported treatment for at-risk young people.
Who Receives Adventure Therapy?

Building on Frank and Frank’s (1991) contextual understanding of psychotherapy, my inquiry found that a common thread amongst participants was the experiencing of a state of demoralisation. Participants had multiple experiences in therapy; some having nearly 20 previous therapy experiences for a range of emotional and behavioural issues. Selekman (2005) argued for problematic behaviours to be seen as coping skills of the demoralised participants. This is further supported by Barish (2009). For example, a socially anxious adolescent may smoke marijuana before school, or a trauma survivor may self-harm as a way of soothing or to punish themselves. Viewing the problem behaviour as a strategy for coping provides opportunity to see how the problem behaviour works to resolve the participant’s distress. The people around them, such as their family or school teachers, however, grow concerned as the behaviour elicits drastic side effects, such as being expelled from school or brought home by the police. As a result of these consequences, adventure therapy participants are experienced at sitting on many therapists’ couches. As treatment failures surmount, participants become more certain that therapy is likely not going to help, no matter how it was packaged to them. Program participants described their previous therapy experiences as boring, typical, and having little to no impact. Some felt as though their therapist was working for their parents and felt the goals of therapy were not aligned with their best interests. Therapists had experimented with varying diagnoses and medications, which had had severe side effects for some.

Although the adolescents varied in their motivation for change, and none actively sought therapeutic support, those around them did. Experiences in therapy and ongoing problems associated with their behaviours left participants experiencing demoralisation. After all, their own efforts to resolve their subjective distress were met with negative consequences and those around them voicing their concerns, thus they were sent to external support, which
could be further demoralising given the potential stigma associated with being removed from their family and community. A participant from Canada provided a contrasting experience as she engaged voluntarily with adventure therapy while she was undergoing cancer treatment. She chose to participate as the program was tailored specifically for young people affected by cancer.

Adolescents were often tricked or coerced to adventure therapy. Some were told it would be like a summer camp or they would only need to stay a certain amount of time, though continuous-flow wilderness therapy programs have no fixed length of stay. In the United States, parents elicited help from education consultants, a private fee-for-service professional who can help find an appropriate placement for the adolescent. Participants who had negative adventure therapy and residential experiences voiced resentment towards a person they had not met who was able to have them involuntarily placed in long-term residential treatment. Extraordinarily, no participant in my inquiry underwent any psychological or clinical assessment prior to being involuntarily placed in their adventure therapy program.

On the extreme end, almost two thirds of U.S. participants interviewed were securely transported to their wilderness therapy program. Typically, two large men would enter their bedrooms in the early hours of the morning to forcibly escort the adolescent to the program. While one of the participants described yelling through the airport that she was being kidnapped, others did not actively resist the transporters, though negative and harmful experiences were shared. My inquiry provided a thorough examination of people’s experiences of being securely-transported, which has been missing from the literature. Exploring the literature around what ingredients are needed for an experience to be traumatic, Carlson and Dalenberg (2000) found the suddenness, lack of control, and negative subjective feelings during an event to be the core ingredients of traumatic experience. Despite secure
transport services clearly including all the ingredients to leave somebody traumatised, its use is still a common practice in OBH. I found it troubling that practitioners in my inquiry and adventure therapy scholars readily refer to their work as “trauma-informed.” I question, however, if these trauma-informed concepts are reconcilable with OBH practice given that trauma-informed approaches must privilege client choice and a sense of physical and psychological safety. Based on my findings, research needs to go beyond characteristically flat narratives of quantitative outcomes to continuously explore the impact of secure transport services.

Although researchers have shown transporting participants does not affect outcomes on the Y-OQ (Tucker et al., 2015, 2018), program participants reported symptoms of posttraumatic stress and long-term effects to their wellbeing. For example, Olivia described not being able to sleep on her own due to fear of someone entering her home and the transport experience ruining her adventure therapy experience. Other participants described transport services as getting “gooned,” being kidnapped, and feeling too afraid to eat. Surprisingly, the use of the term “goon” was used by many participants attending different programs. The use of secure transport services has not been discussed in adventure therapy literature outside the United States, and no participant in Australia, Denmark, or Canada mentioned secure transport services. Such practices deserve urgent and rigorous attention.

As a social worker, and given there are many licensed-clinical social workers practicing OBH in the United States, I have raised numerous concerns regarding the common use of secure transport services and involuntary treatment. The NASW’s (2016) code of ethics makes clear that involuntary treatment should be used only as a last resort and, if necessary, young people should be provided as much information as possible. Withholding any information about the social work service or the average length of treatment is a breach of ethical conduct for U.S. social workers. These breaches were all too common in my inquiry, requiring a thorough
review of the use of wilderness therapy as a residential treatment. Additionally, although the United States was pivotal in drafting the United Nations’ *Convention on the Rights of the Child*, they remain the only United Nations member yet to ratify these standards for youth wellbeing. Based on the evidence presented in my inquiry, there continues to exist many aspects of wilderness therapy, and OBH in particular, that have not made transparent the involuntary and coercive aspects of practice (see Gass et al., 2019). As advocates and researchers strive to position adventure and wilderness therapy as an empirically validated approach for at-risk adolescents, transparency and ethical considerations should not be taken for granted when presenting quantitative outcomes.

**Varieties of Adventure Therapy Experiences**

Program participants attended a variety of adventure therapy programs, the majority of which were continuous-flow wilderness therapy programs in the United States. These programs had no fixed length of stay and utilised rolling admissions, where a new participant was admitted to the program and joined an already-established group. Participants ranged from staying four to 28 weeks on a continuous-flow wilderness therapy program. I observed a continuous-flow program in the United States in November 2017. Other participants took part in a contained expedition. These adventure therapy programs were typically shorter, from one to three weeks in length, and, unlike continuous-flow wilderness therapy programs, participants were told the length of the trip, and the group started and ended the trip together. Five participants from the United States, two from Australia, and one from Canada took part in contained expeditions. I participated in a week-long contained expedition in Norway in June 2017. Two participants from Denmark described participating in an outpatient group therapy program delivered by a community-based mental health program. This program was
ongoing and tailored specifically for those struggling with social anxiety. Only one participant went to a wilderness-based therapeutic boarding school in the United States.

I was interested in looking at the structure and programming similarities and the different types of adventure therapy programs. Continuous-flow wilderness therapy programs provided a controlled environment resembling some kind of residential treatment without walls. Upon arrival to the program, whether by transport or with their parents, participants were strip searched, removed of all identifying information such as jewellery or personal artefacts, and provided uniform clothing. Participants reported feeling scared and shocked when asked to remove their clothes in front of people they had just met. The continuous-flow wilderness therapy process was guided by phases, beginning with (1) a cleansing phase, followed by (2) a social responsibility phase, and finally (3) a transition and aftercare phase.

The cleansing phase lasted for the first few days of the program, and participants were instructed to isolate themselves from the group and not to interact with other participants. During this phase, participants received an impact letter from their parents. This letter gave parents the chance to discuss why they had chosen wilderness therapy for their child. Similar to the use of “gooning” to refer to transport services, every participant who attended a continuous-flow wilderness therapy program described an impact letter or letter of impact.

One ethical question of consent arose, as reading the letter aloud around the fire and with the other participants was compulsory. This led some to experience shame and embarrassment. Craig, for example, described being sent to a wilderness therapy program because his parents were concerned about the homosexual porn they found on his computer. The impact letter left Craig mortified and embarrassed. He was coerced into coming out in front of the group of people he had not yet spoken to. Given consent and confidentiality are core ethics to the professional social worker; informed consent should be revisited in adventure therapy settings where adolescents are involuntarily placed.
Another finding related to the rules and structure of the wilderness therapy setting. Developing from both the programs participants and my visit to a continuous-flow wilderness therapy program, there were many rules and tasks participants had to follow on a daily basis. First, participants were provided with no future information, such as how long the program would last or how far they would hike each day. Some participants did not know they were graduating from the program until the day before they left. Second, participants could not talk freely to each other unless within earshot of staff. If they went to the toilet, they were to call their name or their number while away from the group. During my observation, if two participants were collecting firewood together, they were instructed to name bounce. They would call each other’s names loudly to show staff they were not talking to each other.

Unique to continuous-flow programs when compared to contained expeditions is the role of the therapist. Described further below and in the following section, the therapist on a contained expedition remains with the group for the duration of the program. In continuous-flow programming, the therapist visits a group in the field once or twice a week to conduct individual or group therapy sessions, share letters from family members, and ultimately decide when the participant is ready to graduate the program. The role of the therapist in different settings is presented in the next section.

The social responsibility phase gave participants more to be accountable for, such as cooking dinner for the team, navigating with a map and compass, or working through issues among the therapeutic community. The final transition phase occurred with the participants usually spending two or three days with their family and participating in family therapy. A behaviour contract was arranged to go home, but most participants were referred from the continuous-flow wilderness therapy program to ongoing residential treatment. Despite the referral, some families elect to bring their adolescents home and enrol them in a smaller alternative school.
Contained expeditions were not guided by phases and typically had less structure. Since the group was starting the program together, there was no cleansing phase, and for all but one participant who attended an expedition in the United States, participants were allowed to speak freely with each other. For the one participant, Sophie, her program began with an impact circle where her parents spoke about the problems at home in a group setting with the other participants and their parents. Sophie’s program had scheduled times where participants were allowed to drink water and most days were spent in silence until group therapy at night. For the other participants, contained expeditions tended to be less focused on controlling adolescents’ behaviour and more about social responsibility. The group had places to hike to and were responsible for the set-up and take down of camp. Unlike continuous-flow wilderness therapy programs, most participants were not referred to ongoing residential treatment but returned home. For the two participants in Australia, their programs provided aftercare services and allowed their participants the chance to return and mentor first-time participants.

Community-based adventure therapy settings involved outpatient group therapy for the two participants from Denmark. The facilitators of the program took effort to make participants feel welcomed and did not push them to participate or talk. The group was ongoing, and participants were welcome to continue participating as long as they wanted to. I observed a community-based adventure therapy organisation for young people affected by cancer in Australia. I took part in a five-day expedition the organisation provided during the school holidays. The expedition was unstructured, and participants were perceived as “members” of the organisation instead of clients or kids. Their voice and choice were privileged throughout the experience, and the therapists running the program did not focus on the participants’ negative cancer experiences. The approach was strengths based and positive.
when compared to continuous-flow wilderness therapy programs, which contained strict rules.

One participant, William, attended a wilderness-based therapeutic boarding school in the United States to provide the last type of adventure therapy setting I explored. Like continuous-flow programs, this program was guided by phases and had strict rules for participants to follow. Students lived in the outdoors and practiced survival skills. They cooked over a fire each night and walked to the main campus where school was provided each day. William remained at the program for 18 months until his father came to get him after he wound up in the hospital due to his heart condition.

The variety of adventure therapy settings illustrates the diversity of practice. As I mentioned earlier, defining what is and is not adventure therapy is a contentious debate. For example, the many rules of wilderness therapy practice, such as withholding of future information, are not presented in the literature.

In my analysis, I made links with John Dewey’s pragmatic and experiential philosophy (Dewey, 1938, 1981), Miten’s (1994) feminist critique of adventure therapy, and the contextual model for understanding psychotherapy (Frank & Frank, 1991; Wampold & Imel, 2015). On the following page, Table 9 is presented to illustrate my findings and implications in relation to certain models of adventure therapy. These implications include the need to reconsider levels of coercion and involuntary treatment in wilderness therapy, how adventure therapy practitioners can provide future information to their participants to evoke a sense of hope and expectancy, and the importance of providing participants with voice and choice.

I raised concerns about the strict structure of continuous-flow wilderness therapy programs as this can restrict opportunities for accidental learning. Dewey (1938) felt children are the most vulnerable members of society given they have no choice in what they are taught
### Table 9: Program characteristics and findings

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Core Ingredients</th>
<th>Implications from My Inquiry</th>
</tr>
</thead>
</table>
| Continuous-Flow Wilderness Therapy    | - The most common approach in the United States, such as Outdoor Behavioural Healthcare  
- Involuntary treatment and the use of secure transport services are common  
- Rigid structure with use of behavioural modification phases  
- Common interventions used, such as the impact letter  
- Field staff rotating each week  
- Licensed therapist visits the participants weekly  
- Program length is individualised and not disclosed to participants  
- Most participants are referred to ongoing residential treatment post program | - The ethics of involuntary treatment and coercive nature of continuous-flow wilderness therapy programs in the United States require revisiting  
- Wilderness therapy programming should shift the centre of gravity to the participants’ experience of constructing meaning and their self-determination, as opposed to rigid programming  
- Practitioners and researchers should refrain from calling the referral to ongoing residential treatment ‘aftercare’, and revisit this common practice  
- The use of secure transport services, prior to doctor’s recommendation or clinical assessment, is in need of further analysis, especially given clear breaches to professional codes of ethics  
- Research into continuous-flow wilderness therapy has not given justice to what it is like to be a participant on these programs |
| Contained Expeditions                | - More common outside the United States  
- Though involuntary admission occurred, participants were told the fixed length of the program  
- Therapists and field staff remained with the group for the duration of the program  
- Programming was less rigid with no phases to inform the program structure | - Providing participants with the end date increased hope and expectancy, a necessary therapeutic ingredient  
- Therapists and field staff remained with the group for the duration of the experience, which allowed for participants to experience the genuineness of their practitioner  
- Programs linked to the participants’ community, such as a school group, allowed for an easier transition of |
<table>
<thead>
<tr>
<th>Community-Based Adventure Therapy</th>
<th>Wilderness-Based Therapeutic Boarding School</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Most participants returned home immediately following the program</td>
<td>• Therapeutic boarding schools are common in the United States</td>
</tr>
<tr>
<td></td>
<td>• Programming is rigid with specific phases to inform progress</td>
</tr>
<tr>
<td></td>
<td>• Participants lived in outdoor settings but attended school each day</td>
</tr>
<tr>
<td></td>
<td>• Individual and group therapy conducted by licensed practitioners</td>
</tr>
<tr>
<td></td>
<td>• More research is required to explore this model of adventure therapy programming</td>
</tr>
<tr>
<td></td>
<td>• Participants with numerous therapy experiences benefitted from the opportunity to engage in an alternative approach to therapy</td>
</tr>
<tr>
<td></td>
<td>• Practitioners focused on reducing power differences using examples of walking side by side with participants</td>
</tr>
<tr>
<td></td>
<td>• Participants were provided ‘voice and choice’ throughout their experiences</td>
</tr>
<tr>
<td></td>
<td>• Like continuous-flow wilderness therapy programs, the programming of this wilderness-based therapeutic school had strict programming and rigid phases</td>
</tr>
<tr>
<td></td>
<td>• Programs should explore the rationale for using power differences, such as having senior students control when new students can speak</td>
</tr>
<tr>
<td></td>
<td>• Research literature should provide justification for the level of coercion and inequality students experience in therapeutic boarding schools across the United States</td>
</tr>
</tbody>
</table>
and who instructs them. When adventure therapy settings are rigid with rules, such as withholding future information and dictating when participants can speak to each other, the outcome may be compliance. For example, Kelly said, “All we did was follow the rules.” Sarah, too, described her field staff were “more of a disciplinary person.” For Mitten (1994), compliance is not a therapeutic outcome, but practitioners may see it this way.

Howard et al. (1993) pioneered research into ‘dose effect’ in psychotherapy outcomes. That is, how much therapy is needed for the average person to experience reliable change? The authors found participants entered therapy feeling demoralised and that if therapy was likely to be effective, the participant should experience progress earlier in the therapy process rather than later. Effective therapy provided a sense of success, mastery, and hope, which in turn helped to remoralise the participant. When those experiences were missing, participants were likely to drop out or become worse while in therapeutic care. If the aim of therapy is to provide instances of success and hope early in the therapy, it is time to rigorously examine dose effect in adventure therapy; that is, how much therapy is needed before we should anticipate positive change. Evidence from my inquiry demonstrated that practitioners should focus on their program participants’ experience of care, their feedback when they feel therapy is not helping, and pay particular attention to levels of engagement. When program participants are not engaged, practitioners should explore with their participants what they could change in order for the adventure therapy experience to become more meaningful. This may involve changing the staff with whom the program participants interact, such as with Connor, who described the differences of one field staff to the next.

If adolescents arrive to adventure therapy feeling demoralised, are subsequently strip searched, provided no further information, instructed not to participate with the group, and at the time of graduation, told they will be attending a long-term residential treatment program, it is difficult to wonder how this could not leave the participant further-demoralised. In
addition, when they have graduated the program due to their own efforts, which can induce a sense of success and mastery, they are told they are not ready to return to their community, and are sent to another program. I found that ongoing therapy may prolong the narrative that they are the problem, despite adventure therapy literature suggesting wilderness therapy is a family intervention. As mentioned above, some parents elected not to follow the program’s recommendations and brought their child home.

**Therapeutic Relationship in Adventure Therapy Settings**

Exploring the third research question of my inquiry, “What is a therapeutic relationship in adventure therapy?,” I asked practitioners and participants to describe their experiences of engaging in therapeutic relationships in adventure therapy settings. Practitioners described the importance of engaging in shared experiences, whether it be paddling a boat or climbing a mountain together. They used examples of the weather to describe shared experiences. For example, if it is raining during a hike, the participant and practitioner have to handle the same weather. Participants described shared experiences as a means for practitioners to establish more equitable relationships. For example, participants liked when practitioners were “down and dirty” and did not use their authority to control their behaviour and create a power difference.

Feeling valued and experiencing a genuine relationship was important for participants. Practitioners described having “nowhere to hide” when practising therapy in the outdoors given they spent 24 hours a day living together. Brady from Australia expressed how important it was for his program leaders, a clinical psychologist and youth worker, to make him feel valued. Because of the recent trouble he had been getting into, Brady left his eight-day contained expedition feeling accepted by adults around him. This gave him the confidence to participate fully.
Where participants described boring and typical experiences in therapy before adventure therapy, authentic relationships appeared as a narrative thread. Part of this genuineness, or what C. R. Rogers (1957) described as congruence, occurred when practitioners showed a motherly attitude to the participants. This might be the way in which participants interpreted the empathetic attitude of their practitioners, which has been shown to be a good indicator of positive experiences in therapy (Norcross & Lambert, 2011). The practitioners demonstrating these empathetic and caring skills stood out when compared to the other staff participants with whom they interacted. Genuineness might also be experienced from a practitioner’s self-disclosure, which helped participants like Mark and Nancy to give purpose to the program and see the human within the practitioner.

Some practitioners avoided the term therapist. Crystal, who worked with people with disabilities, mentioned the word therapy might bring more stigma than benefit in her particular context. Others acknowledged that because participants were coming as therapy veterans, it was important to take on a more equitable role, hence the importance of shared experiences. Magnus described how participants coming to his program had grown accustomed to seeing so many different specialists. He hoped to be seen more as a life guide, rather than a therapist.

The program participants distinguished between relationships where adventure therapy practitioners were able to use confrontation as a positive therapeutic tool versus when confrontation was perceived to increase inequality and force. Confrontation was perceived as useful to participants when previous conditions in the relationship were met. For example, Michelle, Lance, and Tony responded to the sternness of their therapist who would “call them out on their bullshit.” However, others, like Craig, found their therapist used their position of power to inflate their role, which created further distance between the two.
As mentioned above, the role of the therapist differs from program to program. DeMille and Montgomery (2017) expressed the challenge for the therapist to establish an equitable relationship and consensus on the purpose or goals of therapy when they are the ultimate gatekeeper in determining when the participant is ready to go home. As with confrontation, there are times when the direction a practitioner takes is at odds with either the treatment preferences or cultural context of the client. In discussing these concerns, I made links to the concept of a practitioner becoming solution-forced (Nylund & Corsiglia, 1994). This occurs when a participant engages in a relationship with a therapist who has already determined the direction and goals of the therapy. The authors described solution-forced therapists are waiting at the finish line before the participant has even begun. Gatekeeping is a similar concern, as articulated by DeMille and Montgomery (2017). This also relates to Mitten’s (1994) original argument that practitioners need to avoid privileging any therapeutic model, whether indoors or out, over and above the participant’s firsthand experience. Taking into account a participant’s right to self-determination and how they freely-construct meaning and change, provides a more useful lens for understanding how therapeutic change does occur.

**Success and Mastery**

Success and mastery are terms used commonly in adventure therapy and Outward Bound literature (for example, Walsh & Golins, 1976), but have traces in the broader psychotherapy literature for example, Liberman, 1978). I explored experiences of success and mastery through the lens of dose effective, using the work of Howard et al. (1993). Evidence suggests that when a person experiences success and mastery, early in the therapy process, therapy is more likely to be successful (Wampold & Imel, 2015). In this case, practitioners should provide adventure therapy experience that guide participants to experience
competence during the session. Specific questioning, such as “How were you able to succeed at starting your fire?”, could help adolescents to construct meaning out of their success.

Outdoor therapies are unique given practitioners are focused and intentional about how they regard the setting in which therapy takes place. For example, the outdoor setting is viewed as an active factor in the therapeutic interaction. Practitioners described the outdoor setting as an effective novel environment where participants are challenged to learn new skills to help them adapt. For some, the novel environment was useful for gaining perspective of how life had been going at home. The outdoor setting also provided opportunities for accidental learning, an experiential concept where participants can apply meaning to an experience on their own. For example, a participant may learn to create a friction fire while at a wilderness therapy program and practice patience and tenacity while doing so.

Natural consequences were discussed to facilitate much of the learning. For example, if the program participant does not set up an adequate shelter and it rains, they may get wet or need to ask for help from someone else in the group. Kelly described the environment forcing her to take care of herself in a way she had not done in the past. Adolescents described the effects of learning to take care of themselves in outdoor settings and accomplishing more than they would have thought they could. Some participants held on to artefacts, such as program equipment or their bow drill set, to remind them of the skills they had mastered. Psychologist Magnus described helping participants who may not have believed they were good at anything to experience success and mastery in an excerpt about teaching participants to steer a sailboat.

As I observed during my visit to Norway, participants from all different types of adventure therapy programs engaged in a solo experience. This was characterised by a participant spending one to three days on their own and in some circumstances out of other participants’ sight. Lance and Willow described their experiences as “amazing” and
“spiritual.” Other participants, like Frank and Sarah, reflected on their solo experiences and felt too young to have got the most from the experiences. Sarah, especially, felt the solo was part of the program’s tough love approach, which consisted of staff telling Sarah not to talk and removing her boots and laces during her solo experience.

Despite literature supporting the notion that time in the outdoors can be inherently-healing, some participants experienced disenchantment about participating in an outdoor therapy. Some participants described symptoms of posttraumatic stress as a result of their participation in adventure therapy. Sophie described not wanting to hike in the outdoors along any path she was not accustomed to. Laura described a fear of breaking any of the program’s rules despite her wanting to engage in something therapeutic, such as journaling under a tree. Although Connor described his fear as irrational, he reported feeling anxious about being in a room with bearded people, as they reminded him of the field staff from his program.

Using the outdoors in therapy provides an environment rich with opportunities for participants to experience success and mastery. Practitioners should feel comfortable with allowing participants to interact freely with the outdoor setting, which also reflects Mitten’s (1994) feminist critique of practitioners causing intentional stress to their program participants. If the practitioner’s role is to control the participant’s experience, then the remedial qualities of outdoor environments would be reduced. By allowing for freedom of interaction, a program participant has the option to use the therapeutic setting as a ‘second facilitator.’ If nature holds the potential for healing, the practitioner’s responsibility is to ensure the participant feels cared for, valued, and competent so they are at their best when experiencing nature’s benefits. If the environment or the practitioner is leaving the participant feeling demoralised, therapy is unlikely to progress positively.
Dose-effect literature suggests early experiences of success and mastery should be on the practitioner’s agenda (Howard et al., 1993). In this case, the hard skills and initiatives should be tailored to the motivation of the participant, and not without ongoing assessment of the quality of the therapeutic relationship, instead of assuming that learning hard skills will be important for every participant. For example, Tony found learning to bow drill too challenging and not important to the reasons he joined the program. Hard skills and the natural environment, when perceived as an effort to re-moralise, might be matched to a participant’s preferences and have their importance revealed to the participant.

**Re-Entry**

Concerns about the ethics of removing a young person from their family and community have been presented in adventure therapy literature (Bolt, 2016; Harper, 2017). Research studies have found it is challenging for participants to reintegrate into their communities following participation in residential treatment, adventure therapy included (Draper et al., 2013). In the U.S. literature, and on most continuous-flow wilderness therapy programs, a referral to an additional out-of-home program, such as a therapeutic boarding school or a residential treatment centre, is routine practice and has been designated best practice (Bettmann et al., 2013). The vast majority of participants who had attended continuous-flow wilderness therapy programs were referred to ongoing residential programming. A select few had parents who elected not to follow the program’s advice and brought their child home to most likely attend a new, smaller, and alternative school. Referral to ongoing residential treatment did not occur for the participants I interviewed outside the United States, though they were able to remain engaged with their adventure therapy providers.
Because not providing future information to participants is common in wilderness therapy programming, participants did not know when they were going to graduate from a continuous-flow program. Some were told one or two days before their parents came to pick them up. Likewise, participants were unaware that behind the scenes, their parents and therapists were organising a new out-of-home placement at a longer term therapeutic boarding school or residential program. Participants expressed being frustrated by the decision, given they had experienced success in the program and attributed this to working hard on the program. They felt downhearted that, despite their success, they were going to start over at a new program. This common progression from one therapeutic setting to the next requires further research. This practice has continued since the start of wilderness therapy in the United States despite no differences in outcomes to support such decisions. This involuntary, coercive, and paternal mode of service delivery, in which participants have no voice and choice, requires justification and research support in order to continue.

As a result of participation in adventure therapy, participants reported a wide array of positive outcomes. Participants described feeling more confident in themselves, improved self-esteem, better ability to maintain relationships with family, and having better performance in school. Drug use continued to be a concern for some, and many of the obstacles faced upon returning home were comparable to the qualitative findings of Draper et al. (2013). Program participants, such as Olivia and Angela, described negative and unhealthy romantic relationships hampered their progress upon returning home. Mark and Louis described ongoing substance abuse made for run-ins with the police, and Barry and Kelly described unchanged environments at home posing difficulty. From my inquiry, it seems participants struggled with reintegration whether directly after their adventure therapy experiences or following ongoing residential treatment.
An interesting thread emerged regarding the number of participants who began working in the helping professions. Two participants in Australia and Yosef from Israel described being invited to continue participating in their adventure therapy programs as mentors. Yosef built on this experience, becoming a high school teacher. Other participants described their experiences of wanting to help others who were experiencing similar struggles to them. For example, Jeanne in Canada participated in a contained expedition after her own experience of cancer treatment. At the time of interview she was training to become a psychologist and wanted to work with sufferers of chronic illness. Angela was multiculturally adopted and completed a social work degree to help adopted young people. It could be interpreted that these participants gave new meaning to their own struggles and repositioned their own identity as people who were capable of helping others. This might be something practitioners encourage when participants voice a preference for joining the helping professions.

Program participants were asked to describe experiences in therapy after adventure therapy. Where some like Sophie, Michelle, and Katy expressed being misdiagnosed and prescribed pharmaceuticals prior to their adventure therapy experiences, this road continued. Sophie described being misdiagnosed again and struggling until she was given the right medication and prognosis. Others described still engaging in therapy, such as Olivia. Although she had different experiences in therapy, she continued to work with a therapist to deal with the “PTSD” from her transport experience. Others, such as Thomas and Tony, rejected the idea that therapy could be useful to them. Neither said therapy could not work, but their experiences had left them dissatisfied with the concept.
Adventure Therapy: A Reflection

One of the last questions I asked my research participants was what they would change about their adventure therapy experiences, or where they would like to see the field headed in the future. Practitioners, such as Jackie, described the slow evolution from boot camp model programs and the transition from potentially abusive and neglectful practice. Others mentioned how the cost of participation in the United States makes wilderness therapy a boutique service for white, middle- to upper-class participants. Some of the participants, such as Sophie and Thomas, described feeling as advocates against abusive practice and experienced feeling worse as a result of participation. Others, such as Angela, wished adventure therapy could be offered to a more diverse range of participants, such as her biological brother who ended up in prison and could not afford wilderness therapy. There was discussion about how participants were sent to wilderness therapy and, despite a positive experience, some like Frank experienced having “abandonment issues” for being consequently sent to a second boarding school.

My inquiry allowed for an important perspective for practitioners to understand how participants construct meaning from their experience and delivers a pragmatic understanding of adventure therapy in response to the evidence-based practice paradigm dominating the psychotherapy literature. For practitioners of adventure therapy, it may be beneficial to revisit program structure to privilege the participants’ experiences of success, mastery, and re-moralisation, rather than favouring the structures, phases, and model of the program. Implications are presented in the following section.

Implications for Helping Professionals in the Field

Based on the evidence from my inquiry, I have shown how pragmatic, constructionist, and humanistic lenses are useful for interpreting psychotherapy experiences. People arrive to
therapy from different contexts and, for adolescents, the problems that bring them to therapy are often distributed across various sites, such as parents, schools, negative influencing from peer groups, or other helping professionals. Practitioners should take these considerations into account when meeting and assessing an adolescent for the first time.

My inquiry demonstrated that it is the interaction between participant, practitioner, and possibly the setting, where change is co-constructed. Viewing service users as self-determining and active participants means practitioners should explore how participants are perceiving therapeutic progress, instead of using only clinical judgement. In this case, as supported my Mitten (1994), the most potent material in the therapeutic interaction is the client’s perceptions of empathy, care, and progress.

I have shown the difficulty of understanding what exactly adventure therapy is and its diversity of practice. While those in my inquiry referred to their work as adventure therapy, there was little-to-no consistency in practice or how they described their work. That is, what two practitioners or two research studies describe as adventure therapy might have zero commonalities. Practitioners and academics must be clear about the practice they are describing. This includes wilderness therapy advocates in the United States who must re-examine the way adolescents are perceived and treated during their programs. As I have stressed throughout my thesis, researchers such as Gass et al. (2019) who omit essential information, such as the involuntary nature of OBH, have the ethical responsibility to be transparent about the structure of their programs.

Furthermore, based on the evidence presented throughout my thesis, I have shown that it is time to revisit the transport process and the “troubled teen industry” in the United States. There were aspects of practice that did not adhere to many, if not all, of the professional codes of ethics informing international adventure therapy practice. Revisiting the ethics of adventure therapy practice is important given the stories represented in my thesis.
Practitioners should aim to build authentic and democratic relationships with participants and ask what they can change to make their programs seem more meaningful to them. If a participant is resisting the program, practitioners should avoid taking actions which may lead to further shame and demoralisation. Because participants attending adventure therapy are experiencing some sense of demoralisation, practitioners might focus their initial efforts on helping participants to experience success, mastery, and re-moralisation, rather than waiting patiently for the participant to engage. Just as Orlinsky et al. (2004) found, the quality of participation in therapy stands out as a strong predictor of change, and the responsibility for engagement relies on the practitioner’s ability to build an authentic and genuine human relationship while attending to the participant’s wounded humanity and packaging the purpose or rationale for improved participation. While many adolescents may be reluctant to engage in therapy, especially so after numerous treatment failures, practitioners should consider how they unpack the rationale for their outdoor therapy work to best invite adolescent engagement.

Some of the adolescent participants voluntarily engaged in their program but found the experience different to what they signed up for. Transparency and honestly are not only as the foundations of human rights and many professional codes of ethics but were reported as important for participants. Focussing on minimising the power differences between the helper and the helped may be achieved through shared experiences, where the practitioner engaged in therapeutic initiatives with the participant. This was described as being just “as down in the dirt” as the participants were. Programs should be transparent and honest about their practice and what the experience of being a participant on them would be like.

As practitioners, we should be aware that while quantitative outcomes support the efficacy of adventure and wilderness therapy, past participants continue to suggest they were harmed and treated poorly. Some believe wilderness therapy left them with ongoing effects,
such as feeling triggered when going outside, or when interacting with people who resemble their field guides. It may take rigorous training of therapists and field staff to shift the assumption that participants are not to be trusted in acting in their best interests in order to see a new evolution of the field. However, data from other fields of therapy suggest partnering with adolescents based on their preferences and desired outcomes can improve outcomes no matter why they were sent to therapy (Duncan et al., 2007).

**Limitations**

It is my hope my inquiry will contribute to adventure therapy literature by providing detailed firsthand accounts of the adventure therapy experience. That is, like all forms of inquiry, there are limitations worthy of discussion; one of which is the generalisability of these experiences, though not intended, which points to the qualitative nature of the study.

The purposive sample of 30 past participants, 26 practitioners, and three experiences for participant observation provided the opportunity for an in-depth exploration, but this is not a broad enough representation of all adventure therapy experiences. I was unable to locate participants from the United Kingdom, Norway, India, or New Zealand, to name a few, where I had interviewed practitioners who worked with people appropriate for participation. Likewise, important other participants and minority groups, such as Indigenous populations, may have been missed through my sampling methods and their experiences were not represented in my inquiry. This is likely due to the amount of U.S. participants I was able to locate. As examined further below, the pragmatist may ask, “What would my inquiry have found if I happened to locate a different sample?” If my inquiry located a more diverse range of participants, different findings may have emerged.

Representation is another limitation, which I presented briefly in Chapters 3 and 4. Because I could not present or capture the original experience of the participant, I provided
rich descriptions by using particular excerpts to emphasise the emerging narrative threads, and avoided small snippets of text void of context. Therefore, readers should take caution when interpreting the assertions made throughout my inquiry and particularly when trying to generalise the findings to other fields or adventure therapy in general.

For my inquiry, I adapted Wampold and Imel’s (2015) definition of psychotherapy. This provided a barrier for inclusion based on the presence of a helping professional and omitting experiences in outdoor education, recreation, summer camps, or one of the many other outdoor experiences with potential for eliciting therapeutic growth. My examination of the therapeutic relationship built on the knowledge around therapeutic interactions in adventure therapy settings.

It is worthwhile to link back to my presentation of Dewey’s (1905; 1910) pragmatism which attempts to move beyond original discussions of ontology and the nature of reality. As Morgan (2014) described, this “leads to questions about what difference it makes not only to acquire knowledge one way rather than another (i.e., the procedures we use), but to produce one kind of knowledge rather another (i.e., the purposes we pursue)” (p. 5, emphasis in original). If this same inquiry was conducted by another inquirer, or by someone bringing different adventure therapy experiences to the table, different forms of knowledge would emerge. The same goes for the people I interviewed and the programs I visited. Similarly, if I had adopted a mixed-method approach, advocated by many pragmatists (Morgan, 2007), I may have included surveys as a form of data collection. While this could have improved sample size by improving the anonymity of the participants, there is a possible reduction in the thick descriptions participants conveyed in their participation.

If I had used different methods to address this same research problem, I would have been led to different assertions. This invites interesting questions for future research. If quantitative studies find adventure therapy, on average, to be effective, but participants are
describing experiences verging on traumatic or demoralising, future research could explore how these two forms of inquiry could locate a democratic common ground.

The medical model provides a specific lens for examining psychotherapy. Proponents of this view believe that with an accurate psychological assessment, a practitioner can select a psychotherapy treatment supported by the evidence to match a person’s diagnosis (Wampold & Imel, 2015). This view is commonly referred to as ‘evidence-based practice’ (Duncan et al., 2004). This view has its limitations given that assessment and specific models of psychotherapy have demonstrated little to no variance in outcomes (Miller et al., 2013). Because the available literature is dominated by the stance that adventure therapy contains unique ingredients which contribute to positive change (Gass et al., 2019), it was timely to provide a different lens for examining adventure therapy experiences. While the medical model’s influence has provided clear support for psychotherapies strong evidence-base, shortcomings have emerged. It is impossible to describe how and why change occurs for individuals or groups (Duncan et al., 2007). However, a researcher adopting this medicalised stance would most likely arrive at different conclusions. Based on the evidence from my inquiry, it is clear this was a timely exploration of adventure therapy experience. Two people, working with the same practitioner, attending the same program, and in the same setting can describe completely different experiences when we provide space for their voice and choice.

Given my solution-focused background, I have avoided diagnosing or interpreting the participants’ description of their problems by using any material other than their own words. As in the traditional narrative approach, my aim was to de-centre myself from the research participants’ lived experience (Beels, 2009). A psychodynamic practitioner might explore the participant’s anxieties, and a cognitive behavioural worker may focus on negative thinking patterns. Just like various methods would lead to different findings, different theoretical
perspectives could direct the inquirer’s attention elsewhere. My focus throughout this piece has been on the interactions, and what helped or hindered therapeutic progress.

**Implications for Future Research**

There is a need to develop more outcome research outside the U.S. wilderness therapy context. The diversity of practice in Europe and Australia has begun to be explored, but less data exists when compared to the OBH Research Council’s dataset. Empirical studies could explore the relationship between the therapeutic relationship and outcome and begin to explore dose effect. Harper et al. (2019) began exploring the dose effect around spending time in nature but more study could help. While no study has found the precise amount of time a participant should remain in an out-of-home program, studies could routinely monitor outcomes in addition to clinical judgement or a program’s pre-established curriculum or phases to determine when participants are ready to return to their community. Examining dose effect, as I have discussed around Howard et al.’s (1993) work, would be enlightening.

Additionally, treatment should only be considered successful based on the life a participant lives outside of therapy, not if they are referred to ongoing residential treatment. Studies, such as Gass et al. (2019), that inflate treatment effectiveness due to 94% of participants completing OBH but neglecting to state that the majority end up in long-term residential treatment are misleading to the reader and potential service users.

Research could begin exploring therapist effects to locate the practitioners building eliciting better outcomes than the rest. Because some therapists outperform others in outcome studies no matter the model of therapy being delivered, it is worth exploring what the most effective adventure therapy practitioners do to engage more clients than the others. A database of individual practitioner outcomes could create a platform for advocating that,
Despite the diversity of adventure therapy practice, working with young people in the outdoors has a robust evidence base.

Ongoing qualitative research should continue to explore the lived experiences of participants in different settings. There was a lack of participant experiences from outside the United States. Although there are more programs around the world than I was able to represent in my thesis, giving participants the chance to share their adventure therapy experiences provides an opportunity to learn from those we intend to help.

My Reflections on the Study

Lincoln and Guba (1985) mentioned that as a study comes to an end, a researcher should reflect on what has changed for them. If nothing has changed, after all, what impact has that study had? I have reflected throughout this experience over the past four years and how much has changed since I entered this exciting field. The most challenging experience for me was recruiting participants and receiving an email from someone asking how I could be involved in a field known for traumatising and hurting young people. I spoke with my supervisor John, about this revelation, and began speaking with my colleagues about the state of our field. Attending adventure therapy conferences, though incredibly fun and full of amazing people, was also a challenge. For example, there was very little presentation of client experiences, and certainly no acknowledgement of the demoralising experiences some adolescents have endured.

As I reflect on my research process, I have grown more angry and frustrated with my original wilderness therapy training. Was it really important that I enforced silent hiking or instructed participants not to talk freely with other group members? As I have throughout my thesis, I questioned whether these structures were in place with any true belief by their
enforcers that these ingredients were 100% essential to outcomes or safe and effective programming.

Shifting the centre of gravity to the participant, I want to loosen the structure of my program, privilege a person’s self-determination, and invite situations that elicit experiences of hope, success, and mastery. One thought that occurred to me related to the number of narratives where therapy was done to or forced on people. The descriptions of multiple diagnoses and medications showed some of the perils of mental health interventions, while the therapeutic relationship seemed to be treated with lip service. I would hope my program is one participants enjoy and look back on believing it helped in some way, no matter how little. People are capable of making changes to their lives, in or out and before or after therapy, and this assumption can create an altogether different relationship in the therapeutic setting. Sometimes what is necessary is to get out of the way.

In the following section, I conclude my thesis, highlighting the initial research questions, and provide a brief overview of the study’s findings.

**Conclusion**

The research questions informing my inquiry addressed the lack of client voice in the adventure therapy literature. I questioned how else we could explore the experiences of those with the most at stake. Although scholars have used diagnostic criteria to dissect adventure therapy participants, such as Hoag et al. (2014), I utilised a pragmatic framework for exploring adventure therapy and the ways participants and practitioners co-construct meaning and change. Interpreting adventure therapy as akin to medicine with specific active ingredients is inappropriate, and not supported by the available evidence (Dobud & Harper, 2018). Social constructionism, pragmatism, and humanism provide more useful lenses for interpreting therapeutic interactions; interpreting how change occurs for a given participant.
Adventure therapy does not work in isolation to the context of the participant and practitioner and this notion is worthy of future study. Participants typically arrive to adventure therapy after myriad therapy failures. Participants outside the United States were coerced and pressured to engage by their school and families but agreed to attend “voluntarily,” while participants in the United States were transported to programs involuntarily.

My inquiry used interviews from practitioners and participants to study the therapeutic relationship in adventure therapy settings. It appears this relationship helps participants feel valued and to become more engaged in the therapy. When practitioners focused on maintaining their authority and gatekeeping the participants’ experiences, participants described the negative experience of being forced into situations they did not deem appropriate or helpful. Although time in nature has been suggested to be an active ingredient, like penicillin is to a bacterial infection, participants described mixed feelings about the outdoor setting. Some participants described symptoms of posttraumatic stress as a result of adventure therapy and feeling triggered by spending time in the outdoors.

Program participants appeared to have difficulty when returning home. Although many in the United States were referred to ongoing residential treatment, the return home had ups and downs, even returning from the extended out-of-home stays. They described ongoing experiences in therapy and returned to therapy to process their adventure therapy experiences. Some held continued resentment towards their parents for sending them away for multiple years of their adolescence.

It was interesting to see who these people have become since their adventure therapy experience. Many were seemingly well-adjusted, university-educated individuals who seemed to live good lives. I reflect on the challenging stories shared throughout this work and wonder what footprint adventure therapy left in their lives. We cannot undo experiences, but
the impression of experiences can change upon each reflection. It is possible adventure therapy had an impact, much like medicine to an illness, in their lives. Similarly, the participant could have been the ‘wild card’ all along, with the resilience to move beyond their difficult teenage years, being within them all along.

I am grateful to the program participants and practitioners who shared their experiences with me and the programs that invited me to conduct participant observation. Through their participation, they have shown how adventure therapy can help someone to improve their wellbeing but can also keep someone demoralised. The participant narratives and my interpretation offer an alternative understanding to inform the helping professions and field of adventure therapy.

As I write this final paragraph, I am doing so from a tent in the field. I took a small group canoeing today with dolphins, slacklining, and ended the day camping in the forest. My reflections above focused on what I have learned from my inquiry and how this will impact my future work. No better time to find out than now.
References


Psychological Association.


   *Journal of Teacher Education, 58*(1), 21–35.


analysis. Paper presented at the North East Regional Conference. Association for Experiential Education, Colebrook, CT.


Journal of Experiential Education.


cognitive autonomy and self-efficacy: Results of a non-randomized trial. *Child and
Youth Care Forum, 43*(2), 181–194.


outcomes from a wilderness therapy program. *Journal of Creativity in Mental Health,
13*, 392–404.

Meichenbaum, D., & Lilienfeld, S. O. (2018). How to spot hype in the field of
psychotherapy: A 19-item check list. *Professional Psychology: Research and Practice,
49*(1), 22–30.

dependence treatment? In B. L. Duncan, Miller, S. D., Wampold, B. S., & Hubble, M.

*InterAction, 2*(1), 67–99.


*Wilderness therapy for women: The power of adventure*.

boarding school: The elite arm of the youth control complex and its implications for
youth justice. *Critical Criminology, 1–16*.


Psychologist, 29(1), 13–21.


Scott, D. A., & Duerson, L. M. (2010). Continuing the discussion: A commentary on
“Wilderness therapy: Ethical considerations for mental health professionals.” *Child and Youth Care Forum*, 39(1), 63–68.


Substance Abuse and Mental Health Services Administration (SAMHSA). (2012).
SAMSHA’s National Registry of Evidence-based Programs and Practices.


Denver, CO: Outward Bound Publications.


Appendices
Appendix A: Example of Journal Records

The 9 participants arrived to the hospital at 12 am with their bags packed. Many Norwegians already were their own gurn so the program came little out. We did a quick introduction and I met the 6 girls and 3 boys. This ratio represented the numbers referred to the hospital for those aged 16 to 18.

I piled in the truck with Lin and we began the drive to Setesdalens Austhei (where are we?) with a short questionnaire they translated themselves.

During the drive we had two stops, one for a quick snack and another for a trip into a grocery store for soda and ice cream. The scenery was lush and green.
Appendix B: Ethics Approval

28 February 2017

Mr Wilson Dobud
By email: wil@truenortheexpeditions.com.au

Dear Mr Dobud,

Thank you for providing additional information in response to a request from the Charles Sturt University Human Research Ethics Committee relating to your research proposal.

The Charles Sturt University Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Human Research (National Statement).

Based on the guidelines in the National Statement the Committee has approved your research proposal. Please see below details of your research project:

**Project Title:** Narratives of the Co-Adventurerers: The Collaborative Exploration of Adolescent Experiences in Adventure Therapy

**Approved until:** 1 January 2019 (subject to annual progress reports)

**Protocol Number:** H17019 (to be included in all correspondence to the Committee)

**Progress Report due by:** 19 January 2018

You must report to the Committee at least annually, and as soon as possible in relation to the following, by completing the ‘Report on Research Project’ form:

- any serious and/or unexpected adverse events or outcomes which occur associated with the research project that might affect participants, therefore, the ethical acceptability of the project;
- amendments to the research design and/or any changes to the project (Committee approval required);
- extensions to the approval period (Committee approval required); and
- notification of project completion.

This approval constitutes ethical approval in relation to humans only, if your research involves the use of radiation, biochemical materials, chemicals or animals, separate approval is required by the appropriate University Committee.

Please contact the Governance Office on (02) 6338 4628 or ethics@csu.edu.au if you have any queries.

www.csu.edu.au
The Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Provider Number for Charles Sturt University is 00038J. ABN: 90 676 708 591
The Committee wishes you well with your research.

Sincerely

Ms Regan McIntosh
Governance Officer

Cc: Dr John Paul Healy, Professor Wendy Bowles and Dr Susan Micek
Appendix C: Information Sheet

PARTICIPANT INFORMATION SHEET

Narratives of the Co-Adventurers:
The Collaborative Exploration of Adolescent Experiences in Adventure Therapy

Researcher
Will Dobud MSW
PhD, Candidate

Project Supervisors
John Paul Healy PhD
Wendy Bowles PhD
Susan Milosek PhD

Invitation
You are invited to participate in a research study exploring the experience of participants and professionals involved with adventure therapy programs around the world. The study is being conducted by social worker Will Dobud, a PhD student from the School of Humanities and Social Sciences at the Charles Sturt University.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. What is the purpose of this study?
As part of my Doctor of Philosophy from Charles Sturt University, this research will explore the experience of participants involved with adventure therapy programs around the world. Collecting information about your experience will be used to inform helping professionals about the lived experience of adventure therapy participants.

2. Why have I been invited to participate in this study?
You have been invited to participate in this study as you are within the ages of 18 to 30 and have attended an adventure therapy program during your teenage years, 13 to 18.

3. What does this study involve?
If you agree to participate, you will be asked to participate in an interview in person or by Skype lasting one hour with the researcher. This interview will discuss how became involved with the adventure therapy program, your experience on the program, and what benefits, if any, you experienced.

This interview will be recorded and transcribed by the researcher removing all identifiable information in order to keep your participation anonymous. Following this process, the researcher will contact you to schedule a follow-up discussion. The transcript will then be returned and you will have the opportunity to add, edit, change, or delete any information you like from it.

4. Are there risks and benefits to me in taking part in this study?
Although participating in narrative research is a potentially empowering experience, we cannot promise you any benefit from participating in this research. If at any time you become uncomfortable, you are free to stop the interview at anytime or ask the researcher to change the course of conversation. Attached to this Information Sheet is a list of resources that may be of assistance should you wish for additional support.
5. How is this study being paid for?
This study is self-funded by the researcher.

6. Will taking part in this study (or travelling to) cost me anything, and will I be paid?
There is no cost or stipend awarded for participating in this voluntary research.

7. What if I don't want to take part in this study?
Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Whether or not you decide to participate, is your decision and will not disadvantage you.

8. What if I participate and want to withdraw later?
If you decide to participate, you may withdraw from the project at any time without giving a reason and have the option of withdrawing any data you provide.

10. How will my confidentiality be protected?
Any information collected by the researchers, which might identify you, will be stored securely and only accessed by the researcher unless you consent otherwise. Upon transcribing your recorded interview, your identifiable information will be given pseudonyms in order to protect your confidentiality. Data will be retained for at least 5 years at in a password secured folder on the researcher’s computer.

11. What will happen to the information that I give you?
The information you provide will be reported in a final thesis to be submitted for this researcher’s Doctor of Philosophy. The individual participants that decide to participate in this study will not be identified in any reports arising from the project.

After the interview, you will be able to review the recording to edit or erase your contribution. Because these recordings are to be transcribed, you will also be able to review, edit, or erase your contribution to the transcriptions. Should you wish, you will be able to attain a copy of the final report once this study is completed.

12. What should I do if I want to discuss this study further before I decide?
If you would like further information please contact Wil Debud by email at info@wildebud.com or by phone +61 0477 716 1768.

13. 'Who should I contact if I have concerns about the conduct of this study?'
Potential participants can obtain further information about the project from Charles Sturt University's Human Research Ethics Committee who has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Tel: (02) 6338 4628 Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Thank you for considering this invitation. This information sheet is for you to keep.
Appendix D: Consent Form

CONSENT FORM

Narratives of the Co-Adventurers: The Collaborative Exploration of Adolescent Experiences in Adventure Therapy

Researcher
Will Dobud MSW
PhD. Candidate

Project Supervisors
John Paul Healy PhD
Wendy Bowles PhD
Susan Minek PhD

I agree to participate in the above research project and give my consent freely. I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained. I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to participating in an interview, having it recorded and transcript. I understand that a follow-up meeting will be scheduled so that I can take part in editing and reviewing my contribution to the study. I understand that my personal information will remain confidential to the researchers except when required by law.

I have had the opportunity to have questions answered to my satisfaction.

Print Name: ____________________________________________
Signature: ____________________________________________ Date: __________________

NOTE: Charles Sturt University’s Human Research Ethics Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Tel: (02) 6338 4628
Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.
Appendix E: Fieldwork Information Sheet

FIELDWORK INFORMATION SHEET

Narratives of the Co-Adventurers: The Collaborative Exploration of Adolescent Experiences in Adventure Therapy

Researcher
Will Dobud MSW
PhD. Candidate

Project Supervisors
John Paul Healy PhD
Wendy Bowles PhD
Susan Micek PhD

Invitation
Your organisation is invited to participate in a research study exploring the experience of adolescents and professionals involved with adventure therapy programs around the world. The study is being conducted by social worker Will Dobud, a PhD student from the School of Humanities and Social Sciences at the Charles Sturt University in Australia.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. What is the purpose of this study?
As part of my Doctor of Philosophy from Charles Sturt University, this research will explore the experience of participants involved with adventure therapy programs around the world. Seeing your program in action is important for providing context to the diversity of international adventure therapy practice. This project is not an evaluation or critique of your approach but an exploration into the variety of approaches in adventure therapy.

2. Why have I been invited to participate in this study?
Your organisation has been invited to participate in this study as you run an adventure therapy experience for adolescents.

3. What does this study involve?
If you agree to participate, I will organise a time with you in 2017 to visit your program observing a group in action. The purpose of this observation is to get an idea about your organisation’s structure and theoretical approach to adventure therapy.

4. Are there risks and benefits to me in taking part in this study?
Although narrative research is a potentially empowering experience for participants, we cannot promise any benefit from participating in this research.

5. How is this study being paid for?
This study is self-funded by the researcher as part of the Australian Postgraduate Award, which is awarded to postgraduate students with encouraging research promise.
6. Will taking part in this study (or travelling to) cost my organisation anything, and will I be paid?
There is no cost or stipend for participating in this voluntary research.

7. What if I don’t want to take part in this study?
Participation in this research is entirely your choice. Only those programs that give their consent will be included in the project. Whether or not you decide to participate, is your decision and will not disadvantage you.

8. What if I participate and want to withdraw later?
If you decide to participate, you may withdraw from the project at any time without giving a reason. You will also have the option of withdrawing any data you provide.

10. How will my confidentiality be protected?
Any information collected by the researchers, which might identify your participants, practitioners, employees, or your organisation will be stored securely removing all identifiable information. This password-protected folder can only be accessed by the researcher unless you consent otherwise.

During observation, all field notes will be kept anonymous giving your participants, staff, practitioners, and your organisation pseudonyms in order to protect confidentiality. Data will be retained for at least 5 years in a password-secured folder on a locked hard drive.

11. What will happen to the information?
The data obtained during observation will be reported in a final thesis to be submitted for this researcher’s Doctor of Philosophy through the School of Humanities and Social Sciences at Charles Sturt University. The individual participants and organisations that decide to participate in this study will not be identified in any reports arising from the project.

12. What should I do if I want to discuss this study further before I decide?
If you would like further information please contact Will Dobud by email at info@willdobud.com or by phone +61 04777161768.

13. Who should I contact if I have concerns about the conduct of this study?
Potential participants can obtain further information about the project from Charles Sturt University’s Human Research Ethics Committee who has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Tel: (02) 6338 4628 Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

Thank you for considering this invitation. This information sheet is for you to keep.