AN EXPLORATION OF ADVENTURE-BASED PREVENTION PROGRAMS FOR YOUNG PEOPLE: A QUALITATIVE THEMATIC ANALYSIS OF PROVIDER INTERVIEWS

By

Daniel Liam Cavanaugh

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ABSTRACT

AN EXPLORATION OF ADVENTURE-BASED PREVENTION PROGRAMS FOR YOUNG PEOPLE: A QUALITATIVE THEMATIC ANALYSIS OF PROVIDER INTERVIEWS

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Introduction/Background: Young people today face increased behavioral health risks that include: mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm. Prevention programs offered by mental health professionals have demonstrated some efficacy in the prevention of challenges. More recently, prevention programs have emerged that use adventure therapy techniques to attempt to prevent these challenges. However, little is known about how adventure-based prevention services are delivered to young people facing behavioral health risks. *Purpose:* This purpose of this study was to attempt to answer the following research question and three sub-questions: How are adventure therapy techniques reportedly used by prevention services providers in adventure-based prevention programs for young people? (1) How do adventure therapy prevention providers describe specific interventions that they utilize in their programs?, (2) How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services?, and (3) How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services? *Methods:* An exploratory qualitative thematic analysis of semi-structured interviews with adventure-based prevention providers (N = 23) was conducted. Interviews were conducted via phone, video conferencing, and in person and recorded. Recordings were transcribed and coded to attempt to answer the research question and three sub-questions. The researchers applied strategies to attempt to increase the trustworthiness of the data. *Findings:* Thirteen

themes emerged following analysis. Five themes about specific **interventions** were, "engagement;" "connecting;" "reflection, processing, and metaphor;" "building resilient kids: to do better in life;" and "program and intervention structure." Three themes about **ethics, equity, and inclusion** were, "ethical approaches/ethical challenges;" "collaboration and oversight;" and "diversity." Five themes about **training and evaluation** were, "mentorship;" "providers' lived experiences leading to adventure-based work;" "education and training;" "evaluation;" and "adventure-based prevention research." *Discussion & Implications:* Findings from this study were compared to what is known about adventure-based prevention and adventure therapy services. New findings included more extensive descriptions of what happens in adventure-based prevention practice; ethics, equity, and inclusion in adventure-based prevention; provider preparation for adventure-based prevention practice; and outcome evaluation in adventure-based prevention practice. Recommendations were offered for social work practice, education, policy, and research. Social work practice recommendations included calls to identify interventions and theory used. Recommendations for education included increased mentorship and instruction for social work students. Policy recommendations included the need for increased funding and access to services. Research recommendations were for longitudinal outcome research and qualitative research with consumer perspectives.

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CHAPTER ONE: INTRODUCTION

Behavioral Health Risks Facing Young People Today

Young people today face a wide array of increased behavioral health risks that include or are related to: mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm (Burke, Hellman, Scott, Weems, & Carrion, 2011; Hawton, Saunders, & O'Connor, 2012**;** Merikangas & McClair, 2012; Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014; Steel et al., 2014). Many young people today face increased risk factors, but some groups of marginalized young people face even greater risks. These groups include lesbian, gay, bisexual, transgender, and queer (LGBTQ) identified youth (Heck, Flentje, & Cochran, 2013), those with a parent with a mental illness (Rasic, Hajek, Alda, & Uher, 2014), urban minority youth (Basch, 2011), Indigenous youth (Gone & Trimble, 2012), and young people experiencing refugee status (Ellis, MacDonald, Lincoln, & Cabral, 2008; Rousseau & Guzder, 2008). For this paper, young people are defined as those ranging in age from 5-25 years old.

Mental illness, substance abuse, and related behavioral health concerns have become a massive healthcare concern in the United States and worldwide. Mental illness prevalence rates are nearly 25% of the general population, or one out-of-four people (Kessler & Wang, 2008; Merikangas et al., 2010; Merikangas & McClair, 2012). Additionally, one out of six, or over 16% of the population, meets the criteria for a substance abuse disorder (Kessler & Wang, 2008, Merikangas & McClair, 2012; Steel et al., 2014). Over one's life, rates jump to 50% for mental illness and around 20% for substance abuse disorders (Kessler et al., 2008). In adolescents, the mental illness prevalence rates are between 10 and 30% (variability is related to location and sociodemographic factors) (Patel, Flisher, Hetrick, & McGorry, 2007). The age of onset of

mental illnesses varies depending on disorder type and severity (Jones, 2013). For example, anxiety disorders often begin before puberty while psychotic disorders commonly emerge in adolescence or early adulthood. Mental illness is also one of the leading causes of disability world-wide (World Health Organization, 2017).

As rates of mental illness have increased, so have rates of suicide and self-harm (Curtin, Warner, & Hedegaard, 2016; Heron, 2007). Suicide is now a top-ten leading cause of death in most demographic brackets (Curtin et al., 2016). Across all demographics, there was a 24% increase in the rates of suicide in the U.S. Suicide is the second highest cause of the death in the U.S. for young people ages 10-24 (Heron, 2007). The U.S. currently funds national suicide prevention initiatives that utilize a variety of interventions, including psychopharmaceutical treatment, psychoeducation, crisis-lines, mental health treatment, and public-health programs (Office of the U.S. Surgeon General, 2012; Zalsman et al., 2016). Many suicide prevention programs have demonstrated some level of efficacy; however, more robust research with randomized controlled trials is needed to strengthen the evidence base (Zalsman et al., 2016).

Mental health concerns also are related to criminal justice involvement for young people. Between 65 and 75% of all youth in juvenile detention facilities meet diagnostic criteria for mental health conditions (Teplin, et al., 2002). Similarly, a guide for state legislators describes the prevalence of mental illnesses in juvenile offenders as between 65 and 70% (National Conference of State Legislators, N.D.). In the U.S. between 50,000 and 100,000 young people are incarcerated at any given time (Sickmund, Sladky, Kang, & Puzzanchera, 2017). These numbers increase if they include other forms of incarceration such as residential care, boot-camps, and incarceration of minors in adult prisons. Despite overlap between mental illness and

criminal justice involvement, research integrating prevention science techniques into the field of criminology is limited (Vaughn, 2016).

Young People Facing Increased Risks

Young people who have experienced trauma and/or adverse childhood experiences (ACEs) face increased risks of future behavioral health concerns as well as physical health maladies (ACEs) (Dube, Anda, Felitti, Edwards, & Croft, 2002; Felitti et al., 1998; Schilling, Aseltine, & Gore, 2007). These experiences include, but are not limited to, child abuse (physical, sexual, and psychological), exposure to community violence, exposure to parental mental illness or substance abuse, and exposure to domestic violence. Children who have experienced ACEs face increased risks for a later diagnosis of a mental illness, a substance abuse disorder, or anti-social behaviors that are related to criminology (Schilling et al., 2007). Those having a higher number of ACEs (6 or more) also face premature mortality (Brown et al., 2009). Brown and colleagues (2009) found that those with higher levels of ACEs die up to 20 years earlier than those without.

Children with parents or close family members with a mental illness are a population of youth whose family members are diagnosed with a psychiatric and/or substance abuse disorder and who face an increased risk of also developing similar disorders themselves (Rasic et al., 2014; Riebschleger, Tableman, Rudder, Onaga, & Whalen, 2009; Reupert & Maybery, 2010). Although exact rates are not known, general population estimates of parental mental illness have been found to be at least 23% in western nations (Maybery, Reupert, Patrick, Goodyear, & Crase, 2009). Also, it is estimated that at least one out of five children have a parent with a mental illness (Reupert, Maybery, Kowalenko, 2013). It is possible that the prevalence is higher due to under reporting and poor service utilization that may occur in marginalized communities that encounter mental illness. In addition to an increased risk of mental health diagnosis, these

children face additional difficulties including financial hardships, an increased risk of exposure to abuse and neglect, young caregiver responsibilities, community stigma, social isolation, poor familial relationships, inadequate coping skills, and underutilization of mental healthcare supports (Cooklin, 2006; Van Santvoort, Hosman, Van Doesum, & Janssens, 2014).

Other populations of marginalized young people also face increased risks of behavioral health conditions. These young people include LGBTQ identified young people (Edwards et al., 2015), young people with refugee status (Ellis, MacDonald, Lincoln, & Cabral, 2008), Indigenous young people (Gone & Trimble, 2012), and other marginalized young people. Young people who identify as LGBTQ face high levels of marginalization and discrimination that may contribute to an array of increased risks, including mental illness, substance abuse, problems in school, suicide, and traumatic experiences such as: sexual victimization, physical violence, and bullying, (Edwards et al., 2015; Heck et al., 2013; Heck, 2015: King et al., 2008). Young people with refugee status experience mental health risks that appear to be related to traumatic events they have experienced, acculturation stress, and discrimination from the resident population in the countries where they have sought refuge (Ellis et al., 2008). Indigenous young people in the U.S. are at higher risk for mental illness, substance abuse, suicide, violence, and other behavioral health concerns (Gone & Trimble, 2012). Additionally, mental health treatment for Indigenous people is difficult because many interventions are not culturally appropriate (Gone & Trimble, 2012). It appears that many young people, in both mainstream culture and distinct subcultures, are facing increased levels of risk for behavioral health concerns.

Theoretical Descriptions of Prevention

Risk and resilience. Social scientists who are interested in preventing the development of behavioral health conditions in young people often develop their programs using risk and

resilience theories (Greene, 2013; Masten, 2014; Rutter, 1993). The core assumption of risk and resiliency theory can be summarized as such: exposure to high levels of biopsychosocial childhood adversity may lead to the development of future mental health struggles (Rutter, 1993). Examples of this adversity include poor relationships in the social environment (with parents and/or peers), neighborhood violence, discrimination, and family conflict (Masten, 2014; Rutter, 1993). However, resiliency-promoting protective factors may reduce the likelihood that the child will experience poor developmental outcomes or future psychopathology (Masten, 2014). These include the presence of supportive relationships, coping skills, positive relationships between parents, and socio-economic privilege. Additionally, it is reported that resiliency may be fostered by learning how to handle risk with supportive relationships or coping skills (Rutter, 1993). Rutter (1993) describes that young people who are exposed to risk in small doses may become better adjusted to dealing with future adversity. However, when risk is overwhelming and omnipresent, the developing person is unable to cope and may face increased mental health and behavioral difficulties (Rutter, 1993). These factors of risk and resiliency are composed of real, observable events and processes that should be studied and operationalized for the creation of future interventions and prevention programs that can support improved developmental outcomes (Masten, 2014). Increasing resiliency through improved coping, increased self-esteem, and inoculative exposure to tolerable levels of risk can help young people to navigate future trauma and adversity (Rutter, 1993; Zimmerman, 2013).

Stress, coping, and adaptation. Another theory utilized in prevention programs is stress, coping, and adaptation (Lazarus, 2006). Scholars have used this theory to describe how social workers can support healthy development in young people who face risks by encouraging them to learn and apply coping skills (Riebschleger et al., 2009). The major tenet of this theory is that

a developing individual will encounter different stressful situations and a transactional process will occur through which the individual appraises the event, applies coping skills (such as self-soothing, or seeking support) to overcome the event, and then adapts with new skills to overcome the stressor, and future stressors, that they encounter (Lazarus, 1993, 2006). Lazarus (1993), describes coping as a dynamic process that "…changes over time and in accordance with the situational contexts in which it occurs" (p. 235). This theory is similar to risk and resilience theories discussed previously in that it examines protective buffers, such as coping skills and cognitive appraisal. Additionally, stress, coping, and adaptation theorists also examine the effects of stressful situations to which young people are exposed. These can be compared to risk factors and protective factors that are discussed in risk and resiliency. Stress, coping, and adaptation theory and risk and resilience theory offer two similar models for understanding how to support developing young people who may face increased psychosocial risk factors.

Programming Aimed at Prevention

Prevention science. Young people today face an array of challenges that may be addressed by participating in prevention programs. These include suicidal behaviors (Bruffaerts, et al., 2010), LGBTQ discrimination (King et al., 2008), and bullying (Olweus & Limber, 2010). Many of these difficulties are comorbid with one another. For example, suicide is related to both bullying and LBGTQ status (Ahuja et al., 2015; Hinduja & Patchin, 2010). In fact, some marginalized groups, such as LGBTQ identified young people, face so many increased risks that prevention may be indicated to protect most members of these groups (Heck, 2015).

Clinicians and researchers have begun to design preventative programs that may delay and/or stop the onset of many of conditions and difficulties experienced by young people (Knapp, McDaid, & Parsonage, 2011; Masten, 2013). For example, effective interventions have

been successfully implemented to reduce the risk that young people will develop schizophrenia and psychotic disorders (McFarlane 2011; McGorry, 2015). Programs also have been developed that appear to broadly prevent mental illness and promote mental health through the use of psychoeducational mental health literacy campaigns (Greenberg, 2006; Kutcher, Bagnell, & Wei, 2015; Yap, Reavley, & Jorm, 2012). Additionally, programs have demonstrated efficacy in preventing some cases of suicidal behavior (Yip et al., 2012; Zalsman et al., 2016). Other populations that have received prevention services include young people who have experienced traumatic events (Masten, 2014), sexual minorities (Heck, 2015), and young people from families who experience intergenerational mental illness (Riebschleger et al., 2009).

Adventure-based prevention. "Adventure therapy is 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" (Gass, Gillis, & Russell, p. 1). Adventure therapy has been used for over a century as treatment for mental health disorders in young people (Gass et al., 2012). Researchers more recently have begun to explore the possibility of using adventure therapy (AT) techniques in the prevention of behavioral health risks (Beightol et al., 2012; Carter, Straits, & Hall, 2007; Epstein, 2004; Neill & Dias, 2001; Ritchie, Wabano, Russell, Enosse, & Young, 2014). Time in natural environments may help promote resiliency and prevent mental illness (Annerstedt & Wahrborg, 2011). Researchers have argued that fostering psychological connections with healthy ecosystems may promote positive mental health outcomes (Davis, 2011). Adventure therapy techniques might be useful to support or enhance programs designed to prevent behavioral health problems in young people. However, scientific research demonstrating that adventure-based prevention (ABP) programs are effective at preventing disorders is scarce. Additionally, there is not enough information about what

processes and intervention ingredients that ABP programs utilize to promote resiliency in young people. To understand these ingredients, researchers need to understand the intentional scaffolding that describes how these activities lead to desired prevention outcomes for clients. This dissertation will explore research, theory, and perspectives from prevention sciences and AT that explore the processes and mechanisms of integrating therapeutic adventure into prevention curricula.

Focus of this Study

Prevention sciences, including prevention programming for behavioral health risks in young people, is a relatively young field (Coie et al., 1993). Although this field is still developing, many programs have emerged that use mental health interventions to attempt to prevent the risks of developing conditions such as mental illness, substance abuse, suicide, and bullying. One such intervention type is adventure-based prevention that utilizes experiential challenges and nature-based activities with the hope of promoting resiliency in young people. A number of programs exist that use activities such as rock climbing, kayaking, hiking, ropes courses, and other challenges in prevention curricula (Gass et al., 2012). However, research on how these programs work and what they accomplish is limited. For example, some programs have used pre and post measures of resilience to make a case for their effectiveness (Beightol et al., 2012; Ritchie et al., 2014). Others have used short-term (up to 18-month) longitudinal studies to demonstrate reduced instances of behavioral health disorders (Carter et al., 2007). No long-term longitudinal studies were found that appeared to demonstrate the ability to prevent or reduce risks of behavioral health disorders. Additionally, a review of the literature found limited information about which components of adventure-based prevention programs are most essential to reduce risk. In fact, programs use such a wide array of different adventure-activities that it is

hard to discern what curricula and activities are actually used in many ABP programs. It also appears that many programs use a mixture of adventure-based and more traditional psychotherapeutic interventions, (such as didactic, psychoeducation curricula). Therefore, research is needed to better understand: (a) what takes place in adventure-based prevention programs; as well as; (b) to what extent programs combine adventure-based prevention techniques with more traditional prevention modalities such as psychoeducation, coping-skill development, and social skill development. This study attempts to address these knowledge gaps by describing the therapeutic interventions that reportedly are utilized in adventure-based prevention programs. This exploration is guided by the following research question: "***How are adventure therapy techniques reportedly used by prevention services providers in adventure-based prevention programs for young people?"*** This will be further elucidated through the following three sub-questions: ***"(1) How do adventure therapy prevention providers describe specific interventions that they utilize in their programs?, (2) How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services?, and (3) How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services?"*** This study attempts to contribute to the knowledge of both prevention sciences and adventure-based prevention by exploring provider perspectives of how adventure-based prevention programming is implemented in the field. To develop stronger research that tests and compares the effectiveness of adventure-based prevention programs, it is imperative that researchers build a foundational understanding of what interventions are being used and how they are delivered. This is supported through qualitative interviews documenting providers' and program developers' perspectives of how these programs operate and work. This study strives to capture

the voices of the providers and program developers who offer prevention programing to young people who face behavioral health risk factors. The researcher intends to use interviews with front line workers to give increased insight into what these programs really offer. Additionally, an understanding of these program curricula and activities may help both providers and researchers to develop improved outcome evaluations and potentially improved programs that are supported by the clinical knowledge and personal perspectives of those involved in this type of programming. This study may yield data that can help adventure-based prevention researchers to be more aware of specific program curricula and activities utilized in ABP practice.

Note: See Appendix A for definitions of common adventure therapy terms used throughout this paper.

CHAPTER TWO: LITERATURE REVIEW

Literature Review Overview

This literature review chapter provides an overview of adventure-based therapies and what is known about their use in behavioral health disorder prevention programs for young people. It begins by describing the rationale for an increased focus on prevention. This includes a description of our current behavioral health epidemic and risk factors facing those with behavioral health needs. Next, it outlines prevention using a systems framework that describes societal and individual benefits. It also includes an overview of risk and resiliency theory that has been used to guide behavioral disorder prevention programs and research; including adventure-based prevention (ABP) (Greene, 2013; Masten, 2014; Rutter, 1987, 1993; Zimmerman, 2013). Next, it provides overviews of prevention sciences, adventure therapy (AT), and ABP. It also provides a description of prevention science and its three levels of implementation: primary, secondary, and tertiary (Gordon, 1983). Finally, it describes the evidence base for ABP (Beightol, Jevertson, Carter, Gray, & Gass, 2012; Carter et al., 2007; Ritchie, Wabano, Russell, Enosse, & Young, 2014). This includes evidence for the psychological and developmental benefits of time spent in nature (Townsend & Weerasuriya, 2010).

This review includes an exploration of the histories of both prevention sciences and AT that appeared to lead to the development of ABP (Gass, Gillis, & Russell, 2012; White, 2015). This portion starts with the roots of prevention sciences in public health, epidemiology, and mental health (Coie et al., 1993) Next, it provides a summary of the historical use of AT in social work practice and mental health treatment (White, 2015). This includes descriptions of pivotal early AT/ABP programs.

This chapter is used to provide a critical review of the empirical literature on ABP programs. Research on ABP is limited therefor; both prevention programming and AT literature is examined. This begins with a description of the increased risk factors and psychosocial developmental needs of young people today. It also provides an overview of techniques used in both general prevention programming, as well as ABP programming. The chapter describes specific prevention programs (McFarlane, 2011; McGorry, 2015; Pike, 2010) as well as ABP programs (Beightol et al., 2012; Epstein, 2004; Neill & Dias, 2001). This review also discusses the epistemological, ontological, and methodological perspectives used in prior research. The chapter concludes by describing gaps in the literature including clear descriptions of how ABP is implemented, ABP techniques, ABP program outcomes, diversity, and ethical practice.

This review of the adventure therapy and prevention literature bases was conducted over a six-month period. The researcher utilized Google Scholar and Proquest databases to search available literature on three main topics: adventure therapy, prevention science, and adventure-based prevention. Although adventure-based prevention was the primary goal, it is a new enough field that most associated articles came from adventure therapy or prevention literature. Search terms included: adventure therapy, adventure-based prevention, prevention science, mental illness prevention, substance abuse prevention, wilderness therapy, nature-based therapies, and experiential prevention. This search reviewed only articles that were published or translated into English. Search terms were combined to narrow results. The researcher searched for articles published between 2005 through the present. Additionally, earlier seminal articles on ABP that were cited in multiple publications were reviewed. The researcher also reviewed text-books, conference proceedings, governmental reports, and dissertations that were prevalent throughout

the literature. Overall, the researcher reviewed approximately 200 publications on adventure therapy, prevention science, and adventure-based prevention.

Definitions. In this paper, the author uses the terms adventure therapy, prevention science, and adventure-based prevention programs to refer to a wide array of clinical interventions that are offered to young people. Adventure therapy (referred to throughout this paper as AT) is the prescriptive use of experiences that include some sort of challenge activity (such as games, hiking, or an obstacle course) and post-activity processing to guide a client towards pre-established therapeutic goals (Alvarez & Stauffer, 2001). Adventure therapy is used throughout the peer reviewed literature as an umbrella term that covers more specific therapies that include wilderness therapy (expedition programs), adventure-based counseling (an adventure-based group counseling approach), and bush-adventure therapy (an Australian wilderness approach to adventure therapy) (Dobud & Harper, 2018). Prevention science is a field that seeks to develop programming aimed at both promoting healthy human development and at stopping the onset of major human dysfunction, which may be biological or psychological, through interventions that are delivered preemptively (Coie et al., 1993). Adventure-based prevention (referred to throughout this paper as ABP) describes a number of programs that utilize adventure therapy-style challenges and interventions in programming that aim to prevent the development of behavioral health risks that include or are related to: mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm. A more thorough glossary of terms used in this paper is included in *Appendix A.*

The Need for Prevention

Behavioral health risks. Young people today experience an assortment of behavioral health risks that may adversely affect their lives that include or are related to: mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm (Burke, Hellman, Scott, Weems, & Carrion, 2011; Hawton et al., 2012; Merikangas & McClair, 2012; Modecki, Minchin, Harbaugh, Guerra, & Runions, 2014; Steel et al., 2014). Mental illness prevalence rates have risen to almost 25% of the U.S. population, or one in four people (Kessler & Wang, 2008, Merikangas & McClair, 2012). Clinicians and researchers have designed prevention programs to attempt to delay and/or stop the onset of these conditions (Knapp, McDaid, & Parsonage, 2011; Masten, 2013). Furthermore, they have begun to explore the possibility of using components of AT in their prevention programs (Beightol et al., 2012; Carter et al., 2007; Epstein, 2004; Neill & Dias, 2001; Ritchie et al., 2014). Adventure therapy has been used for decades as an effective treatment for mental health conditions in young people (Gass et al., 2012). Also, time in natural environments may promote resilience and prevent mental illness (Annerstedt & Wahrborg, 2011). Davis (2011) has argued that fostering psychological connections with healthy ecosystems promotes positive mental health. A handful of programs have emerged that are using techniques from adventure therapy to support the delivery of prevention programming that is aimed at counteracting the impact of behavioral health risks in young people (Beightol et al., 2012; Epstein, 2004; Neill & Dias, 2001; Ritchie, et al., 2014). This paper presents research and theory from prevention sciences and AT to explore the development of future behavioral disorder prevention programs that integrate nature and therapeutic adventure into prevention curricula.

Behavioral health prevalence, effects, and risk factors. Behavioral health concerns represent a massive public health need. At any given time, between 20 and 25% of people meet the criteria for a mental illness and 15% meet the criteria for a substance abuse disorder (Kessler & Wang, 2008, Merikangas & McClair, 2012; Steel et al., 2014). Over one's life, prevalence rates jump to 50% for mental illness and approximately 20% for substance abuse (Kessler et al., 2008). In adolescents, the prevalence of mental illness is between 10 and 30% depending upon location and sociodemographic factors (Patel, Flisher, Hetrick, & McGorry, 2007). Approximately 25% of children in the U.S. and the world experience mental illness each year (Merikangas et al., 2010). The age of onset of mental illnesses varies depending on disorder type and severity (Jones, 2013). Jones describes that anxiety disorders often begin before puberty while psychotic disorders commonly emerge in adolescence or early adulthood. Additionally, there has been an increase in the abuse of opiates and heroin, leading to a national epidemic (Dart et al., 2015).

Specific populations. Specific groups of people may face higher risks of mental illness. For example, gay, lesbian, and bisexual identified persons were one-and-a-half to two-and-a-half times more likely to experience mental illness, substance abuse, and/or suicide (King et al., 2008). Another group facing increased risks are children with parents with mental health conditions. Those with a parent diagnosed with a mental illness are more than twice as likely to experience mental health conditions (Rasic et al., 2014). Native Americans also experience disproportionate levels of mental illness that may be related to high levels of economic, educational, and health disparities (such as poor healthcare and increased rates of diseases), as well as experiencing intergenerational trauma (Gone & Trimble, 2012). Refugees face higher risks of mental illness and experience increased rates of PTSD and depression that are related to

traumatic experiences before and after resettlement (Ellis, MacDonald, Lincoln, & Cabral, 2008). Discrepancies in rates of mental illness in ethnic and cultural minorities may also be related to misdiagnosis and pathologizing cultural differences (Liang, Matheson, & Douglas, 2016). Prevention services may be appropriate buffers to offer these specific populations that experience increased risk of mental illness.

People diagnosed with mental illnesses may face many lifetime difficulties. They experience stigma and discrimination in housing, employment, relationships, and public services (Corrigan and Wassel, 2008). Also, their life span is up to 30 years shorter than those without a mental illness (Colton & Manderscheid, 2006). This may be related to the relationship between mental health conditions and severe physical ailments, such as heart disease (Ormel et al., 2007). Those having severe mental illnesses, such as schizophrenia or bipolar disorder, are between 6 to 140 times more likely to be victims of violent crimes than those with other forms of mental illness (Teplin, McClelland, Abram, & Weiner, 2005).

Economic discrimination is also a concern for many people who experience mental illness. People with severe mental illnesses earn a third less than those without a disorder (Kessler et al., 2008; Levinson et al., 2010). This may be related to higher rates of unemployment or underemployment in people with mental illnesses (Evans-Lacko, Knapp, McCrone, Thornicroft, & Mojtabai, 2013). People with any mental illness are a third less likely to find work (Mechanic, Bilder, & McAlpine, 2002). Additionally, in individuals with severe mental illnesses, employment rates are as low as 12%. They also are often paid lower wages than those without mental illnesses (Kessler et al., 2008). Economic discrimination is only one of the ways that those with mental illnesses are treated unfairly.

People with a mental illness are more likely to be involved with the criminal justice system than those without a mental illness (Soderstrom, 2007). Additionally, those with severe mental illnesses are incarcerated at higher rates and often do not receive the treatment they require while they are incarcerated (Steadman, Osher, Robbins, Case, & Samuels, 2009). While incarcerated, they may face increased discipline, which can lead to lengthened time to parole (Matejkowski, Caplan, & Wiesel Cullen, 2010). Once released, they may experience increased rates of recidivism and reincarceration (Baillargeon, et al., 2010; Cloyes, Wong, Latimer, & Abarca, 2010). Time to reentry into the criminal justice system is twice as fast for those diagnosed with SMIs (Cloyes et al., 2010). Mental health courts have been developed to address mental illness in the criminal justice system. However, these courts also have been criticized for forcing unfair plea deals (Seltzer, 2005).

No one knows for sure what causes a young person to develop a mental illness, but many risk factors have been identified (Patel et al., 2007). Some include: intergenerational mental illness and substance abuse, maladaptive behaviors, genetic factors, traumatic events, sexual minority status, environmental toxins, developmental delays, discrimination, community violence, grief and loss, academic difficulties, and other stressors (Lehavot & Simoni, 2011; Patel et al., 2007; Rasic et al., 2014). People experiencing poverty also face a higher risk for mental illness (McLaughlin et al., 2011). Also, those who experience severe trauma are more likely to experience a mental illness (Álvarez et al., 2011). Alvarez describes that in a sample of people diagnosed with severe mental illnesses, almost half reported high levels of childhood trauma. Sexual and physical abuse also are strongly correlated with mental illness symptoms later in life (Bruffaerts et al., 2010). By limiting exposure to some risk factors and preparing

young people to encounter others, some cases of mental illness may be preventable (Masten, 2014).

Risk and Resilience Theory

Risk and resilience theory provides direction for ABP researchers who are seeking to use this modality to promote healthy development in young people who experience increased risks of developing a mental illness. Risk and resilience offers a framework to describe how prevention promotes psychological development in young people who face increased risk of mental illness (Greene, 2013; Masten, 2014; Rutter, 1987, 1993; Zimmerman, 2013). Additionally, researchers have described how AT may promote resilience in young people by teaching them coping skills that they may use to overcome future encounters with challenge and adversity (Booth & Neill, 2017; Ungar, Dumond, & McDonald, 2005). These theorists posit that adversity and protective factors work in opposition to affect a young person's biopsychosocial development (Masten, 2014). Resilience is not an innate protective buffer with which people are born. In contrast, Masten (2014) urges, "resilience arises from ordinary resources and processes" (p. 3). Resilience is a process that is facilitated through activities and events that support healthy human development. Masten (2014), calls this "ordinary magic" because it is a result of regular support systems that can be encouraged for most young people through resiliency promoting processes.

Resilience may be promoted through interventions that counteract adversity by reducing its effect on an individual while also increasing their support systems and coping skills (Masten, 2014). For example, researchers have proposed that traumatic events may have a damaging neurobiological effect that could be buffered through the use of resilience promoting coping skills (Feder, Charney, & Collins, 2011). These skills are comprised of individual and social skills including: learning activities that promote relaxation, learning to challenge difficult

thoughts, and using social supports while navigating adversity and challenges (Masten, 2014; Podell, Mychailyszyn, Edmunds, Puleo, & Kendall, 2010). Coping skill development may also include the acquisition of knowledge about mental illnesses to help youth facing increased development risks (Riebschleger, Grové, Cavanaugh, & Costello, 2017). Outdoor education may promote coping skill development through the supported reinterpretation of challenging activities to promote resilience in the face of adversity (Booth & Neill, 2017).

Resilience may also be promoted by fostering connections within the ecological systems in a young person's world (Masten, 2014; Ungar, 2011). Masten (2014) states that "most resilience arises from the operation of the fundamental adaptive systems that are the legacy of human biological and cultural evolution" (p. 272). Resilience promoting efforts must focus on the totality of ecological systems that include family, community, and cultural supports (Ungar, 2011). Young people can benefit from tapping into the supports of nurturing adults in their lives that may include: teachers, parents, helping-professionals, coaches, clergy, and others. These adults from differing social systems in which a child is involved (school, home, community) come together to help the developing person build a strengthened network of interpersonal supports (Khanlou & Wray, 2014).

Models of risk and resiliency theory also have been proposed to describe psychosocial development in young people. The model proposed by Rutter and colleagues is based upon the presence of support and protective factors as well as learning to overcome early adversity (Greene, 2013). Other models of risk and resiliency are based upon the cumulative exposure to risk factors that eventually reaches a tipping point for the individual (Greene, 2013; Zimmerman, 2013). Additional risk and resiliency theories, titled protective models, assert that the developing person learns to navigate adversity because of the presence of mediating factors that increase an

individual's coping skills. Different models of risk and resilience have conceptualized these mediating factors as "compensatory factors," "buffers," and "protective factors" (Zimmerman, 2013, pp. 2-4). Compensatory factors are a form of resiliency that help the child to counteract the negative effects of the encountered risk and adversity. An example of this is that a youth may use running to provide a countering effect to their overeating or poor diet. Protective factors, such as increased mental health literacy, improved coping, and positive adult relationships, could provide the skills to help a child navigate the struggles of mood difficulties. Similarly, the Rutter model uses what has been termed a challenge model, in which early encounters with risk in smaller doses prepare the youth to overcome larger difficulties later in life (Rutter, 1987, 1993; Zimmerman, 2013). These stressors must be challenging enough that the child builds necessary coping skills to overcome future adversity. However, the scenario must not be so difficult that it defeats too many of the child's coping strategies and leaves them traumatized. The style of risk and resilience theory utilized appears to help shape the interventions used in programs aimed at preventing behavioral health conditions in young people.

Adventure-based prevention programs have demonstrated promise that they may help to promote resilience in some young people (Beightol et al., 2012; Carter et al., 2007; Ewert, & Yoshino, 2011; Hans, 2000; Ritchie et al., 2014; Whittington, Aspelmeier, & Budbill, 2016). These studies have utilized quantitative measures of resilience to demonstrate improvements following participation in ABP curricula. These measures assess traits such as self-efficacy, problem solving skills, emotional regulation, and social skills (Ewert & Yoshino, 2011). For example, one ABP program utilized a curriculum that integrated mountain biking with psychosocial group work, self-reflection, and an educational curriculum for a group of college students (n=85) (Ewert & Yoshino, 2011). The students demonstrated increased resilience when

assessed with a 37-item resilience measure built from previously normed and validated resilience scales. They also reported subjective experiences of feeling more confident, self-aware, responsible, and a sense of achievement.

History of Prevention and Adventure Therapy

Prevention history. Prevention science, in its current name and form, is a relatively young field of the behavioral and health sciences that began to emerge in the 1980s and 90s (Anthony & Cohler, 1987; Coie et al., 1993; Gordon, 1983; Sloboda & Petras, 2014). However, it is important to note that preventative interventions have been used in social work, medicine, and allied professions for hundreds of years. Prevention science is multidisciplinary and draws on research from medicine, epidemiology, social work, sociology, psychology, biology, and other behavioral and health sciences (Sloboda & Petras, 2014). Early prevention science research was based upon risk and resiliency theories and the idea that certain young people are more resilient against developmental challenges (Anthony & Cohler, 1987; Masten, 2014). These early theorists sought to define how resiliency develops and how it can be promoted to prevent mental illness and psychopathology. Although modern prevention sciences is a young field, its roots go back over 100 years to the early days of social work and mental health care.

Scholars have argued that prevention science to combat mental illness is a phenomenon that has gained traction in the last 30-50 years (Coie et al., 1993, Sloboda & Petras, 2014). Although the term *prevention science* was not used until recently, the roots of prevention have a history as long as mental health care. In fact, early pioneers of the social work profession were interested in the prevention of the social problems of their day. Until the late 1900s, social welfare work was utilized primarily to treat social problems and distress; however, the settlement house movement shifted the focus to preventing problems in entire communities (McCave,

Rishel, & Morris2013). Jane Addams' Hull-House sought to prevent problems for communities through the use of education, hygiene, employment, nutrition, and other services that were thought to uplift the people (McCave et al., 2013, Trattner, 2007). This community approach to preventing problems resembles modern epidemiology and primary prevention. Also, as do modern prevention scientists, the settlement house workers believed in the use of evaluation tools to assess their programs. Jane Addams's movement organized their work under the "3 R's, residence, research, and reform" (Trattner, 2007, p. 171). Their evaluation led Addams and her colleagues to push for legislative action to improve social welfare in the United States. They called this early lobbying effort "preventive social work" (Trattner, 2007, p.184).

In the early 1900s social workers and others were pioneering early prevention with the emergence of the mental hygiene movement (Aistis & Vitalija, 2016; Trattner, 2007; Weisz et al., 2005). The movement was pioneered by Clifford Beers, a wealthy businessman who spent time in a psychiatric hospital (Beers, 1921; Parry, 2010). During his hospitalization, Beers was appalled at the treatment to which he was subjected. Upon his release, he wrote *A Mind that Found Itself* as a call to action against the abuse he suffered while institutionalized. This movement emerged in response to the destitute conditions and poor outcomes of those in institutional care. These pioneers were interested in improving treatment as well as understanding the etiology of disorders to prevent their onset. They were focused on domestic conflict, psychological distress, emotional struggles, and environmental stressors that may lead to the development of psychopathology. This movement provided an early scaffold for the interdisciplinary structure of modern prevention. Mental hygienists included psychiatrists, medical workers, social workers, educators, and concerned citizens who strove to improve the mental health of the country. They adopted the name *The National Committee for Mental*

Hygiene. This organization, which later became the National Mental Health Association and now Mental Health America, was co-founded by Beers and a group of physicians. They also started the International Committee for Mental Hygiene that now operates as the World Federation for Mental Health (Brody, 2004). The World Federation for Mental Health is a powerful NGO that advises the World Health Organization and international governments on mental health policy development.

History of adventure therapy. Although the term prevention has not been used in AT until recently, it can be argued that early camping programs were predecessors to prevention. The mental hygiene movement embraced camping programs to encourage positive youth development and psychological health (McNeil, 1957). Similarly to modern prevention programs, early camping programs were designed to promote resiliency, psychosocial development, and character-building activities (McNeil, 1957; White, 2015). These camping programs were influential in the development of AT as a field (White, 2015). Camping programs were used to foster positive development in young people long before they shifted to the mental illness symptom treatment focus of modern AT (White, 2015). Within the last twenty years, a small number of projects has emerged examining the use of AT in primary and secondary prevention (Beightol et al., 2009, Carter et al., 2007; Epstein, 2004; Gass at al., 2012; Neill & Dias, 2001; Ritchie et al., 2014). Interestingly, it seems the field of therapeutic adventure started with early prevention style programs, shifted to therapeutic interventions, and has now returned to its prevention roots. In fact, prevention was such a large component of early AT programs that a strong argument can be made that AT began with prevention and later moved to more treatment-oriented modalities.

Early youth camps. Historians have traced the roots of both AT and prevention to organized camping programs that began in New England in the mid to late 1800's (Kimball & Bacon, 1993; White, 2015). These programs were developed by educators to offer structure, education, and support to affluent students during the summer months. These camps began more than 50 years prior to the birth of The Boy Scouts and 100 years before the start of Outward Bound. They provided physical and mental engagement under the supervision of positive role models to foster positive development in young people (White, 2015). The first known camping program designed to support youth development began in 1861 (White, 2015). Twenty years later, the first therapeutic camping programs in the U.S. began to emerge. These were the first camps that resembled modern residential AT. The first program that used outdoor adventure to improve young people's behaviors was Camp Chocorua in New Hampshire in 1881. (Gass, 1993; Maynard, 1999; White, 2015). Camp Chocorua taught campers responsibility and a strong work ethic. It was a live-in summer camp for boys from affluent families in the Northeast (Maynard, 1999). They pioneered a movement of similar style camps in the Northeast. This included notable programs such as Camp Ramapo (1922) and Dallas Salesmanship Club Camp (1946) (White, 2015). Early camp programs provided a model for AT's use of residential treatment-style wilderness camps. However, unlike modern residential programs, these camps worked to prevent bad behaviors rather than treating behavioral disorders (White, 2015). Most camping programs were available only to white males while only a limited number were later available to young women and people of color (White, 2015).

Tent treatment. Around the time of the camping movement, another early predecessor of AT was being developed, largely by accident, at the Manhattan State Hospital (Caplan, 1974; Haviland & Carlisle, 1905; White, 2015). In 1901, the state hospital system in New York was

running out of space to quarantine its tuberculosis patients (Caplan, 1974; White, 2015). They decided to move the patients to tents outside of the facility. To the surprise of the clinicians, the patients who were moved outside began to show improvements in physical and psychological symptoms that their peers inside did not exhibit (White, 2015). Additionally, the hospital supplied the patients in the tents with outdoor recreation that included popular yard games of the day such as croquette and yard bowling (Caplan, 1974). These changes reportedly led to continued measured improvements in patients' psychiatric and physical symptoms (Caplan, 1974). Other psychiatric hospitals integrated tent treatment and outdoor recreation during the early to mid-1900s (Caplan, 1974; White, 2015).

Influential organizations. Outward Bound and the National Outdoor Leadership School (NOLS) have been two of the most influential organizations in AT. Although these organizations did not offer therapy, they were pioneers of experiential education in wilderness environments. Outward Bound was started by Kurt Hahn (1886-1974), a German/Jewish outdoor educator who fled to Britain before WWII (Schoel, Prouty, & Racliffe, 1988; White, 2015). Kurt Hahn is one of the most influential pioneers in AT due to his creation of the Outward Bound outdoor education program, which still operates today (Freeman, 2011; White, 2015). In Britain, Hahn founded Outward Bound to teach wilderness techniques to sailors and others. In 1961, Outward Bound was brought to the mountains of Colorado (Freeman, 2011; White, 2015). Paul Petzoldt (1908-1999) was an instructor at Outward Bound who became dissatisfied with the safety and technical aspects of the program (Wagstaff & Cashel, 2001). In response to his dissatisfaction, Petzoldt left and started NOLS in Lander, Wyoming to expand safety and preparation training for outdoor programs. Since this time, Outward Bound and NOLS have become regarded as two of the most respected and prominent programs in experiential education in North America

(White, 2015). Prominent AT researchers and historians have credited Hahn and Outward Bound as pioneers and founders of the AT approach (Becker, 2010; Gass et al., 2012; Hill 2007; Kimball & Bacon, 1993; Russell, 2001; Schoel et al., 1988; White, 2015).

Adventure-based counseling. Kurt Hahn, also described the application of experiential learning in classrooms near cities that he called "islands of healing" (Schoel et al., 1988; Schoel & Maizell, 2005; White, 2015). This term was later coined as the title of a seminal guide to an influential form of AT called *adventure-based counseling.* Adventure-based counseling (ABC) is a form of AT that brings OB's wilderness challenge model to parks near cities (Schoel et al., 1988; Schoel & Maizell, 2005). This modality is delivered in groups that use adventure-challenge activities, such as games or obstacle courses, and post-activity processing as a format for counseling. Adventure-based counseling became one of the most widely practiced forms of AT with thousands of educators, therapists, and social service employees trained in the methods. The largest and most influential ABC organization is Project Adventure in Massachusetts (Project Adventure, n.d.).

Jerry Pieh, the founder of ABC, received his training from Kurt Hahn (Schoel et al., 1988). Pieh's father, a professor who started the Outward Bound school in Minnesota, instilled the importance of experiential education in his son (Schoel et al., 1988). Schoel and colleagues described that Pieh supported the Outward Bound approach but was concerned about accessibility due to the cost and location of programs. Jerry received a large federal grant to infuse Outward Bound-style teaching into US schools. This led to the founding of Project Adventure in 1971. Thousands of educators and social service workers have been trained in ABC techniques. This programming is used throughout the world with more than 6,000 young people annually (Project Adventure, n.d.).

Programmatic abuse and neglect. Throughout the history of AT, abusive programs have hurt clients and damaged public and professional perceptions of the field of AT (Kutz & O'Connell, 2007; Gass et al., 2012; White, 2015). Many AT programs are offered in wilderness settings far away from formal standards that regulate other mental health practices. However, programs also are offered in more controlled environments, including schools, community health centers, and private offices (Lung et al., 2008). Lack of regulation and isolated programs in remote environments may have allowed for malpractice and abuse to occur unchallenged. All instances of abuse found in AT appear to have occurred in wilderness programs, residential care, or boot camps (Anderson, 2014; Behar et al., 2007; Kutz & O'Connel, 2007; Lilienfield, 2007; White, 2015). No reports of abuse, neglect, or harm were found in relationship to any ABP program. However, it is still important to understand these programs to help ensure ethical practice in all forms of AT. It is imperative that all AT providers, ABP included, understand the field's history of abuse and neglect and seek training and supervision to assure this does not happen again.

Client deaths and abuse have been reported across a number of AT programs (Behar et. al, 2007; Kutz & O'Connel, 2007; Salt Lake City Tribune, 2007; Scott & Duerson, 2010; White, 2015). An early example is Camp Anneewakee, in Georgia, that was repossessed by the state after staff and administration were found guilty of sexual abuse of clients, forced labor of clients, and insurance fraud (Gass et al., 2012; White, 2015). More recently, in 2007, a Government Accountability Office report outlined thousands of incidents of abuse and neglect that occurred in residential programs that included AT. Specific incidents from this report include a young person dying of exposure and dehydration while being forced to hike in hot conditions. Another example was a young person who died of injuries after being physically restrained by staff.

Also, a number of informal support groups have surfaced on social media outlets, such as Facebook and Reddit, for survivors of abusive programs (W. Dobud, personal communication, August, 2019). In the media, T*he Salt Lake City Tribune* published the names of 31 young people who died in AT treatment between the years of 1980-2007. These young people reportedly died of causes such as exposure to the elements, physical abuse by staff (during restraints of clients), or in accidents that occurred during activities (such as falling in a crevasse or being hit by a falling tree). Some of these programs were members of the Outdoor Behavioral Healthcare Council that promotes safety standards (Gass et al., 2012). Programs from this list have also been described in the literature for their treatment efficacy as therapy programs (Harper, Russell, Cooley, & Cupples, 2007). In order to move forward and assure AT and ABP can be implemented safely and effectively, strict safety standards and best practices must be implemented. Although much mental health practice in cities is regulated, only nine states currently have statutes that regulate the practice of AT organizations in the backcountry (Pollack, Eisenberg, & Shipp, 2013).

Another instance of a possibly abusive practice in adventure therapy (specifically wilderness therapy programs) is the use of secure transport services to escort involuntary clients to programs (Dobud, 2020; Mooney & Leighton, 2019; Pfaffendorf, 2019). Transport services are arranged between clients' parents and program staff to assure that young people make it to the program that has been selected for them (Dobud, 2020; Money & Leighton, 2019; Tucker et al., 2015). Escort services have been described as often employing two large, physically imposing agents who may use physical force and restraint devices to get clients to a program (Dobud, 2020; Tucker et al., 2015). Dobud, describes escort services often come to a client's home while they are still asleep in the early hours of the morning. While the client is asleep, the

men come into their room and wake them and escort them to a van. If the client resists, they may be handcuffed. Some reports of transport services also state that young people are blindfolded during the process. The use of transport services has been described as "legal-kidnapping" (Mooney & Leighton, 2019, n.p.) or getting "gooned" because of the two large goons who forcefully take the client to the program (Pfaffendorf, 2019, p. 121). These practices have been the focus of debate in the wilderness therapy industry. Recent quantitative research has asserted that the use of these practices does not have negative effects on therapeutic outcomes of treatment (Tucker et al., 2015, 2016). However, more recent qualitative works have documented clients describing the experience as "terrifying and violent" (Mooney & Leighton, 2019, n.p.), or as making them feel as if they were going to be "raped or murdered" (Dobud, 2019, p. 163). Currently, The Outdoor Behavioral Healthcare Council (OBH) is sponsoring a committee to further evaluate the ethics surrounding the use of secure transport services (C. Norton, personal communication, December 2019).

Behavioral Health Disorder Prevention

According to seminal prevention scholars Coie et al., (1993):

> The goal of prevention science is to prevent or moderate major human dysfunctions… Preventive efforts occur, by definition, before illness is fully manifested, so prevention research is focused primarily on the systematic study of potential precursors of dysfunction or health, called risk factors and protective factors, respectively (p. 1013).

Prevention science offers an alternative to traditional treatments by using intervention *before* illness occurs to promote healthy development. Behavioral health disorder prevention is focused specifically on promoting positive psychological development through the mitigation of risk

factors and promotion of resiliency promoting factors that correlate with healthy psychological development (Coie et al., 1993; Sloboda & Petras, 2014).

Prevention science can be categorized into three levels of delivery: primary, secondary, and tertiary prevention (Gordon, 1983). Primary prevention, or general prevention, is delivered population wide to prevent disorders across society. Next, secondary prevention is the use of preemptive interventions with those facing increased risks for a disorder who have not yet developed symptoms. Last, tertiary prevention is used for those who have early symptoms of a disorder. For example, early symptoms of schizophrenia that do not meet diagnostic criteria for a disorder could lead to the use of tertiary preventative measures.

Benefits of prevention. Although there is no simple solution to completely eradicate mental illness, prevention efforts may be helpful at both macro and micro levels. Prevention outcomes can be understood through individual and community health and economic benefits (Knapp et al., 2011). Many studies have demonstrated that prevention programs may reduce the chance that young people will develop a behavioral health disorder (Weisz, Sandler, Durlak, & Anton, 2005; Siegenthaler, Munder, & Egger, 2012; Weare & Nind, 2011). It is also known that the costs of behavioral health disorders total in the billions in both direct costs, such as health-care and social services, and indirect costs, such as lost earnings and family burden (Kessler et al., 2008; Knapp et al., 2011).

Participation in prevention programs may reduce the risk of mental illness for those who display early symptoms (Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009; McFarlane, 2011; McGorry, 2015) or risk factors (Siegenthaler, et al., 2012). An assessment of 25 randomized controlled trials (RCTS) utilizing the *Coping with Depression* course demonstrated that individuals with early depression symptoms experienced a reduced risk of a full diagnosis of a

depressive disorder after completing a prevention program (Cuijpers et al., 2009). These RCTS occurred over 30 years, with continuous success in preventing the onset of depressive disorders. Similarly, those with early signs of psychosis who enrolled in prevention programs displayed a reduced risk of serious mental illness (SMI) diagnoses (McFarlane, 2011; McGorry, 2015). A meta-analysis of 13 RCTs (n=1,490) for children with increased risks due to a parental psychiatric disorder found that young people were 40% less likely to get an illness after receiving prevention services (Siegenthaler et al., 2012). The programs they reviewed included a mixture of family-focused, parent/dyad-focused, and young people-focused interventions. They also displayed a reduction of internalizing symptoms (defined as negative emotions and symptoms of depression or anxiety) that may be predictors of a future diagnosis. This collection of meta-analyses offers a synthesis of evidence that demonstrates that individuals may benefit from participating in behavioral health disorder prevention programs.

Many social benefits are attributed to the prevention of mental illness, including reduced economic burden, increased workforce productivity, and reduced incidents of suicide (Knapp et al., 2011). Health economists have estimated that mental illness prevention could save billions of dollars in treatment costs, lost earnings, and societal burden (Levinson et al., 2010). The economic benefits of prevention programs were most clear with adolescents and young people (Zechmeister, Kilian, & McDaid, 2008). Additionally, economic analysts have found that $1 spent on early mental illness prevention can lead to $28 in savings over one's lifetime (McDaid & Park, 2011). Further research is needed to gain a deeper understanding of the benefits and outcomes of societal level prevention programs, but the initial results appear promising.

Behavioral disorder prevention programs have been utilized with young people who face increased mental health risks as well as those in the general population. This includes specific

populations such as young people with parents with a mental illness, (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012; Riebschleger et al., 2009; Solantaus & Toikka, 2006), those exposed to trauma (Berkowitz, Stover, & Marans, 2011; Masten, 2014), and LGBTQ identified young people (Heck, 2015). Researchers also have used school and community-based prevention programs for youth in the general population (Greenberg, 2006; Kutcher, Bagnell, & Wei, 2015). These programs have used interventions to promote resilience through coping and social supports (Heck, 2015; Masten, 2014) as well as psychoeducation and increased mental health knowledge (Beardslee et al., 2012; Kutcher et al., 2015; Riebschleger et al., 2009).

Prevention programs may offer a protective buffer against future mental illness for young people facing increased risks (Siegenthaler, Munder, & Egger, 2012). These programs can be offered to young people directly (Heck, 2015; Reupert et al., 2013), in a school context (Bruland, Schulze, Harsch, Pinheiro, & Bauer, 2017; Reupert & Maybery, 2010; Riebschleger et al., 2009), or in a family-centered approach (Nicholson, Albert, Gershenson, Williams, & Biebel, 2016). For children who do not have direct access to a prevention program, web-based services may fill in the gap (Drost & Schippers, 2015). The reviewed programs used combinations of mental health literacy (MHL) psychoeducation, coping skill development, and social support to promote resilience in young people facing increased risks of mental illnesses.

School-based prevention may promote resilience in young people in high-risk demographics (Reupert & Maybery, 2010; Reupert et al., 2013; Riebschleger et al., 2009). Schools provide an opportunity to offer services to young people who may otherwise be overlooked. School social workers can provide direct programming to children, build relationships with the family system, and foster community networks (Reupert & Maybery, 2010). Social workers engage educators and parents to identify children who may benefit from

prevention programming (Riebschleger et al., 2009). For example, a program in the Midwest provided a psychoeducational intervention to increase the MHL and resilience of students who experience family mental illness (Riebschleger et al., 2009). Prevention programs also are offered by camps, community groups, and mental health providers (Reupert & Maybery, 2010; Riebschleger et al., 2009). Many of the programs found in this review were focused on MHL knowledge and peer social support (Reupert et al., 2013).

General population, school-wide prevention programs have shown that they may promote increased resilience in young people (Kutcher et al., 2015). School-wide programs focus on increasing MHL knowledge in both young people and in educators (Whitley, Smith, & Vaillancourt, 2013). Teachers may also benefit from MHL training as they often have limited MHL knowledge (Bruland et al., 2017). Research on school-based prevention appears to have mixed outcomes. A recent systematic analysis demonstrated poor research rigor and low generalizability in clinical trials of school-based programs (Wei, Hayden, Kutcher, Zygmunt, & McGrath, 2013). In contrast, in a massive systematic review that included 52 systematic reviews and meta-analyses, researchers found consistent positive outcomes across school-based prevention programs (Weare & Nind, 2011). Their outcomes included improved mental health, increased academic success, and positive child developmental outcomes. They also found a wide variation in intervention types and evaluation that made it difficult to identify the most effective intervention components. They observed that school-based programs were most effective when implemented with model fidelity.

Exemplary prevention programs. A number of key interventions have been implemented that have had high rates of success in preventing the onset of behavioral disorders. Some of the most effective programs have been used to prevent the onset of schizophrenia and other

psychotic disorders in those who are exhibiting early symptoms (McFarlane, 2011; McGorry 2015). Other evidence-based practices (EBPs) have been developed to help children who have been identified as facing increased risks for a wide array of mental illnesses (Posthumus, Raaijmakers, Maassen, Van Engeland, & Matthys, 2012). Additionally, large-scale programs have been used to reduce the impact of mental illness across the general population through knowledge of specific illness and how to respond to behaviors and symptoms of mental illness (Jorm et al., 2006; Robinson et al., 2006). An understanding of these programs may help to inform the development of future prevention modalities.

One of the strongest cases for behavioral disorder prevention comes from programs designed to offer indicated prevention and early intervention for those who show early warning signs for schizophrenia and psychotic disorders (Yung et al., 2007). Two programs that offer promising results are the Portland Identification and Early Referral (PIER) program and the Early Psychosis Prevention & Intervention Centre (EPPIC) (McFarlane 2011; McGorry, 2015). Both of these programs rejected the previously held notion that early symptoms or even a diagnosis of schizophrenia and other psychotic disorders meant life-long disability and poor mental health. These programs focus on the earliest identification of symptoms and risk followed by immediate intervention and support.

Before receiving a diagnosis of schizophrenia, most people experience a prodromal period of lesser symptoms that do not qualify for a full diagnosis (George, Maheshwari, Chandran, Manohar, & Rao, 2017). Over 30% of these people will go on to develop schizophrenia or another psychotic disorder. Both of these programs deliver a package of biopsychosocial treatments in this period to reduce the number of people who develop an actual diagnosis of schizophrenia (McFarlane, 2011; McGorry, 2015). In the PIER program,

intervention and support consisted of family mental health education, counseling, supports for education/employment, and psychiatric medications, all delivered using an assertive community treatment model (commonly referred to as ACT) (McFarlane, Cook, Downing, Verdi, Woodberry, & Ruff, 2010). Similarly, the EPPIC model uses a community-based, early intervention model that uses early symptoms identification and intensive community-based treatment (counseling, case management, psychiatric services) to intervene before a person reaches a diagnosis of schizophrenia (McGorry, 2015). Both evaluated programs used a wide array of psychological assessments to provide ongoing monitoring of client program outcomes. They also used longitudinal assessments of clients who experienced a conversion from prodromal symptoms to schizophrenia (McFarlane, 2011). McFarlane describes that, following these interventions, the number of people who experience this conversion falls from a third of all cases to about one-tenth.

Beyond Blue is an exemplary national public health program from Australia designed to increase awareness of depression, substance use, anxiety, suicide, and treatment (Pike, 2010; Pirkis Hickie, Young, Burns, Highet, & Davenport,, 2005). *Beyond Blue* includes community partnerships, advertising, public education, and marketing (Beyond Blue, 2018). The objectives of the *Beyond Blue* campaign include a decrease in stigma, community stakeholder input in program development, improved community education, increased mental health service utilization, and increased mental health knowledge (Pirkis et al., 2005). Because this program is believed to have reached the entire country of Australia, researchers chose to evaluate it based on assessments of outcomes from each program objective rather than using clinical trials or comparison groups (Pirkis, et al., 2005). The outcome evaluation report did not offer statistics and measures for each objective, but they did report that improvements had been assessed across

Australia for each area. Additional studies described below may offer more insight into specific metrics. *Beyond Blue* was designed with the input of a consumer advisory panel comprised of people with lived experiences of depression, anxiety, and suicide (Beyond Blue, 2018). *Beyond Blue* has a depression literacy website that has had over 600,000 visits by the mid 2000s (Pirkis et al., 2005). The program also offers psychoeducational groups for young Australians. They also have provided sponsorship and collaboration with key mental health partner initiatives such as Reach Out!, a mental health web support network, and The Children of Parents with a Mental Illness Initiative (COPMI). It is also designed for diverse perspectives with targeted information that is specific to the needs of populations such as, Indigenous peoples, LBGTQ identified people, older adults, women, and others. They also provide direct outreach to individuals and support to professionals, such as healthcare workers and educators. This initiative offers a comprehensive, wide-scale, and universal approach to behavioral disorder prevention.

Beyond Blue has successfully raised awareness of depression, anxiety, and suicide in Australians from a variety of age and demographic brackets (Goldney & Fisher, 2008; Pike, 2010). This national initiative has reportedly positively affected knowledge and help-seeking in those who have symptoms of depression or suicidality (Goldney & Fisher, 2008). This knowledge increase was assessed using a nationally-representative sample of Australian households (n=3,015). Mental health literacy knowledge was assessed using a vignette (short story) based tool developed by Jorm and colleagues (1997). Mental health literacy is an individual's knowledge of mental illness, coping, treatment, and stigma (Jorm, 1997, 2000). These vignettes were descriptions of people who had mental health conditions. After reading the vignettes, people were asked questions about the person's mental health. The answers they gave were used to assess the test-taker's knowledge and attitudes about mental illness. Knowledge

increase included a reduction in negative attitudes and beliefs about mental illness and treatment known as stigma. In another general population evaluation, researchers found that areas of the country having the greatest exposure to *Beyond Blue* demonstrated an improved knowledge of disorders and their treatments and a reduction in mental illness stigma (Jorm, Christensen, & Griffiths, 2006). Additionally, researchers also have found that young people (15-25) having exposure to *Beyond Blue* have higher levels of MHL and improved attitudes toward seeking mental-health treatment (Yap, Reavley, & Jorm, 2012). In this research, mental health literacy knowledge was assessed with both a vignette-based tool and a follow-up questionnaire. Vignettes and knowledge of mental health were determined based on whether knowledge of disorders reflected current diagnostic criteria. The broad success of this program is related to its ecological approach that engages individuals, families, workplaces, healthcare workers, government, and others.

Adventure Therapy

Adventure therapy is the clinical and theoretical foundation for ABP. Adventure-based prevention is one of the many techniques that exist under the greater umbrella of adventure therapy practice (Gass et al., 2012). To understand ABP, it is important to have a solid understanding of AT practice and research (Gass et al., 2012; Beightol et al., 2012). According to Alvarez and Stauffer (2001), "AT is any intentional, facilitated use of adventure tools and techniques to guide personal change toward desired therapeutic goals" (p. 87). Several terms are used for AT including wilderness therapy, outdoor behavioral healthcare, therapeutic adventure, adventure-based counseling, experiential education, outdoor experiential therapies, and wilderness experience programs (Ewert, McCormick, & Voight, 2001; Houston, Knabb, Welsh, Houskamp, & Brokaw 2010; Russell, 2001; White, 2015). Some of these terms, such as

therapeutic adventure and adventure-based counseling, are generally used as synonyms for AT while other terms are specific subtypes. For example, wilderness therapy describes programs that use group therapy in remote expeditions to improve behavior in clients (usually adolescents) (Gass et al., 2012; Russell, 2001). Outdoor behavioral healthcare is a type of wilderness therapy program that has incorporated strict training and safety certification standards by a third-party accrediting body (Russell, 2003). These are specialized sub-disciplines under the greater AT umbrella (Gass, et al., 2012).

Adventure therapy has been used to treat an array of mental health concerns, including conduct disorders, depression, addiction, trauma, anxiety, and other disorders (Bettmann, Gillis, Speelman, Parry, & Case, 2016; Bowen & Neill, 2013; Gass et al., 2012). Adventure therapy has been evaluated primarily with young people, but has also demonstrated positive outcomes with adults, couples, and families (Becker, 2010; Gass et al., 2012; Koperski et. al, 2015; Neill, 2003). Young people treated with AT have demonstrated improved interpersonal, educational, and familial functioning as well as reduced symptoms of mental illnesses and substance abuse (Harper & Cooley, 2007; Harper, Russell, Cooley, & Cupples, 2007). Adventure therapy also has been beneficial in more unique populations that include teen weight management interventions and well-being programs for teens fighting cancer (Epstein, 2004; Jelalian et al., 2006).

A case example of a high school boy who participated in an AT intervention may further illustrate what happens in AT social work practice. A school in Michigan has developed a peer-to-peer support program that uses AT techniques to help build social skills and independence in students having an autism spectrum disorder diagnosis (Karoff, Tucker, Alvarez, & Kovacs, 2017). In this program, the school social worker paired ASD students with other students to participate in school-based challenge activities. These activities included challenges such as

stacking balls to build a pyramid or passing a balloon through a group without using one's hands. Activities were facilitated outdoors or in a gymnasium. These activities were used to facilitate the creation of environments in which the students could practice overcoming challenges with their peers. The social worker would facilitate the activities and process how the activities went after they were completed. They would also check in with the young people to manage their treatment goals (such as decreasing levels of anxiety or increasing communication skills) during the interventions. Following participation in this program, the students exhibited a reduction in disciplinary problems and an increase in social skills with their peers. The students also reported enjoying the activities and feeling successful in the program (Karoff, Tucker, Alvarez, & Kovacs, 2017).

Adventure therapy has been used for both prevention and treatment, although the majority of research on AT appears to focus on treatment (Gass et al, 2012). Adventure therapy and ABP both are delivered by licensed mental health professionals who prescriptively use experiential activities to develop skills and promote healing (Gass et al., 2012; Lung et al., 2008). These professionals are referred to by a number of terms, including experiential educator, outdoor educator, wilderness therapist, and adventure therapist. For this paper, these professionals will be referred to as adventure therapists.

Coping skills. Techniques from AT have been noted for their ability to support the development of healthy coping skills in participants (Dobud, 2016; Koperski, Tucker, Lung, & Gass, 2015; Russell, Widmer, Lundberg, & Ward, 2015). Coping skills include learning how to overcome stressful and difficult situations (Masten, 2014). Adventure therapists foster these skills by providing challenge and adversity with support and guidance to build the necessary social and emotional skills to cope with adversity (Russell et al., 2015). A key component of

many AT programs is overcoming challenge and post-challenge processing to identify how to generalize one's new coping skills to other difficulties in their lives (Russell et al., 2015).

A recent study showed that AT participants reported an increased use of adaptive coping skills such as walking in nature, gardening, meditation, and tracking gratitude (Koperski et al., 2015). These activities favor the development of active coping strategies with a lesser focus on avoidance and acceptance. For example, a facilitator may guide a client to find their personal strengths to navigate a challenging section of a hike or an experiential activity. However, they may also use these activities to help a client identify a challenge that is too difficult and must be avoided. They may also learn to cope through accepting the physical discomfort that may come from carrying a heavy backpack for a long hike. Additionally, adventure activities may promote increased social coping skills for overcoming challenges together with peers (Ritchie et al., 2014).

Learning styles. Learning style theorists posit that individuals have different strengths that help them learn best from differing teaching styles (Fleming, 2001; Kolb & Kolb, 2005). The visual, auditory, reading/writing, and kinesthetic (VARK) model describes how people are oriented in their learning styles (Fleming, 2001). The learning styles inventory model proposes that learning styles are "diverging, assimilating, converging, and accommodating" (Kolb & Kolb, 2005. p. 196). Learning assessments using these models provide descriptions of learning strengths at one point in time. Individuals learn in multiple styles and these styles can shift throughout their lives (Kolb & Kolb, 2005). Following the VARK model, kinesthetic learners do best when they experience an activity in a hands-on fashion (Fleming, 2001). Similarly, the learning styles inventory model proposes that accommodating learners do best when they engage

in hands-on, experiential, and action-oriented learning activities, such as AT (Kolb & Kolb, 2005). Both of these styles support the methods utilized in AT and ABP.

Many behavioral disorder prevention curricula utilize psychoeducation delivered in a didactic fashion via conversational learning in group and individual therapies (Cuijpers, van Straten, & Smit, 2005). Others use a blend of didactic psychoeducation and experiential activities such as crafts and playing games (Riebschleger et al., 2009). Information delivered in didactic curricula may be harder to access for those with a kinesthetic or accommodating learning style (Fleming, 2001; Kolb & Kolb, 2005). Adventure-based prevention curricula offer an alternative that may engage young people with these styles. For example, an ABP program offered in schools used experiences doing high-ropes activities with peers to improve social skills, frustration tolerance, and problem solving (Gass et al., 2012). This course supports ongoing didactic prevention learning in the school offering a way to engage students with multiple learning styles.

Benefits of the natural world. AT and ABP can be conducted in multiple settings, including an office, schools, day camps, or the outdoors (Lung et al., 2008). However, it is possible that interventions offered in natural settings may offer added benefits due to nature's ability to support psychological well-being in the individual (Adams & Savahl, 2017; Barton, Bragg, Pretty, Roberts, & Wood, 2016; Berman, Jonides, & Kaplan, 2008; Taylor, Kuo, & Sullivan, 2001, 2002; Wells & Evans, 2003). In a recent systematic review, researchers showed therapeutic healing effects across disciplines and multiple diagnoses for clients who participated in therapies in natural settings (Annerstedt & Wahrborg, 2011). The researchers reviewed studies that used measures of physical, emotional, social, and intellectual well-being. In this meta-analysis of nature-based therapies (n=38 studies), six studies demonstrated high levels of change

while 29 others demonstrated low to moderate evidence (3 other studies were previous meta-analyses with effect sizes of .34, .31. and .18). This study supports the notion that interventions offered in natural settings may be an effective treatment option for clients having a wide array of physical and mental health concerns. Therapies included in this analysis were AT, horticultural therapy, and therapies offered in natural settings.

A young branch of the behavioral sciences called ecopsychology or ecotherapy has emerged to explore the relationship between an individual's mental health and the health of the natural world (Roszak, Gomes, & Kanner, 1995). Ecotherapy is an interdisciplinary field composed of environmentalists, humanist philosphers, social workers, psychologists, and others at the intersection of environmentalism and human services. These scholars argue that psychological health of the individual is linked intrinsically to a healthy natural world (Norton, 2009, 2012; Roszak et al., 1995; Scull, 2008). Furthermore, they have described human existence and the natural world as inseparable concepts and state that a connection to a healthy natural world promotes positive human development (Davis, 2011). Researchers have found that a stronger connection with nature correlates with improved psychological well-being in the individual (Wolsko & Lindberg, 2013). This correlation was demonstrated by comparing college students' scores (n=265) on a 14-item connectedness to nature scale (a=.91) to scores on scales of mindfulness (r=.15) and psychological well-being, composed of scales of subjective vitality (r=.37), flourishing (r=.32), , positive emotions (r=.26)., and negative emotions (r=-.31).

Time spent in or near natural settings may improve well-being by reducing measurable levels of stress (Hansmann, Hug, & Seeland; 2007; Wells & Evans, 2003). Initial research has linked time spent near trees and greenspaces to reduced levels of cortisol, a stress hormone (Jiang, Chang, & Sullivan, 2014). Being in nature has also been shown to reduce ruminations

and stress-related brain activation in fMRI assessments (Bratman, Hamilton, Hahn, Daily, & Gross, 2015). The psychological benefits of nature happen in three levels: (a) viewing nature through a window; (b) being in nature; or (c) physical activities that interact with nature (Pretty, 2004). Although benefits accrue within all three tiers, time spent doing physically engaging activities appears to be the most beneficial because it promotes physical and mental health concurrently (Pretty, Peacock, Sellens, & Griffin, 2005).

A multi-study analysis of 10 programs (n=1252) that use physical activities in the outdoors demonstrated that psychological well-being (operationalized as mood and self-esteem) was increased across demographic groups during and following participation (Barton & Pretty, 2010). Self-esteem and mood were measured with the Rosenberg Self-Esteem Scale (10-item) (Rosenberg, 1965) and the Profile of Mood States (37-item) (McNair, Lorr, & Droppleman, 1992). The overall effect difference for self-esteem was d=.46 and for mood was d=.54. Interestingly, the greatest well-being improvements were displayed in those who had been previously diagnosed with mental health disorders (d=.68 in comparison to d=.41 for those without a diagnosis). The therapeutic, stress-reduction benefit of time spent in nature may be an important aspect of ABP programs.

Empirical literature on adventure therapy. Adventure therapy outcomes have not been evaluated widely using rigorous methods such as randomized controlled trials (RCTs). Researchers have reported concerns conducting RCTs due to the ethics of withholding AT from young people who desire it (Gabrielsen, Fernee, Aasen, & Eskedal, 2016). They also reported difficulties making comparable groups between hospital-based clients and those receiving AT services. However, longitudinal studies using pre, post, and follow-up evaluations have demonstrated that this method may be an effective treatment for young people (Bowen, Neill, &

Crisp, 2016). Bowen and colleagues demonstrated that youth who completed a 10-week AT program in Australia demonstrated clinically significant improvements across an array of mental health measures (effect size .26). Additionally, in an early seminal outcome evaluation of seven AT programs (n=858), researchers demonstrated lasting mental health improvement for young people with a variety of diagnoses, including oppositional defiant disorder, depression, anxiety, and substance abuse disorders following adventure therapy programs (an average length of about 45 days) (Russell, 2003). There is a need to strive for increased rigorous outcome evaluations, such as these, to further ascertain the effectiveness of AT.

Outdoor Behavioral Healthcare Research Cooperative. Much of the current research in AT has been published by the Outdoor Behavioral Healthcare Research Cooperative (OBHRC). The OBHRC is a group of researchers who assess client outcomes, using measures such as the Youth-Outcome Questionnaires (Y-OQ) (Wells, Burlingame, Lambert, Hoag, & Hope, 1996) or the Achenbach Child Behavior Checklist (Achenbach & Ruffle, 2000), to demonstrate treatment effectiveness across studies (Gass et al., 2012). The Y-OQ is a measure of youth functioning and mental health that assesses for frustration tolerance, common mental illness symptoms, social communication, high-risk behaviors, and somatic symptoms (Gass et al., 2016; Wells et al., 1996). Additionally, they publish research on risk assessment, the state of the industry, other outcome evaluations, and a limited amount of qualitative research. The OBHRC has published over 90 journal articles and books (Outdoor Behavioral Healthcare Center, 2018). These articles examine a wide array of outcomes. For example, large scale quantitative studies (n=659) have examined young people's outcomes using parental behavioral ratings (Combs, Hoag, Roberts, & Javorski, 2016). Other research has examined client characteristics in relationship to outcomes (Roberts, Stroud, Hoag, & Massey, 2017). Additional studies have explored workforce stress and

retention (Marchand, Russell, & Cross, 2009). The most breakthrough studies from this cooperative and in AT may be large outcome studies of multiple programs that demonstrate the effectiveness of treatment across providers (Bettmann et al., 2016; Bowen & Neill, 2013, Gillis et al., 2016; Russell, 2003).

Researchers from the OBHRC have published an array of studies on treatment outcomes for thousands of young people involved in AT (Bettmann et al., 2016; Bowen & Neill, 2013, Gillis et al., 2016; Russell, 2003). These analyses are large multiple program evaluations of secondary clinical data using an outcome database of Y-OQ assessments of thousands of young people who have participated in OBH programs. Each study reportedly adhered to OBH standards that mandate licensed clinicians, treatment evaluation, ongoing assessment, and ethical practice mandates (Gass et al., 2012). The first analysis was conducted by Russell (2003) using outcome data from 858 young people receiving AT services across seven, OBH residential-style programs that averaged 45 days in length. Participants were between 16 and 18 years old and primarily had mental health diagnoses of oppositional defiant disorder, substance abuse disorders, or mood disorders. They found that the young people experienced reduced symptoms across all categories assessed with the Y-OQ. Bettmann et al. (2016) conducted another large meta-analysis with private pay clients in OBH programs (n=2,399, across 36 programs). They found symptom reduction using 6 separate meta-analyses on the following outcomes: "...self-esteem, locus of control, behavioral observations, personal effectiveness, clinical measures, and interpersonal measures" (Bettmann et al., 2016, p. 2663). The OBH research council sponsors multiple ongoing quantitative empirical research initiatives on AT programs (Behrens, Santa, & Gass, 2017). Similar results were found in another study that demonstrated that older teens showed the greatest reduction in symptoms (Neill & Bowen, 2013). Research initiatives from the

OBHRC use rigorous quantitative outcome evaluations to demonstrate the body of evidence supporting AT as a treatment modality. To date, the OBHRC appears to be one of the strongest voices in the AT research community. Despite contributing strong evidence supporting the use of AT in mental health treatment, even OBHRC offers limited research on the use of adventure techniques in prevention.

A meta-analysis of 24 early programs (n=1,632) demonstrated that young people in AT programs exhibit increased resilience evidenced by an internalized locus of control that may indicate improved problem-solving capacity later in life (effect size = .38) (Hans, 2000). This evidence from a mental health treatment intervention may be helpful for ABP providers who desire to produce similar resilience effects in clients using prevention programming. Although research on resilience and ABP is in its infancy, these initial articles provide a footing for future work. Additional ABP outcome evaluations are needed using longitudinal methodologies to demonstrate long-term increases in resiliency and the prevention of behavioral health disorders.

Another important study from AT that may be directly applicable to ABP is the recent development of the adventure therapy experience scale (referred to in the literature as the ATES scale), which is reported to measure core components of adventure therapy interventions (Russell & Gillis, 2017). The ATES is the first known tool that is designed specifically to evaluate outcomes of adventure therapy programs. This was reportedly designed to capture five core factors of adventure therapy practice: time in wilderness and nature, adventure therapy challenge, group adventure, and reflection on AT activities. This scale has undergone psychometric evaluation with clients (n=720) from eight programs across North America. This scale has strong internal consistency (a=.92) with subscale internal consistency of .92 (group adventure), .72 (reflection), .80 (nature), and .68 for (challenge). This scale can be administered with other

standard mental health outcome scales to better understand how specific ingredients of adventure therapy correlate with mental health outcomes at the completion of a program. It is possible that this scale could be used to better understand ABP programs as well. There are no known examples of this newly developed tool being implemented in ABP practice.

Qualitative and mixed-methods research. A lesser amount of research in AT and ABP has included qualitative and mixed-methods approaches. A small body of qualitative research has been conducted that describes client perceptions of AT participation and perceived outcomes. Within this body of research, a few select articles exist that use qualitative and mixed methods research to describe the effects of ABP programs (Beightol et al., 2012; Ritchie et al., 2014). Additionally, qualitative research has been conducted on related concepts such as resilience promotion using AT (Dobud, 2016; Ungar et al., 2005). Young people have described AT as a catalyst for improved social relationships, exposure to healing environments, and supports for their therapeutic goals (Kyriakopoulos, 2011). They also have described AT as using challenging activities to increase their social and emotional skills (Albright, 2016). Additionally, they have described improved psychological functioning after participating in adventure-based activities (Norton, 2009).

Qualitative research that details consumer and provider perspectives in AT may provide insight and understanding into the processes that drive quantitative outcomes assessed in previous studies (Dobud & Harper, 2018; Fernee et al., 2017; Harper, 2017). Fernee et al. (2017), conducted a realist synthesis of qualitative research on the specific processes in AT that drive client outcomes. They did an extensive review of qualitative literature on AT interventions for adolescents. They then built a program theory of change based on three categories of ingredients of AT drawn from the literature: “wilderness, physical-self, and psychosocial-self”

(p. 125). Wilderness was described as a healing place where adolescents could take a break from their existing social milieu. Physical-self was a clients' physical engagement overcoming challenging activities. Psychosocial-self pertained to the relationships built with therapeutic groups and clinicians over the course of treatment. This description of how AT works offers an intentional scaffolding that describes how these ingredients of AT may support therapeutic outcomes. This framework offers one of the only program theories of AT built on perspectives from multiple qualitative research studies. Future qualitative research should further examine these specific ingredients. This may provide the groundwork for direct quantitative comparisons of specific ingredients of AT interventions.

In a seminal study titled *Risk, resilience*, *and outdoor programmes for at-risk children,* Ungar et al. (2005) explored the connection between participation in AT programs and risk and resilience of participants. Data were extracted through thematic analysis of client interviews and program evaluation responses. This vital research offered insight into client perceptions of risk and resilience adventure programs that included activities such as: environmental education, kayaking, climbing, and hiking. They also examined specific aspects of program curricula and their link to factors that may inhibit risk and promote resilience. These aspects included immersion in activities, meaning-making, spirituality, and rites of passage. The participants reported feeling that they improved their social skills, personal development, and leadership abilities. This growth reportedly was related to leadership tasks, overcoming challenging activities, and social collaboration during experiential tasks. They also reported feeling a greater sense of purpose by participating in programs in natural spaces. Further research is needed to elaborate on these themes and develop a more comprehensive theory of change.

Adventure-based prevention. Adventure-based prevention groups may provide a unique opportunity to deliver mental health information while driving coping skill development through the implementation of exciting and challenging experiential activities (Beightol et al., 2012; Gass et al., 2012). Their curricula utilize techniques from AT to attempt to promote psychosocial resilience in youth who have been identified as facing increased risks (Beightol et al., 2012). In contrast to talk-based, didactic prevention models, ABP combines psychoeducation, challenging adventure activities, and post-activity processing to promote psychosocial growth, coping skills, and resilience. ABP models are strengths-based; they celebrate the clients' internal assets and social supports with group-based resiliency promoting experiential exercises (Gass et al., 2012).

Adventure-based programs have been used in primary prevention to attempt to counteract problems such as substance-abuse (Gass et al., 2012), bullying (Beightol et al., 2012), court involvement (Sveen & Denholm, 1998), and violence (Beightol et al., 2012). Additionally, targeted adventure-based secondary prevention programs have been used to try to increase resilience and self-esteem in children facing psychosocial adversity and risk factors (Carter et al., 2007; Epstein, 2004; Ritchie et al., 2014; Shek & Sun, 2008; Sveen & Denholm, 1998). Despite some promising evidence from the few studies that have been conducted on ABP, the overall body of literature remains small. Also, no research was found that directly compares outcomes between ABP programs and those that offer prevention services without the inclusion of adventure techniques. Additionally, prevention curricula appear to vary from program to program and it is often unclear how ABP programs choose which activities to include in their curricula.

Exemplary adventure-based prevention programs. A limited number of ABP programs were found in this review of the literature; however, a few stand-out programs have been

described that are promising. Four of the most promising programs include those offered by The Native American Youth Leadership Project (Project Venture) (Carter et al., 2007), The Santa-Fe Mountain Center (SFMC) (Beightol et al., 2009, 2012; Gass at al., 2012; Neill & Dias, 2001, The Wikwemikong Outdoor Adventure Leadership Experience in Canada (Ritchie et al., 2014), and Project Hahn in New Zealand (Lan, Sveen, & Davidson, 2004; Sveen & Denholm, 1998). These programs use a blend of experiential activities, group processing, and mentorship to promote resilience in young people facing high levels of risk. These programs have demonstrated improvements in client resilience following participation in their prevention curricula. Two of these programs, Project Venture and SFMC, have been recognized, in the US, by the National Registry of Evidence-based Programs and Practices as evidence-based practices (Carter et al., 2007; Beightol et al., 2012).

Project Venture is one of the strongest examples of adventure-based prevention practice found in this review of the literature. Project Venture is an ABP program that is designed for Native American youth (5th-8th grade) who face increased risks of behavioral health disorders (Carter et al., 2007). This program was developed within a Cherokee community and has been expanded for use with other Native American groups. This program was first developed in 1990 and since then has served over 4,000 young people in different tribal groups across the United States. The curriculum used by Project Venture includes in-school and after-school problem-solving experiential activities, summer camps, weekend and summer experiential outdoor activities (hiking/camping), and youth community service projects. This strengths-based curriculum does not focus on avoiding behaviors such as drugs and alcohol. Instead, it teaches young people problem-solving skills using experiential education in the outdoors (Carter et al., 2007).

The efficacy of Project Venture has been evaluated using longitudinal outcome measures to compare levels of substance use in 6th graders (n=262) who had completed the curricula to those in a control group who did not (n=135) (Carter et al., 2007). The study assessed the young people at baseline, six-months post-treatment, and 18-months post-treatment, using a substance abuse measure from the Center on Substance Abuse Prevention (Springer, Sambrano, Sale, Kassim & Hermann, 2001). Substance abuse increased for both groups, but this was to be expected as they were at an age when substance use commonly begins to emerge. At baseline, substance abuse estimated marginal means were similar between treatment (.08) and control (.1) groups (Carter et al., 2007). However, substance abuse increases were far greater for the control group at 6 months (treatment=.40 vs control .63) and 18 months (treatment=72, control=.35). Carter and colleagues described that the outcomes from this study were the first of their kind to demonstrate that positive youth development using components of adventure decrease rates of substance abuse in Native American youth.

The National Youth Indian Leadership Project's *Project Venture* has been described as a program that uses a strengths-based, positive youth development model in their ABP services (Carter et al., 2007; NIYLP, 2018). *Project Venture*'s program uses a blend of techniques from traditional tribal wisdom as well as prevention science techniques (NIYLP, 2018). This program was designed primarily for middle school students in 5th-8th grades, although it also has been adjusted for older students (Carter et al., 2007). Carter and colleagues describe the primary components as: "1) in-school problem-solving games and initiatives delivered weekly; 2) afterschool, weekend, and summer skill-building experiential activities delivered weekly; and challenge activities (e.g., hiking, recreation, camping) delivered monthly; 3) summer camp immersion lasting three to ten days; and 4) service leadership projects throughout

the year that involve several age cohorts of youth and adult participants" (p. 7). Another key component of *Project Venture* is that it does not use psychoeducation on substance abuse or mental illness and instead focuses on developing social skills, positive self-concept, and problem solving abilities. They also integrate traditional Indigenous story-telling and coming-of-age ceremonies into their practices. Another key component of their program is that it is staffed primarily by Native Americans. This program consists of at least 20-hour-long sessions that are delivered throughout the school year. It is supported through a detailed program manual that outlines interventions for *Project Venture* staff. (Carter et al., 2007).

Another example of ABP has been provided by SFMC in schools in New Mexico. The SFMC is a New Mexico non-profit organization that provides an array of AT and ABP services (The Mountain Center, 2016). The organization also describes being currently accredited through the Association of Experiential Education. The SFMC offers a curriculum called *Adventures in a Caring Community* (ACC) that has been used to attempt to prevent substance abuse and bullying in teens (Beightol et al., 2009, 2012; Gass at al., 2012; Neill & Dias, 2001). The ACC program was listed on the National Registry of Evidence-based Programs and Practices as an EBP for substance abuse prevention (The Mountain Center, 2016). The SFMC's *Experiential Adventure-based Resiliency Model* is used in their *Adventures in a Caring Community* program (Gass et al., 2012). This model appears to be one of the more clearly described ABP models in the empirical literature. It is reportedly focused on fostering social relationships with peers, improved relationships with supportive adults, and personal skills such as self-efficacy, problem solving, and cooperative behaviors. These skills are described as being facilitated experientially through cooperative learning on ropes courses and through other challenging activities (Gass et al., 2012; Beightol, et al., 2009). This model assumes that individuals arrive to an ABP program with

preexisting personal and social assets and supports. These assets are strengthened through "prescriptive programming and adventure-based activities" (Gass et al., 2012, pp. 114-115). These activities then reportedly lead to improved outcomes that include increased resiliency, empathy, teamwork, problem solving, and self-awareness that then can be applied in a client's life in the real world. These skills reportedly are built during activities with peers (and coaching from supportive adults).

This ACC model has been evaluated in an anti-bullying initiative in public schools (Beightol et al., 2009). This initiative was delivered to students (n=81) and compared to a control group (n=102) in thirteen, two-hour sessions that included adventure activities such as high ropes, rock climbing, and group problem solving during challenge activities and games. Resilience outcomes from the anti-bullying initiative were assessed with an eight-item resilience subscale in a 36-item anti-bullying initiative measure (Beightol et al., 2009). This scale was adapted from a previously validated Resilience Assessment Module. Psychometrics for their instrument were moderate to weak (alphas between .294 and .611). There were no significant differences on total resilience scores from pre to post-tests for either the treatment or control groups. Treatment groups from this study did, however, demonstrate small to medium effect size increases in resilience subscales related to "goals and aspirations" (pre m= 3.49, post m=3.56) and "self-efficacy" (pre m= 3.56, post m=3.75) from pre to post-treatment. However, no statistically significant differences were found when scores were compared between treatment and control groups. The ACC program also has been evaluated as a primary prevention model within a New Mexico school where it appeared to support increased resilience in students in the form of student skills and social assets (Gass et al., 2012).

In another paper on this same study, a mixed methods evaluation of ACC demonstrated similar outcomes on aspects of resilience in Latinx 5th grade students who attended this anti-bullying program (Beightol et al., 2012). This program was delivered in an elementary school to 5th grade Latinx students in the American Southwest (n=51). Researchers quantitatively evaluated resilience using the same 36-item anti-bullying scale with a resilience subscale. Interestingly, this study showed that females demonstrated greater improvements than their male peers following participation in this program. Statistically significant improvements were in subscales related to "goals and aspirations" (*chi square*=7.483, p=0.024) and "self-efficacy" (*chi square*= 6.540, p= 0.038) (Beightol et al., 2012, p. 316). The researchers described this as a preliminary study exploring how ABP programs can promote resilience. They described the need for further mixed-methods studies to understand youth outcomes as well as their perspectives of participating in ABP programming.

The SFMC also reportedly delivers secondary prevention programs for LGBTQ identified young people, adjudicated young people, Indigenous persons, and young people transitioning into adulthood, although outcome data on these programs were not found (The Mountain Center, 2016). Prevention programs offered by the SFMC are accredited through the Association of Experiential Education and Outdoor Behavioral Healthcare Council. These programs appear to be some of the most comprehensive ABP services offered today.

The Outdoor Adventure Leadership Experience (OALE) is an ABP program that is designed to promote resilience and mental health in First Nation adolescents in northern Ontario (Ritchie et al., 2014). The developers described their intentions to increase cultural capacity and stakeholder engagement by collaborating with Wikwemikong tribal leaders to design and implement the 10-day prevention curriculum. This program included AT concepts such as the

Outward Bound model as well as tribal concepts such as the medicine wheel. The program was delivered to young people (ages 12-18, n=73) on the reservation. Participant outcomes were compared to those of young people in an employment program in the same community. Resilience was assessed using a 14-item resilience scale (RS-14) that had undergone psychometric validation and was reported to be found to be acceptable by the Wikwemikong people (Ritchie et al., 2014; Wagnild, 2009). This measure was combined with nine additional mental and physical well-being scales to better represent Indigenous beliefs about well-being as related to the medicine wheel model. These combined scales created a 72-item measure. These scales were administered, pre-intervention, post-intervention, and one-year post-intervention. Those involved in the program demonstrated significant improvements on quantitative measures of resilience from pre to post (pre, m=73.65, SD=9.78, post, m=77.05, SD=9.07). These scores were supported further through qualitative data reported by participants describing feelings of increased resilience. Improvements in resilience did not, however, appear to be stable in the one-year follow up measure. However, scales demonstrated improved mental health at the end of the program and at a one-year follow up. The OALE program may offer some insight into how to provide ABP programs for diverse populations by integrating AT techniques with community cultural practices.

Another promising example of ABP was offered in a prevention program in Tasmania and New Zealand called Project Hahn (named after adventure therapy pioneer Kurt Hahn) that used adventure techniques in primary and secondary prevention with young people who were broadly identified as at risk of difficulty transitioning from adolescence to adulthood (Lan et al., 2004; Sveen & Denholm, 1998). Project Hahn is a voluntary program in which youth are paired with adults (eight youth to three adults) and complete three phases: a one-day program introduction, a

five-day wilderness immersion experience, (such as backpacking), and a three-day follow-up expedition (Sveen & Denholm, 1998). This program teaches cycling, hiking, and rock climbing to young people with a focus on increasing self-esteem and self-actualization. Researchers further explained that the young people in project Hahn were at risk of behaviors that include truancy, school refusal, criminal justice involvement, substance abuse, mental illness, and suicide (Lan et al., 2004). The researchers described that young people (n=79) who completed this program were assessed longitudinally (pre, post, and 30+ day follow up) on an array of measures thought to predict healthy development that include self-esteem, self-actualization, existential well-being, and hopelessness. Positive effects were assessed across the scales, but the greatest improvement was exhibited in a reduction in hopelessness from pre-test to follow up (d=.55). Project Hahn researchers also collected qualitative youth perspectives from young people (n=46) who completed this ABP program. Youth perspectives were analyzed using thematic analysis techniques from which the researchers described major themes across responses. Young people described themes that included: perseverance, developing trust, courage, mutual social support, improved coping skills, and improved well-being. No current information can be found about Project Hahn and, from an Internet search, it appears that they may have ceased operations.

These programs may provide a starting point to begin to understand what is happening in some aspects of this newly emerging field. However, it also must be cautioned that the interventions and curricula appear to vary widely across these programs. These programs appear to use a wide variety of adventure-based techniques and it is unclear to the reader how each technique was chosen and how it relates to prevention. Also, in addition to adventure-based activities, the programs appear to use more traditional prevention interventions such as adult mentorship and psychoeducation. It is often unclear to the reader how a program chooses each of

its activities and how these activities may relate to eventual increased resilience and prevention of behavioral health challenges.

Research Gaps and Adventure-based Programs

Limited research on adventure-based prevention. A primary gap that exists in ABP research is the scant number of studies in general. It is unknown how many studies have been conducted in total because programs that may be using adventure in prevention use a wide array of terms to describe their practice. These terms include prevention, adventure therapy prevention programs, outdoor adventure interventions, therapeutic recreation, and many more terms. This literature review focuses primarily on literature from general AT instead of prevention-focused programs because too few studies are available for ABP to stand on its own and because of frequent crossover between terms. Simply put, research on ABP is in its infancy. However, despite ABP research being in its infancy, a number of programs doing ABP have yet to be described in the literature (T. Alvarez, personal communication, January 2018).

Although a small number of studies have been conducted on different ABP interventions, many more are needed to understand how this practice works and to support its efficacy (Beightol et al., 2012; Epstein, 2004; Ritchie et al., 2014; Shek & Sun, 2008; Sveen & Denholm, 1998). First, more information is needed on the core concepts and program theory that informs ABP programs. Models such as the *experiential adventure-based resiliency model* (Beightol et al., 2012), *the outdoor adventure leadership experience* (Ritchie et al., 2014), and *Project Hahn* (Lan et al., 2004; Sveen & Denholm, 1998) should be compared to other resilience-focused prevention programs. Recent research on these projects (Beightol et al., 2012; Lan et al., 2004; Sveen & Denholm, 1998) did not appear to produce significant outcomes on total resilience (Beightol et al., 2012) or lasting effects when assessed longitudinally (Sveen & Denholm, 1998).

Additional research may be needed to understand which components of these programs are effective and why. The few studies that exist appeared to be introductory research that often used small samples.

Also, program developers should be asked to elaborate on how they decided to integrate adventure-based activities into their programming. Were these techniques used because an adventure therapy provider was interested in providing prevention services? Were they used by prior prevention service providers because they wanted to find a way to reach clients who may have had trouble engaging in other styles of prevention? Were they used because they produce different preventative effects than other, more traditional forms of prevention? The literature on ABP should elaborate on how these activities were chosen and why they are preferred over other styles of preventative interventions. Also this exploration should explore how they are similar or different than other styles of preventative interventions.

What happens in adventure-based prevention practice. Much remains to be learned about how ABP programs are implemented across the field. Additional research is needed to clarify how these programs work and how they are delivered. Also, research is needed comparing specific ingredients of programs to understand which components of ABP interventions are reported to be most necessary when delivering these services. Possible ingredients may include which interventions are used, the dosage of these interventions, how they are implemented, who implements them, and the theories that guide them. It is important that researchers do not just learn what ingredients are used in ABP, they must also understand the intentional scaffolding that supports the use of these ingredients. This scaffolding should include theoretical descriptions of how these activities promote resilience and promote positive prevention outcomes for participants. Prior research gave vague descriptions of activities

utilized, but more depth is needed. Future research is needed to understand the details of how adventure is used in prevention practice. This research should include a description of with which populations adventure is used, how adventure is applied in prevention practice, which specific ABP interventions are utilized, the theoretical frameworks under which it is implemented, how providers are trained to use ABP, and provider perspectives of how ABP works. Although research on the efficacy of ABP programs is important, it may first be necessary to develop an understanding of how these programs are implemented and what really happens in them before conducting further outcome studies.

Summary

A number of programs have utilized adventure therapy techniques in programming designed to prevent behavioral health concerns in young people (Beightol et al., 2009, Carter et al., 2007; Epstein, 2004; Gass at al., 2012; Neill & Dias, 2001; Ritchie et al., 2014). These include school-based primary prevention programs (Beightol et al., 2014: Gass et al., 2012), programs for Indigenous youth (Carter et al., 2007; Ritchie et al., 2014), and programs for at-risk teens (Lan et al., 2004; Sveen & Denholm, 1998). Reportedly many more providers are using adventure therapy techniques in prevention who have never shared their research within the peer-reviewed literature (T. Alvarez, personal communication, January 2018). However, there appears to be limited information about how adventure therapy techniques are actually used within these interventions. Also, which adventure therapy techniques are used appear to vary widely across studies. However, the research on ABP is much more limited than that on its predecessor of AT. Although the limited research on ABP may be promising, much remains to be learned to understand this modality. Additional research is needed to learn whether or not ABP is an effective form of prevention.

However, before this work can be done, researchers should strive to build an understanding of the processes that are occurring in ABP practice. Qualitative studies seem to be a good fit for collecting exploratory knowledge (Creswell, 2013) about what goes on in adventure-based prevention programs. A beginning sample of providers of ABP services would likely be a good place to begin. This research should include an exploration of what techniques are used in ABP programs and how they are believed to work. There does not appear to be enough information to understand how adventure techniques are utilized to encourage resilience and prevent disorders in young people. Of the limited number of ABP programs found in the literature, there appears to be limited consistency of which components of adventure are used in each program. Research should be conducted to understand how programs use techniques from adventure therapy in prevention. This research also should focus on providers' perceptions of how these interventions work and how they might be improved. By developing a better understanding of how ABP works and is implemented, it is possible that future researchers could move the state of knowledge of ABP toward findings drawn from rigorous quantitative or mixed methods evaluations of the outcomes of these programs. Additionally, this work can build the foundation for future studies to capture youth and family perspectives on participation in adventure-based prevention programs. Simply put, once researchers have elaborated on what is done in ABP, then they may be more well prepared to capture client perspectives and then conduct outcome studies. Therefore, research is needed to better understand: (a) what takes place in adventure-based prevention programs; as well as (b) to what extent programs combine adventure-based prevention techniques with more traditional prevention modalities such as psychoeducation, coping-skill development, and social skill development.

CHAPTER THREE: METHODS

Introduction

This study attempted to address the knowledge gaps of how AT techniques are used in ABP practice by using qualitative interviews of ABP providers to explore perspectives on how adventure therapy techniques are used in prevention programming. This study was guided by the following research question: "***How are adventure therapy techniques reportedly used by prevention services providers in adventure-based prevention programs for young people?"*** This was further elucidated through the following three sub-questions: ***"(1) How do adventure therapy prevention providers describe specific interventions that they utilize in their programs?, (2) How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services?, and (3) How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services?"***

Study Design: Thematic Analysis

This is a qualitative study that used thematic analysis as both an overarching research design and as an analytic method. Thematic analysis is a qualitative research method that is used for "identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). Braun & Clarke describe thematic analysis as a stand-alone qualitative method that was previously considered to be an analytic tool of other methods.

Research Map

Padgett (2008), encourages those who are conducting research to develop a map of their research plan. This map describes the epistemological, theoretical, conceptual, and methodological plans for their study. This qualitative study was designed with a post-positivist epistemology that challenges objectivist paradigms (Creswell, 2013; Padgett, 2008). It is guided

by risk and resilience theories (Masten, 2014). Its conceptual frameworks include psychoeducation and experiential-learning. The approach and methodologies used in this study are from qualitative thematic analysis (Braun & Clarke, 2006; Castleberry & Nolen, 2018; Guest, Namey, & MacQueen, 2011). The methods used for data collection were video-conferences (Zoom/Skype) and personal semi-structured qualitative interviews. Qualitative methods of data analysis included first cycle coding (open coding, in-vivo coding), and second cycle coding (focused coding) (Saldaña, 2016). The researchers used memoing (Padgett, 2008), intercoder reliability (Creswell, 2013), and triangulation (Creswell, 2013), in-vivocoding (Saldaña, 2016) and member checking (Padgett, 2008) to try to improve the trustworthiness of qualitative data analysis. These strategies are further explained later in this chapter. Qualitative data analysis was conducted by the researcher using a mixture of traditional pen-and-paper analytic methods and MAXQDA qualitative data analysis software (VERBI Software, 2019). Traditional methods were chosen to support computer-based analysis because they encourage the researcher to take additional control over how data is coded (Bight & O'Connor, 2007). The researcher chose to use these methods to assure that they spend the maximum amount of time with the data without taking shortcuts. Additionally, MAXQDA software has been utilized to supplement traditional methods with visual representations of the data, categorization of coding, and analytical tools (VERBI Software 2019).

Padgett's (2008) "The Foundations and Processes of a Qualitative Study (p. 14).

I. Epistemology: Post-positivist

II. Theoretical Lens/Sensitizing constructs: Risk and resilience

III. Conceptual Frameworks: Psychoeducation, experiential-learning

IV. Approach: Qualitative thematic analysis

V. Methodology: Semi-structured interview analysis

VI. Methods/Techniques of Data Collection: Phone and face-to-face interviews with program administrators and providers.

VII. Methods/Techniques of Data Analysis: First cycle coding: open coding, in-vivo coding, thematic development. Second-cycle coding: Focused coding. Strategies for trustworthiness and rigor: memoing, member checking, researcher reflexivity, intercoder reliability, triangulation, in-vivo coding

VIII. Format for Writing and Presentation: Visual diagrams, dissertation, conference presentation, and multiple manuscripts

Operationalization

For this study, ABP programs are operationalized as programs that reportedly use adventure therapy techniques with a stated goal of preventing the development of behavioral health conditions that include or are related to mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm, all of which are maladaptive behaviors that are treated by mental health providers. Additionally, ABP providers are operationalized as those who self-identify as providers and educators in these programs facilitating therapeutic adventure for prevention purposes. Those providing adventure therapy are most often required to be licensed mental health professionals (Gass et al., 2012; Russell, 2001; Stauffer & Alvarez, 2001). However, the review of the prevention literature found that programs may also be facilitated by educators, certified prevention specialists, allied professionals, and peer support specialists (who came to the field via lived experiences and may not have formal education). Therefore, to be inclusive to the field, as it stands, this study considered ABP providers to include doctoral and master's level

mental health clinicians, bachelor's and master's level certified teachers, certified prevention specialists, recreational therapists, and professionals with self-reported training to provide prevention services.

Sampling and Recruitment

Purposive and snowball sampling. Purposive sampling was used to select providers and program developers in ABP for qualitative interviews. Purposive sampling is when the researcher selects subjects with a high likelihood to have the necessary experiences to provide information that is relevant to the research question (Creswell, 2013). In order to find subjects, the researcher sought guidance from six field experts in the leadership of professional AT organizations (Therapeutic Adventure Professionals Group [TAPG] and Association for Experiential Education) and those with a publication and teaching history in this area for consultation. These are individuals with decades of experience working in this field. These experts included professors, program administrators, and published scholars in the field of adventure therapy. These experts have provided referrals to providers and administrators for qualitative interviews. Additional recruiting was done through connecting with the TAPG network of AT providers. Many providers in TAPG worked within organizations providing ABP services. The researcher contacted members of the TAPG Leadership Council that agreed to support recruitment. The researcher also engaged in additional outreach among TAPG membership to connect with ABP providers. Outreach was conducted with an email sent to the TAPG listserv, OBH program members, and with individual outreach phone calls based on referrals from members of the TAPG Leadership Council.

Sample inclusion criteria were as follows: (a) must be an ABP program developer, clinical administrator, or prevention service provider with one or more years of experience providing

ABP services; (b) must speak English; (c) must have done ABP work in the USA, Canada, or Commonwealth nations; and (d) must have professional training and/or certification that qualifies them to provide ABP services in their respective nation/state. Additionally, interviews led to additional respondent-driven snowball sampling where by those interviewed referred the researcher to additional providers who were overlooked in the initial sampling process. Snowball sampling is when subjects interviewed provide contact information for other subjects of interest to the researcher (Creswell, 2013). When snowball sampling occurred, decisions about including these individuals were based on the same sampling criteria and then those meeting the criteria were interviewed.

Data credibility in qualitative research can be increased by sampling participants with a wide array of perspectives (Graneheim & Lundman, 2004). To do this, the researcher strove to sample participants from varying types of ABP programs, including those targeting mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behavior, and suicide/self-harm. The researcher worked to find a diverse array of cultural, gender, racial, and other demographics to increase this credibility. To try to increase this diversity, the researcher consulted with researchers in the TAPG professional network who are currently providing programming for diverse clientele to attempt to access their networks. For example, the researcher consulted with professionals providing ABP services to those in a large urban school district that serves large numbers of undocumented youth. Another example is a provider consultant that offers ABP services to young people who identify as LGBTQ. Also, the researchers spoke with program administrators who offer curricula serving young people who identify as females.

Sampling and interviewing continued until the data reached saturation. Data saturation is when the qualitative interviews do not offer new and distinct data content for themes or categories (Corbin & Strauss, 2008; Creswell, 2013). Data that has reached saturation will show "depth and variation" in terms of categorial development; there is no agreed upon, steadfast rule for sample size to reach saturation; however, the researcher initially aimed for 20-25 interviews before reaching this point (Corbin & Strauss, 2008, p. 149).

Sample characteristics. Research subject characteristics were provided in response to an open-ended demographics questionnaire. The sample used in this study icluded ABP providers and program administrators (*n*=23). The mean age of the sample was 49.04 years of age, standard deviation was 13.01 years and the range was 30-73 years. These providers self-identified as 56.52% male and 43.48% female; no one in the sample identified as transgender or non-binary. The mean self-reported time practicing ABP was 20.1 years, the standard deviation was 12.53 years, and the range was 1-45 years. This professional roles of those sampled included CEO/directors (39.13%), supervisor/management (39.13%), providers/service providers (17.4%), and professors (4.35%). Those sampled identified their race as Filipino (4.35%), Latinx (8.7%), multiracial/mixed heritage (13.4%), Native American/Indigenous (4.35%), and White (69.75%). These individuals came from a range of professional backgrounds, including social work/counseling/psychology (60.87%), nursing/medicine/health (8.7%), criminal justice (4.35%), education/outdoor education/adventure fields (21.74%), and unspecified (4.35%). Research subjects reported their education as doctoral/ABD (17.4%), master's (65.22%), bachelor's (4.35%), and trade school/associate's/some school (13.04%). Sample characteristics are further described in (*Table 1.).*

Table 1. Sample Characteristics (*n*=23).

Variable	%, M, or Range
Gender	
Male	56.52%
Female	43.48%
Age	
Mean	49.04 years
Range	30-73 years
SD	13.01 years
Years Practicing	
Mean	20.1 years
Range	1-45 years
SD	12.53 years
Organization Role	
CEO/Director	39.13%
Supervisor/Management	39.13%
Clinician/Service Provider	17.4%
Professor	4.35%
Race	
Filipino	4.35%
Latinx	8.7%
Multiracial/Mixed Heritage	13.04%
Native American/American Indian	4.35%
White	69.57%
Profession/Education	
Social Work/Counseling/Psychology	60.87%
Nursing/Medicine/Health	8.7%
Criminal Justice	4.35%
Education/Outdoor Education/Adventure	21.74%
Some college/Unspecified	4.35%
College Degree	
Doctoral/ABD	17.4%
Master’s	65.22%
Bachelor’s	4.35%
Trade School/Associate’s/Some School	13.04%

Qualitative Semi-Structured Interviews

Semi-structured interviews are a form of in-depth qualitative interviews that use a set of sequenced, open-ended interview questions about a topic of interest (Padgett, 2008). Semi-structured interviews are guided by an interview protocol that contains both questions and flexible probes to collect data from the interviewees in a qualitative study (Creswell, 2013). Semi-structured qualitative interviews provide enough structure to encourage comparison of responses between subjects (Whiting, 2008). Whiting describes that semi-structured interview questions are open enough that they encourage the interviewer and subject to go off-script and let the topic lead the conversation as needed.

Semi-Structured interview protocol design. The qualitative tool that was utilized for interviews in this study is a semi-structured, open-ended questionnaire. This 10-item questionnaire was designed to capture perspectives about how a provider reportedly provides adventure-based prevention services *(see Appendix C)*. Questions included were related to the following topics: ABP models used, ABP interventions used, the mechanics/ingredients of specific ABP interventions, how effectiveness is evaluated, how providers are trained in ABP, the pros and cons of using adventure in prevention, ethical practice, and equity and inclusion in ABP. These questions were developed following an extensive review of the literature of AT and ABP programs to isolate and identify which ingredients ABP programs were most likely to utilize. Peer-reviewed research publications (Beightol et al., 2012; Bloemhoff, 2006; Ritchie et al., 2014) and seminal practice and theoretical textbooks (Gass et al., 2012; Masten, 2014) were consulted to compare the research protocol to known programs. Known programs included those offering adventure-based prevention in public school programs (Beightol et al., 2012; Gass et al., 2012), in juvenile justice settings (Bloemhoff, 2006), and in Indigenous community-based

programs (Carter et al, 2007; Ritchie et al., 2014). The interview protocol also included open-ended questions to capture information about the demographics of ABP providers who participated in qualitative interviews. The interview protocol was designed using easier warm-up and cool-down questions at the beginning and end of each interview to ease the participant in and out of the interview (Patton, 2002). The peer-reviewed literature was consulted during protocol development and questions were developed to correspond with supporting literature (*Table 2.).*

Table 2. Empirical Literature Support for Interview Protocol Questions.

Adventure-Based Prevention Construct	Question	Literature
Adventure-based Prevention Models	Question 2	Beightol et al., 2012; Gass et al., 2012; Wabano et al., 2014
Adventure-based Interventions	Questions 2, 3	Gass et al., 2012; Lung et al., 2008
Mechanics of ABP Interventions	Question 5	Russell & Gillis, 2017
Effectiveness and Evaluation	Question 6	Combs et al., 2016; Ewert & Yoshino, 2016; Russell & Gillis, 2017; Harper, 2010; Roberts et al., 2016
Training in ABP	Question 7	Tucker & Norton, 2013
Benefits and Drawbacks of using Adventure in Prevention	Question 8	Booth & Neill, 2017; Ungar, et al., 2005
Ethics, Equity, and Inclusion in ABP	Questions 4, 9	Gray, 2016; Hoffert, 2008; Karoff, , et al., 2018; Mitten, 1994; Orren & Werner, 2007; Whittington & Mack, 2010

The researcher also consulted with field experts about interview protocol development. These experts included: three providers offering ABP services, three prominent scholars in the fields of AT/ABP (who teach AT and have published in this area), and three program

administrators who currently offer ABP services. Additionally, these experts included members of the following three groups: Therapeutic Adventure Professionals Group, The Association for Experiential Education, and The Outdoor Behavioral Healthcare Council. The researcher interviewed these individuals on their reported practices and reviewed the research protocol questions with these individuals. The researcher examined the activities reportedly offered in these programs (such as experiential games, outdoor recreational activities, and peer social support activities) as well as population demographics that were reportedly served (age, location, prevention type).

Next, the semi-structured questionnaire was pilot tested in three rounds with four AT researchers and ABP providers in the field. The questionnaire was revised for content, clarity, and length based on the input of pilot testing. For example, after pilot testing with those providing prevention services in schools, questions were rewritten to include educators, as well as mental health professionals, who also often provide ABP services. Another example comes from talking to a prevention provider who offers services to diverse clientele; they recommended that the researcher included additional questions that focused on diversity, equity, and inclusion in ABP services. Also, following pilot testing rounds two and three, the questionnaire was shortened from 16 questions to 10 questions to shorten interview time. This was based on input from providers who described becoming tired and losing interest as the interview went over an hour. Pilot testing demonstrated the interview should take approximately 45-55 minutes. However, actual interview time was longer and averaged approximately an hour-and-a-half.

Ethical Considerations

Institutional review board. To assure that strict ethical principles were followed throughout this project, research approval was sought through Michigan State University's

Human Research Protection Program: Institutional Review Board (IRB). After being reviewed by the IRB, this study was found to be exempt from further oversight.

National Association of Social Workers (NASW) Code of Ethics. The researcher and research assistants involved in this project are all licensed social workers or current social work students who are bound by the NASW's (2017) professional *Code of Ethics.* This code of ethics mandates that social work professional practice is guided by, "…social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence" (n.p.). The researcher team worked diligently to assure that all aspects of this research project were informed by the *Code of Ethics.*

Informed consent. Informed consent to participate in research is a foundation of ethical research practice (Remler & Van Ryzin, 2011). Before participating in the study, subjects were asked to review and sign an informed consent and research purpose form (*see Appendix B).* This form described consent to participate, the purpose of the study, benefits and risks of participation, and whom to contact if the participant had any questions about the research before, during, or after it was conducted. The document also described confidentiality and limits to confidentiality related to the researchers' status as mandated reporters.

Confidentiality and data storage. All physically collected data for this project was securely stored in a locked box and room. All digital data was securely stored on encrypted hard-drives requiring passwords to access, or in a secure Dropbox folder that was only accessible by the doctoral dissertation chair and the doctoral student researcher. Data was cleaned of any identifying personal information and each case was assigned a unique case identifier to protect their identities. Additionally, any identifying information in transcripts was blacked out or changed to protect participant identity. All people with access to identifying data have undergone

training in ethical data management and participant confidentiality offered by the Michigan State University's Human Research Protection Program's Institutional Review Board. All data will be stored for a period of at least three years following the submission and publication of final research reports. Following this period, all data will be destroyed.

Before semi-structured interviews were conducted, the researcher obtained written and verbal informed consent from each provider. This included discussing information about standards for confidentiality, purpose of the research, time expectations, topic clarification, a description of recording equipment, and assurances to the participant that they could ask questions and seek clarification throughout (Whiting, 2008). For this study, these criteria were established in written informed consent to the provider (see *Appendix B)* and were verbally explained before the semi-structured interview began. This included assurances to minimize the possibility that those interviewed or their clients could be identified within disseminated content. Additionally, the purpose of the research, topic clarification, and time expectations were described in recruitment materials (see *Appendix D).*

Data Collection

Qualitative semi-structured interviews were conducted both face-to-face and over an internet connection (Zoom) with those who work in, or have worked in, the field of ABP. Face-to-face interviews were conducted in private areas at offices where ABP services are provided. The interviews were recorded using a dual microphone audio recorder device (Tascam PCM recorder). Internet-based interviews were recorded with software that captures both audio and video (Zoom). This was chosen so that the researcher could also code non-verbal communication. Internet software recorded the interview to a video format that is securely stored on a password-encoded server. Recorded audio files are stored on encrypted and password-

protected hard drives. Additionally, the interviewer took field notes during the interviews, which were reviewed later when coding data. Also, during each interview, member-checking was conducted to attempt to increase the trustworthiness of the data (Creswell, 2013; Padgett, 2008)

Qualitative Thematic Analysis

Braun & Clarke (2006) have described thematic analysis as a foundational qualitative method that early career researchers should learn before moving on to more complex qualitative methods. This technique also has been described as an inductive method that researchers may use to develop thematic categories from observations or data (Guest, et al., 2011). Thematic analysis can be used with a wide array of qualitative data types that include interviews, written text, or any other form of verbal dialogue (Braun & Clarke, 2006; Guest et al., 2011).

Thematic analysis is a qualitative method that can be broken into sequential steps that allow the user to distill large quantities of qualitative data into clearly defined themes (Braun & Clarke, 2006; Castleberry & Nolen, 2018). Braun & Clarke describe these steps as: data familiarization, initial code development, searching for themes, reviewing the themes, labeling the themes, and producing the finalized report. Similarly, Castleberry & Nolen offer steps for thematic analysis, "…compiling, disassembling, reassembling, interpreting, and concluding" (p. 807). These steps were originally developed by Yin (2015), to provide a framework that can be used across different qualitative methods. Castleberry & Nolen offered a model that describes how to use Yin's qualitative framework in applied thematic analysis. Although the two thematic analysis approaches offered differ, they appear to cover similar concepts. For this paper, the researchers utilized the Castleberry & Nolen methodology because of its use of the Yin framework that has been used across qualitative research.

Compiling. Thematic analysis begins with *compiling* the data that has been collected (Castleberry & Nolen, 2018). During this initial compilation, the researchers become intimately familiar with their data set (Braun & Clarke, 2006; Castleberry & Nolen, 2018). This step of research often begins with multiple readings of the data. The first stage of these readings is often done during transcription of data into word processing software (Castleberry & Nolen, 2018). It is also likely that a level of familiarization occurred during the data collection process (Braun & Clarke, 2006). This stage of analysis also helps the researcher to organize their data into a useable format for later analysis. During the compiling stage, the researcher must make decisions such as whether or not to have the data transcribed by a third-party or software or to do transcription themselves. Those who do transcription themselves will spend more time with the data than those who use transcription services. Those who use transcription services may have to spend additional time familiarizing themselves with the dataset before disassembling and coding the data (Castleberry & Nolen, 2018). For this study, the researcher utilized a digital transcription service. The researcher then reviewed each transcription while listening to the original recordings of the interviews to check for accuracy. This practice was done to preserve the familiarization that occurs during the compiling stage when using outside transcription services.

Disassembling: First-cycle coding. The next step of thematic analysis is called *disassembling* (Castleberry & Nolen, 2018). During data disassembly, the researchers began the initial coding processes. Saldaña (2016), describes a code as "…a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data" (p. 4). Coding labels were assigned to sections of the data (usually sentences, groups of words, or small paragraphs) in order to label or organize those

sections of the data (Castleberry & Nolen, 2018). For the purpose of this study, MAXQDA software was utilized to assist in the coding process (VERBI Software, 2019).

In this study, disassembly began with a process known as first-cycle coding, which included open coding and in-vivo coding. Open coding was used in the beginning of the coding process in which the researchers reviewed the transcribed interview and added codes to small sections of text (usually groups of words or sentences) (Saldaña, 2016). Open coding can be done using descriptive labels (called descriptive coding) or using in-vivo coding, that uses labels directly from participant's words to preserve participant voice during data analysis (Saldaña, 2016). Saldaña describes in-vivo coding as a flexible method that can be used in a variety of qualitative research to honor the voice and perspectives of the research subjects. This study prioritized using in-vivo codes, but also utilized descriptive codes when they appeared to offer a more appropriate label. Also, the researchers utilized intercoder reliability to attempt to increase the trustworthiness of the data (Creswell, 2013). Once the transcripts had been coded, the researchers were ready to move towards thematic development (Castleberry & Nolen, 2018; Saldaña, 2016)

Reassembling: Thematic development, and focused coding. In the next step of thematic analysis, the researchers began *reassembling* the data into useable themes (Castleberry & Nolen, 2018). The process of sorting data into themes, or categories, is also called thematic development, or theming the data (Padgett, 2008: Saldaña, 2016). At this point in the thematic analysis, the researchers developed a hierarchy of themes that may be called higher-order themes and sub-themes (Castleberry & Nolen, 2018; Saldaña, 2016). This helps the researcher determine whether data components stand on their own as separate categories or if they are sub-categories of other themes. For example, in this project the researcher developed the theme "connecting,"

which included the subthemes of “connecting with others,” “connecting with self,” and “connecting with nature/creation.” In this project, the researchers prioritized using in-vivo language drawn from participant interviews to name the categories and honor participant perspectives.

After thematic development, the researcher utilized a second-cycle coding technique called focused coding to organize the codes into thematic categories (Saldaña, 2016). Saldaña describes focused coding as a technique that fits particularly well with thematic analysis because it lends itself to categorical development. However, he also cautions that many times codes may overlap between categories and fit into multiple places. Focused coding also provides an opportunity for the researcher to begin to assess the frequencies of codes that correlate with specific themes (Padgett, 2008). This provided the researchers with insight into which themes had a stronger presence in the data. As the final coding method applied, focused coding leads the researcher to begin the process of interpreting the data further. Intercoder reliability was calculated during focused coding to help reach consensus about which codes are associated with which themes.

Interpreting. In the next step of thematic analysis, the researcher interpreted the data to make sense of the information that they collected and organized in previous steps (Castleberry & Nolen, 2018). Interpretation is the process in which the researcher takes the themes a step further to discuss connections and relationships between the themes and their relationship to the research question (Castleberry & Nolen, 2018). Although interpretation is described as happening after the reassembly stage of thematic analysis, this is actually a process that should occur throughout the research. As the researcher is compiling and organizing their thoughts, they should be making interpretations about the data as they go along. Qualitative memos that are taken during

the earlier stages of the research provide some strong insight into these early interpretations that the researcher should revisit at this point (Birks, Chapman, & Francis, 2008; Padgett, 2008).

Concluding and report development. Concluding is the final step of thematic analysis in which the researcher applies their interpretations of the findings to begin to answer the research questions (Castleberry & Nolen, 2018). Braun & Clarke (2006) describe this as the stage of research in which the research report should be developed and disseminated to the scientific community. During the conclusion step, it is important to maintain transparency about which methodologies led the researchers to make their final conclusions (Braun & Clarke, 2006; Castleberry & Nolen, 2018). It is also important that the researchers frame the contextual factors of how the research was conducted to make it apparent that their qualitative findings may not be generalizable to others (Castleberry & Nolen, 2018). During the concluding stage for this study, the researchers will prepare reports to be disseminated with the scientific and clinical communities in the form of multiple manuscripts, conference presentations, and this completed doctoral dissertation.

Training. For this study, the researcher utilized two trained research assistants to assist in compiling and coding the data. The research assistants were one graduate student at an outside university and one practicing MSW-level clinician. Both research assistants work in the fields of adventure therapy and have conducted previous adventure therapy research. The research assistants were trained by the researchers in the coding methods used by the researchers. They were also utilized to assure intercoder reliability and triangulation between multiple coders.

Strategies to Attempt to Increase Trustworthiness of the Data

In qualitative research multiple threats to the trustworthiness of data include "reactivity, researcher bias, and respondent bias" (Padgett, 2008, p. 187). Creswell (2013) recommends that

qualitative researchers use at least two strategies to attempt to increase the trustworthiness of their data. To increase rigor and reduce risk of threats to data trustworthiness, this study used the following six strategies: researcher reflexivity, memoing, intercoder reliability, triangulation, in-vivo coding, and member checking (Creswell, 2013; Padgett, 2008; Saldaña, 2016).

Reflexivity. Reflexivity means that the qualitative researcher examines their own personal biases, perspectives, and beliefs and then considers the effects that they may have on the research project (Corbin & Strauss, 2008; Creswell, 2013; Padgett, 2008). Although reflexivity includes the epistemological and ontological assumptions outlined previously, it also includes the personal experiences and individual biases that are accumulated over a lifetime (Padgett, 2008). The researcher attempted to make reflexivity more transparent through the use of a personal reflexivity statement (*Appendix E)* and ongoing reflexivity updates in memos written during the qualitative process. Also, the researcher met regularly with their research mentor to discuss reflexivity and bias in the research process.

Memoing. Qualitative researchers acknowledge the impact of the subjective experience and perspectives of the researcher conducting the study (Padgett, 2008). By memoing during the qualitative research process, the researcher used memoing to increase transparency and reflexivity about their subjective research perspectives throughout the project (Birks et al., 2008). This memoing was conducted by recording thoughts and personal reflections on interactions with the research data and the research process from the beginning of the research to the end. Qualitative research acknowledges the effects of the subjective perspectives of those conducting the research (Creswell, 2013; Padgett, 2008). Memoing can provide insight into a researcher's subjective thoughts for those who later utilize the research.

For this study, the researcher kept digital and written research memos by writing short reflections on the research process after any major unit of work (time of more than 1 hour spent conducting research). This form of reflexive memoing was an important part of data analysis because it explored the impact of the researcher's relationship to the subject matter throughout the data analysis portion of the research (Creswell, 2013). Units of work included data collection, analysis, and writing. These reflections were reviewed throughout the research process and before writing and interpretating to increase researcher awareness of the subjective impact of personal research perspectives on research outcomes. These memos also were discussed with the doctoral dissertation chairperson to increase reflection and discussion about subjective research experiences.

Analytic triangulation. Researchers can improve the trustworthiness of the data by using analytic triangulation in which more than one coder assesses the same set of data (Padgett, 2008). In this study, content was coded by the researcher, his doctoral dissertation chair, and two research assistants to encourage analytic triangulation. Additionally, memos were written by the researcher and research assistants during coding to support analytic triangulation. These memos were examined during coding and interpretation to encourage increased reflection on the researcher perspectives throughout the research process.

Multiple coders and intercoder reliability. To try to increase the trustworthiness of the data, the interviews were open-coded by four separate coders. The coders met to discuss emerging themes and discussed the themes they identified until consensus was reached. This led to development of 13 thematic categories. These themes were operationally defined and operational definitions were discussed between the researcher and research assistants. For example, the theme "building resilient kids" was operationalized as any sentence or section of

text that discussed the following components of resilience development: coping skill development, empowerment, autonomy development, learning “to do better in life,” developmental stages, perseverance, overcoming challenges, life skill building, and rehearsal. Next, the researcher and an assistant independently conducted focused coding on two cases to calculate intercoder reliability. Qualitative researchers may use a calculation of agreement between coders to demonstrate rigor in during the coding process of data analysis (Creswell, 2013). Intercoder-reliability was calculated based off of focused coding agreements between a researcher and an assistant on two separate cases. Intercoder agreement was calculated using MAXQDA’s intercoder agreement tool (VERBI Software, 2019). The co-coders were found to agree on coding decisions 83.5% of the time. Once intercoder agreement was calculated, the remainder of the coding was conducted and themes and subthemes were developed.

In-vivo coding. In-vivo coding strives to use verbatim language directly from participants’ interviews to encourage the preservation of participant voice throughout data analysis (Saldaña, 2016). In this study, the researcher attempted to use in-vivo codes to honor and preserve the voice and perspectives of those who were interviewed.

Member-checking. Member-checking can be used to try to increase the trustworthiness of the data by giving those who are interviewed an opportunity to review interview content, make corrections, and add additional comments as needed (Padgett, 2008). Padgett describes that this process also increases dignity and respect for the respondent by validating their perspectives during the research process. For the purpose of this study, member checking was done by verbally reviewing the researcher’s understanding of the interview throughout the interview process and at the conclusion of the interview. For example, the researcher asked a respondent about their education in adventure-based prevention and then repeated their understanding of

their education experience before moving on to the next question. At the end of the interview, the researcher then summarized and paraphrased their understanding of the providers’ answers and asked for confirmation from the provider.

CHAPTER FOUR: RESEARCH FINDINGS

The purpose of this research project was to gather information about what occurs in adventure-based prevention practice by interviewing adventure-based prevention (ABP) providers and program administrators. This study was guided by the following overarching research question and 3 sub-questions: "***How are adventure therapy techniques reportedly used by prevention services providers in adventure-based prevention programs for young people?"***
The three sub-questions were: "***(1) How do adventure therapy prevention providers describe specific interventions that they utilize in their programs?, (2) How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services?, and (3) How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services?"***

The analysis of the data led to the emergence of 13 themes that provide insight into these aspects of ABP practice as reported by this sample of ABP providers (*Table 3.)*. The sub-questions were ordered to first, describe the interventions, next, describe how these interventions integrate ethics, equity, and inclusion, and last, to describe training and evaluation. The author chose to do this because evaluation of ABP services logically occurs following the delivery of these services.

Table 3. Research Question/Sub-Questions and Related Themes

Research Question	Sub-question	Qualitative Themes
How are adventure therapy techniques reportedly used by prevention services providers in adventure-based prevention programs for young people?	*(a) How do adventure therapy prevention providers describe specific interventions that they utilize in their programs?*	1.Engagement 2.Connecting 3. Reflection, processing, and metaphor 4. Building resilient kids: "To do better in life" 5. Program and intervention structure
	(b) How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services?	6. Ethical approaches/ethical challenges 7. Collaboration and oversight 8. Diversity, equity, and inclusion
	(c) How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services?	9. Mentorship 10. Providers' lived experiences leading to adventure-based work 11. Education & training 12. Evaluation 13. Adventure-based prevention research

Themes for Sub-Question One: Interventions

How do adventure therapy prevention providers describe specific interventions that they utilize in their programs? The first sub-question guiding this study was used to seek descriptions of how AT providers use specific interventions in ABP programming with their clients. This questions also sought to learn about specific interventions that providers describe using in their ABP work. Providers were asked to describe their interventions, programming, and their perceptions of how ABP works. Providers responded to these questions by describing the

intervention they used in five thematic categories: engagement; connecting; reflection, processing, and metaphor; building resilient kids: "to do better in life;" and program and intervention structure.

Engagement: "Everyone buys into it voluntarily"

Client engagement. It appears that one of the strongest themes to emerge from this study was engagement. Adventure-based prevention was discussed as a tool for engaging clients in the prevention process by all 21 providers. Many providers described working with young people in non-adventure settings and struggling to get young people to engage in prevention programs. They then described "aha moments" in which they realized that using adventure-based experiential activities led their clients to become excited about participating in these activities. They stated that young people would come find them in the halls at their schools and other service delivery settings to remind them that it was time for adventure group. When speaking of engaging youth, another provider exclaimed, "My gut reaction in the first part of that is, if you're doing prevention work with kids, and you're not using experiential, expressive play or adventure approaches, then you're an idiot. Write that down!"

Some providers spoke of the clients' voluntary participation as a component of engagement. One provider explained that the clients stayed engaged throughout the program because "The clients knew they always had a say in their participation." Similarly, another provider described, "everyone buys into it voluntarily." The providers further elaborated that the clients wanted to do these activities and "became excited" when they knew it was adventure day and they improved their behaviors in other settings so they would not miss the opportunity to participate in ABP activities.

Many providers also spoke of ongoing client engagement after their programs ended. Providers said that young people who participated in their programs would return after the completion of the program to volunteer and stay engaged with their programs. One provider reported, "by the time I was done, a lot of the kids that were in my first groups were the counselors for the programs that I was leading." They also described family members of past participants who would find the facilitator to seek to participate due to the positive experiences described to them. One provider who worked with Indigenous clients described how the entire community became engaged and the ABP program became a "rite of passage" in the community. Multiple providers stated that past program participants now work in their programs or have volunteered to remain engaged years, and even decades, after their program was completed.

Provider engagement. Several providers described the merits of ABP for keeping themselves as providers engaged in this work. One provider explained, "For me, you know, it was a lot more fun…I don't think I could have sat down, you know, for that extended period time…eight hours a day…and just sit there and teach somebody." For example, some other providers described adventure work as "keeping myself" engaged as a helping professional. One provider said that they often "became bored" doing office-based activities and described ABP programming as more fun for both the client and the provider. Many providers described themselves as not being the types of people to work in an office-based setting every day. They described the hands-on, kinesthetic nature of ABP practice as a "tool" for supporting their longevity in this form of prevention practice.

Connecting

Connecting with others. Those interviewed stated that ABP interventions are a tool to encourage interpersonal social connections between program participants and with providers.

Some of the providers who worked in crime prevention programs described using ABP activities to help young people to connect with police officers in a positive fashion. In their program, the young people would do outdoor adventure activities with officers before learning that they were officers. They then described how, in nature, power dynamics change and the young people perceived officers in a less threatening fashion and became “more comfortable” – even seeking officers’ support once they returned to the community.

> We will take seven to eight adjudicated youth…and I will have four to five adults and we're going camping for a week. They don't know anything about the adults. But the adults know everything about the kids for a reason…we go camping and we do horseback and all kinds of stuff. At the end of the week, they're all getting along. They're all kind of high fiving each other and again, but the juveniles don't know that. One was a parole officer. One was a judge.

Providers also described the use of positive group norms such as cooperation and peer support in their ABP practice. “Well, we're building a positive peer group plan that everybody buys into a set of positive norms. It’s kind of magical how it works in a way that they've created a culture of positive behavior.” They continued to describe how the students learn to support each other through challenging activities, such as hiking or mountain biking. They said that the youth encourage and support one another throughout their program.

Another provider described using adventure tokens such as beads or carabiners to foster community and connection between participants. Students who participated in adventure group received one of these items as a token. When they saw other students with the same item, they had “an immediate bond” connecting them as participants in a shared adventure community:

> I was at the mall…and I saw this kid with a carabiner and I asked him where he got his carabiner and he said he was from adventure group. And he was like, "I'm in adventure group! And you're in adventure group! That's cool, right?" So kids were knowing each other in the whole county because they had carabiners.

Similarly, another provider described students becoming more connected to one another because they shared experiences and overcame challenges together while doing ABP activities: "We spent a lot of time using…interactive activities, cooperative activities, to build community what some people would call team building, but really helping the kids see each other a little bit different connect to each other." They elaborated that students connected with peers outside of their friend groups and this led to stronger social cohesion and reduced bullying in the student body.

Connecting with nature and creation. Providers also described clients connecting with nature during ABP programming. They explained how being in nature helped young people to connect with the natural world and reset their sleep and eat cycles to correspond with the daylight cycle. One provider elaborated, "three days camping in nature, it's going to reset our circadian rhythms and things like that. So being in the natural environment, it kind of helps people reset their balances and their regulation." In another example, a provider recalled a client who yelled, "There's a big dog out there!" when the client saw a deer in nature for the first time and became excited by this novel experience to connect with the natural world. The provider explained that the student had never experienced wildlife in natural settings like this and developed a new appreciation for time in natural settings.

Three providers described connections with creation or spirituality as facets of their ABP practice. They described how young people connected with creation, which they described as

"anything outside of themselves." Another provider described how the silence experienced in the program gives the students time to reflect on their spiritual connections and what brought them to this point in their lives. An administrator for a program that works with Indigenous youth described their program as helping young people to connect to traditional tribal spiritual beliefs. They stated that they use a spiritual guide to connect their ABP groups with spiritual protections throughout the course of their wilderness programming. The administrator then provided a story of feeling connected to spiritual protection when the adventure group awoke after a wildfire had burned around their camp in the night while they slept, but left their tents and camp unharmed:

> We went back up there and not a thing was touched, not a tent damaged or anything. You can see where the fire just burned around where we were. And, you know, I don't tell that story very often because people wouldn't believe it unless you were there. And so we've had that sort of protection and spiritual guidance.

Another provider described a spiritual awakening when they were at a low point in life, leading them to do this form of helping work with young people in their community:

> …every step of this program…comes from my own personal brokenness and being face down in a gutter…and asking, if there is a God, I need help…and I had three very real invisible fingers, lift my chin and say I love you and…I asked at that moment who, who you are? And he said, I'm Jesus…and I'm very, very conscious that that was my experience.

Reflection, Processing, and Metaphor

Many providers spoke of the use of reflection, processing, and metaphor as tools to help program participants generalize adventure activities from ABP programming into their lives at home and in their communities. This was often stated as "processing" that is done in a group

circle, or around a campfire, after an activity is completed to reflect upon the day's activities. One provider offered an example of the use of reflection and processing in their programming:

> We debrief everything and reflect on it and try to get them to think about how they will be different now when they go back home, when they come up against a situation before that used to really intimidate them. Now they've got this kind of extra confidence going and they'll deal with it in a different way and get them to talk about how that might look.

Other providers elaborated that they choose activities that might challenge the participants; after they complete the activities, they reflect on what personal skills and strengths that the young people used to overcome the challenges. They explained, "everything we do is couched in very clear metaphor…where the application comes from them rather than from me. So they discover their own life application of what we did. And then it becomes more meaningful." They continued that the young people then think about how those strengths may help them to overcome other challenges at home. Another provider explained that processing involves group conversation with others in the group and the participants are able to share with each other about which skills they used to find success during challenging activities. Another provider explained that students "continue to reflect on this work for years" and many have approached them to discuss their reflections on the impact of the program many years later:

> …a lot of times the prevention effort isn't salient or noticeable in the moment, or even by the time they graduate, but oftentimes, it's five years, 10 years, 15 years, 20 years later, I'll get feedback from the student and they'll say that day that I spent doing that has changed me forever. And I will…always remember that. In fact, it dictates who I am and how I do with my family or how I deal with my people.

Metaphor was described by many providers as a “processing tool” that was used to guide reflections in their programming with young people. Metaphor was explained to be a technique to help clients take the activities they do in ABP programs and apply them to real life situations they encounter later on. One provider described their use of metaphor:

> The activities open up space for people to really connect in ways that's not available in typical education or therapy…creating metaphors that they can use to rewrite the narratives of their life experiences or to apply their technique to the narrative of their life experience.

Another provider stated that they often begin their programs with an archery activity in which the clients shoot at metaphorical goals that they would like to attain in their lives. Other providers described using metaphor after challenge activities, such as rock climbing and white water kayaking. One provider further explained:

> …creating metaphors that they can use to rewrite the narratives of their life experiences or to apply their technique to the narrative of their life experience. So the idea is that we take an activity and we make it relate to a person's problems, a person's needs. So if a person has difficulty…with…opening up, and there's an activity where they have to open up…there are metaphors…and I believe the left side of the brain and so it bypasses that conscious resistance that happens in the logical side of our brain. And the person is able to, you know, the same habits, the same behaviors that have always happened are going to appear. But there's suddenly an opportunity, with the support of the adventure therapist, to rewrite that ending and to change the behavior and to see you know, and then after the fact, there is the opportunity for reflection or testimony.”

Building Resilient Kids: "To Do Better in Life"

Most of the providers interviewed described different ways in which their programming led to "building resilient kids." They offered a number of components of their ABP practice that they described as related to developing resilience. These concepts included, "developing coping skills," "developing empathy," "social skills," "empowerment," "matching interventions to developmental stages," "perseverance," "self-reliance," "overcoming challenges," and "learning life skills." One provider elaborated on empathy development:

> …develop that authentic empathy and feel it and name…that's what that feeling is right now. And…how to call up that feeling later when you're like, oh, man, I don't really like that kid. But what that other kid is saying to him is like, Okay, and so you know, I don't really like that kid. Anyway. I'm still gonna go tell that other kid "Stop!" because I know I can imagine or I know what that feels like…and that's awful, too. So…giving them the knowledge, trying to teach empathy, and trying to increase motivation to intervene, and then teaching the actual intervention skills.

Many providers described using a neuroscience approach to help young people build resilience. One provider elaborated:

> …neuroscience part about…where you have to regulate, relate, then redirect and then rehearse. That is going to be consistent…every time we do something. We never start with redirection. We always start with regulation. That's one of the primary things of all of our prevention programs is teaching people about regulation, about not just self-regulation, but we co-regulate that this approach led to them teaching regulation skills to help clients that better navigate stressful situations that may occur during experiential activities.

Coping skill development was a key subtheme of building resilient kids that came up in many interviews. One ABP provider offered:

> They developed coping skills. The ability to manage frustration. The ability to experience emotion. Without acting out; and I think the mechanism is that…that we had real live experiences with all of those things. I wasn't just talking with them about developing those skills. I saw those things happen. The population that I worked with didn't have the skills or the ability to talk in abstract about something that had happened a week ago. Like, I got in a fight with my family a week ago and now they're going to come in and talk to me about it in a way that they understand.

Another provider who works with young people who have been diagnosed with cancer described having conversations with participants to understand what coping skills they use in their daily lives and how they work. She reported that they then look to build "thriving skills" to improve coping and use this as a segue into teaching, "…awareness, breathing, meditation, gratitude, and appreciation." Another provider discussed how clients learn to develop frustration tolerance. They explained that students arrive to their program without the skills to overcome stressful situations, but then later are able to share how they worked through stressful activities with support from their peers or by using internal skills they developed in the program.

Program and Intervention Structure

Program and intervention structure was one of the most prolific themes to emerge from this study. Every provider offered descriptions of how they deliver ABP services to clients. This theme included detailed descriptions of specific interventions, how adventure and prevention are blended, program settings, program length, intervention sequencing, intervention matching with clients in the moment, group work, psychoeducation, and guiding theories and models.

“In the moment: Grab bag of activities” Interventions used in ABP programs were described as coming from a “grab bag of activities” that were matched with presenting clients “in the moment.” A number of providers stated, that when picking an activity, they must assess “who showed up” and an appropriate activity is then chosen based upon how the client, or group of clients, is presenting. For example, one ABP provider shared a story of a group that became highly competitive in a basketball activity that they used. To decrease competitiveness and increase collaboration, they made a game in which the ball had to be passed to multiple people before a shot could be taken. They described how this intervention matching shifted the intervention to one that encouraged teamwork among the more competitive clients who presented in session that day.

Many different activities were described in the grab bag of activities that were used in ABP programs. Examples that were shared included adventure activities such as paddle sports, climbing, cycling, hiking/backpacking, meditation, camping, puzzle games, group juggles, cooking, ropes challenge courses, fishing, solo hikes, archery, snow sports, primitive survival skills, and fireside chats. Examples also included more traditional prevention activities such as didactic education about mental health/mental health awareness, mindfulness, and feeling identification. Activities were said to be used in both office-based settings and in nature-based settings. They were also described as being used in groups, family, and individual practice. Providers described choosing activities that best fit both the practice style of the providers and the presenting needs of the client or group.

Theoretical models. ABP providers said that they used a variety of theoretical models to guide their activities and programs. These included restorative justice, neuroscience, the experiential learning cycle, and the experiential wave model. Multiple providers referred to the

experiential wave model, which was described as an adventure specific-model that is used to match the experiential activities chosen to "squigglies" (challenges or difficulties) the client encounters in their outside lives. This model also was described as providing a framework to debrief activities and facilitate post-activity processing. Other providers described using eclectic models that may be chosen based on the individual therapists in their program. They explained that providers arrive with their own skill-set and theories of change. They said the providers were encouraged to integrate their clinical models into the experiential methods used in the ABP organizations. For example, if a provider was trained in cognitive behavioral therapy methodologies, they may use that approach, or if they were trained in psychoeducation, they would use that. However, whichever model they were trained in would be paired with experiential activities.

Program settings. Providers discussed the settings in which they deliver ABP services in each interview. Settings described included public schools, juvenile detention centers, parks, wilderness settings, therapy offices, community centers, challenge courses, and in the community. Also, many of the programs described in the interviews appeared to take place in multiple settings. They would start in an office, school, or community center, but then would later progress to wilderness or nature-based settings for later outings. Some providers stated that they would work with clients to build the outdoor adventure skills needed for longer activities in off-site settings later in the programming. Some providers said that their programs occurred in permanent therapy offices or centers to which the clients would come. Other providers described taking the services to their clients at their schools, in community halls, or in their homes. One provider explained that the interventions he used were "setting dependent" and stated that he

would do high ropes activities at the challenge course but could use games that involve string and small objects in schools.

Program sequence. Most ABP providers offered descriptions of an intentional intervention sequence that they used to structure activities throughout their programming. Sequencing appeared to be described in two ways: 1) the sequence that each session follows and 2) the sequence of interventions throughout the length of their program. Most providers explained that the sequence of activities in individual sessions begins with some kind of check-in or ice breaker activity to assess "who showed up." Next, providers discussed doing intentional, post-activity processing and discussion; this included the use of metaphors to help clients apply lessons from the activities to their lives outside of session. For example, a client may be guided to draw a metaphorical connection between communication difficulties during a group challenge activity and difficulties they have in school with their peers. Last, some providers stated that they would give assignments in which clients would complete additional activities between sessions. For example, one provider said they would ask clients to go on nature hikes with their families and practice describing what they noticed on hikes. This homework was described as being used to help them generalize skills developed in ABP to their lives at home.

Providers also shared ways that they would sequence interventions throughout their program. One provider described their session sequence:

> So then when we talk about sequence, we really do follow the adventure wave model… from the early 2000s, about "Where are we starting?" "And where are we ending?" So there's always…an introduction and a contract setting set of agreements that happen, then there is, "where are we trying to get to by the end of our time today?" whatever that is,

> knowing that how we meet today may be different than how we meet tomorrow or how we meet over the weekend or on a spring break trip.

One provider described selecting activities in their ABP groups to follow stages of group development, including “forming, norming, and storming.” Providers said that early sessions were focused on using activities to both set goals and build trust and relationships among participants. One provider said that they focus on “safety and, you know, enjoyment, effective communication, trust, all the adventure beliefs.” They then described moving into more challenging adventure activities that required collaboration. This is where many of the group activities would occur in which participants were described as learning adventure skills. They also explained that many activities would build up to a longer adventure activity later in their program, such as a long canoe expedition, a trip to go rock climbing outdoors, or a backpacking challenge. These culmination trips were described as often finishing with “homecoming celebrations” that celebrated the participants’ success and led to planned program termination.

Themes for Sub-Question Two: Ethics, Equity, and Inclusion

How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services? The second research question was used to inquire about how ABP providers deliver services in an ethical and equitable fashion. Three themes emerged from the research data that were related to the second sub-question: ethical approaches/ethical challenges, collaborating/coordination/integration, and diversity.

Ethical Approaches and Challenges

Professional and organizational ethics. When discussing their ethical approaches, providers commonly referred to professional codes of ethics that they reportedly used in their practice. These included professional codes for social workers, counselors, police officers,

recreational therapists, psychologists, physicians, and teachers/educators. One program administrator described their approach:

> So each individual provider has to follow the ethics of their professional background. So social workers do *National Association of Social Workers*, counselors do *American Counseling Association*, if we had a psychologist, we do *American Psychological Association*, and marriage and family therapists do the *American Marriage and Family Therapy Association*.

Providers also shared that they follow ethical guidelines that are established in rules of the organizations in which they work. This included statements about ethical standards in schools, hospitals, and youth serving organizations. One provider explained, “I work within a high school. So then I've got the Department of Education and their ethical framework, which I have to work under, and I run my programs as part of the school excursion.” These ethics also included local laws and standards about mandatory abuse reporting for their professions. “We’re all mandated reporters, you know, and would report accordingly.”

Some providers also described professional guidelines used in adventure therapy practice. These included guidelines from the Therapeutic Adventure Professionals Group (TAPG), a subgroup of the Association of Experiential Education (AEE) and the Australian Activity Standards. They explained that these guidelines were developed to guide ethical practice in adventure-based programming. They described how they applied these ethical guidelines for best practice in adventure therapy and in their ABP practice.

Ethical practice to protect clients and to protect the natural world. Adventure-based prevention standards for ethical practice appeared to fall into two categories, those designed to protect the client and their systems and those to protect the outdoor environments in which they

practice. One provider talked about having to juggle both ethical categories and described applying counseling ethics, such as confidentiality while working with young people, but also explained that they must prioritize conservation and taking care of the environments they visit. A few providers mentioned following *Leave No Trace* environmental stewardship guidelines in their practice. One provider volunteered an anecdote about taking young people to parks and focusing on both confidentiality and keeping kids from damaging the environment by carving their names into things or leaving litter on the ground. They explained, “But then also, there's ethics said, when we go into state parks, and kids want to start carving into tables, right? So that those kinds of things so there's the ethics of taking care of nature while we're out there.”

Confidentiality was one of the most common subthemes to emerge among discussions of client protection. One provider described their approach to managing confidentiality in public spaces:

> …on a kayaking trip, there was one (a guide) out there that was there using the same river the same time that we were, and they started to come…question me as the guest. They saw me as the authority figure there….”So hey, are you guys contributing to like, fees and public parks? And are you doing all this stuff?” And it's not really a conversation I could have with him there. It's something I declared with the San Antonio River Authority. But…I can't tell that other outfitter, No, we're nonprofit. We're doing counseling sessions here. So it's not the kind of stuff that we can do right.

Some providers spoke of taking “additional precautions” to assure that client identity was protected in natural spaces that are open to the public. One ABP provider described prearranging a confidentiality “memorandum of understanding” with organizations, such as a climbing gym or canoe livery, where they take clients to assure confidentiality is maintained. They described that

confidentiality is much different in ABP settings where services are delivered in parks or other places where they may run into other members of the community.

Another common theme for ethical practice with clients was client safety, or risk management. One provider stated, "definitely risk management is there, you know, how to keep them safe. Yeah…I should have mentioned that with the ethics, a huge part is risk management." Providers discussed different strategies for risk management that included timing for specific activities, program protocols for client safety, how to manage higher risk clients in the outdoors, instructor/client ratios, and emergency response training.

Some providers described other client ethical considerations, including informed consent (voluntary participation) from clients, parents, and partner organizations, clinical supervision, trauma-informed practice, access to treatment, mandatory abuse reporting, crisis response protocols, and a commitment to social justice/restorative justice. One provider elaborated on informed consent in their ABP program:

> …multiple levels of informed consent, the district knew, the school knew, the parents knew. And then the kids knew. So when we talked to the kids, we would explain what kinds of things we would be doing. And…getting them what to expect. And that looks different if we were doing a classroom day, or the ropes course day. So we definitely would give them different…intros to what was about to happen, but then even within a program day, you know, we always give them informed consent before each activity. So explaining, hey, in this activity, we're going to do this and you might have to hold somebody's hand or we're going to we're going to be, you know, doing this activity and you will have to be on belay on a team belay for, you know, this length of time so really helping them know what was about happen. Because, you know, sometimes we treat kids

like kids more than we should, you know, we should give them information and trust them.

Ethical challenges. Qualitative data included many descriptions of ethical challenges that providers stated they had encountered in their practice and programs. Some areas discussed as ethical challenges and ethical practice had a great deal of crossover, so they were combined into one theme. For example, some people discussed confidentiality as both an ethical challenge and an important part of ethical practice.

Access challenges were some of the most common ethical challenges described in the interviews. Access challenges were described as being related to resources, such as insufficient funding, leading to a lack of programming for young people who need it. One provider described ongoing political advocacy to increase access; "this is so important to me that I annually go to the legislators…to talk about adventure, and why it's important for the health of our communities and for people and why we need to do this for both prevention and as an intervention." Many providers described the need for increased funding streams to support prevention services for young people.

Other ethical challenges that were described by providers included "staff microaggressions," "prevention funding," "our biggest challenge was confidentiality," "barriers to participation," and "access to mental health resources." One program administrator described the ethical challenges associated with a lack of funding: "were finding…our funding is 97% private and only 3% government."

Collaboration and oversight: "When an elder speaks, you listen."

During interviews, providers shared their experiences working with communities, organizations, and with stakeholders to implement their ABP programs through collaborative

efforts. These experiences of collaboration and oversight were described by providers as seeking guidance and oversight from multiple sources that included community/tribal elders, spiritual leaders, institutional review boards, organizational administration, and clients' parents. They described receiving this guidance on topics such as program structure, evaluation and research, intervention activities, risk management, food, clothing, and cultural expectations. One provider described oversight they received:

> The elders drilled into us…they have these grandfather teachings….I think we met with the elders two months before our first trip was to go out. And so we…had the program designed and when we met with the elder group in the in the community. They say, "you have to instill the grandfather teachings into the program."... It's wisdom, love, respect, bravery, honesty, humility, truth. But the one that was most important, they felt for this trip, was respect. And they wanted the youth to respect themselves, respect the land, respect the trees, respect others. So that became sort of something that, in our training, we kept in mind because, when an elder speaks you, you listen.

In one example of community oversight, a program administrator described working with tribal leaders in a native-serving organization to use program evaluations:

> We needed to get approval from chief and council. So we had a motion supporting the project from chief and council. And they referred us to the health committee in the community. So we presented to the health committee in a project and the health committee reinforced that we needed a research advisory committee. So I would say the ethical guide guidance mostly came from that advisory committee...one of the early meetings, I learned that, that measures of dysfunction, the higher score more dysfunctional the youth is, so you want to lower scores at the end of the experience. And,

> I learned that we needed to be viewing this program in a positive light, now, nothing negative. So we, we immediately chucked out any potential measure that had any measure of dysfunction in it at all. So I would say that would be an example of that committee sort of advising in an ethical way about how to measure.

They described how they were able to use collaboration and oversight to choose and develop "more appropriate measures" that were informed by community cultural perspectives.

In another example, a school social worker shared an experience with elementary children who would participate in a weekly ABP program:

> I'm working with elementary school-aged kids, that their participation and engagement in adventure diminished. And when I made the observation that I thought, well, people were seeming to not show up for group and, and fully engage in their response to us. You know, we're a school with uniforms and our group happens on Wednesday. And when we engage in our adventure on Wednesday, our uniforms are dirty at the end of the day, because we're sweating, we're crawling, we're doing all the stuff, and then parents are getting angry at us because they have to do an extra wash and we don't have the money to do the extra wash. And once we realized this, we brought a whole bunch of clothes, they became the adventure clothes. So when kids would come to the group, they change to their adventure clothes, we would engage in all our crawling, and minefield, and swinging, and getting dirty. And then at the end of group, they take off those shirts brought back their uniforms, and their parents stopped complaining about laundry and the kids started showing up again.

They described how, by using oversight and input from parents, they were able to increase parents' buy-in and improve program participation.

Diversity

Diversity was a consistent theme that was discussed in every interview. Diversity included many subthemes, including racial/cultural diversity of clients and staff, Indigenous culture, gender/sexual diversity, socioeconomic status, lived experiences, different abilities, challenges to diversity, and using culture/diversity to inform ABP practice. Providers shared experiences and perspectives about diversity in their programming and practice throughout their interviews. There were specific questions related to these areas; however, these topics also emerged in other parts of the interviews when they were not prompted by the questionnaire. Although most content related to diversity appeared to demonstrate an understanding of diversity, equity, and inclusion, some comments appeared to be insensitive and contain microaggressions.

Diversity of clients and staff. Most providers described their experiences with diversity in their programs that included the diversity of both the clients served and the staff delivering their services. Some providers described working primarily with people of color in their programs. Others described serving primarily White clients. Most commonly, providers described serving client populations that were representative of the demographics of the communities in which they practiced. Most providers shared other aspects of their diverse clientele, including groups specifically for LGBTQ identified clients, clients experiencing homelessness, refugee clients, and clients with differing levels of physical abilities.

Some providers also discussed the diversity of their providers and staff. A common theme when discussing staff was that ABP providers were often from more privileged groups than their clientele. One program administrator described their recruitment:

> And it was very difficult as we know, looking at the demographics of those in adventure therapy work, administering, you know, there's definitely a skewed demographic there as

> well as some of the other prevention programs like the prevention programs with the queer youth and the adult queer folks really trying to have, also,…people of color, for sure, having transgender individuals, having queer people as staff, running those programs, was also really, really important as much as possible.

Other providers also described challenges in recruiting people of color to work in their programs. They explained that their programs actively work to recruit a diverse staff that is representative of the clients they serve. One elaborated, "And we've been working to hire more diverse staff in this field. That's always been a challenge for me." One program administrator shared how they recruit past program participants in order to build a diverse workforce that is more representative of the racial, cultural, and geographic demographics of their clientele. A number of providers discussed using extensive training on diversity, equity, and inclusion to prepare their staff to work with clients from different backgrounds. This included in-house diversity training as well as sending staff to outside seminars and courses. One provider described bringing outside restorative justice trainings to their staff. "We'll do a two-week staff training which is really focused on a lot of the things I mentioned before with choice theory, restorative practices, de-escalation." Another provider described how they encourage inclusive practice in their program:

> …we actually have an expectation that staff do their very best to check their own privilege, check their own bias, be aware of their privilege. So if you're coming in as a white staff and you have primarily a group of color, what does that mean? What do you need to do with that? What do you need to look at coming in? What do you need to think about? What do you need to educate yourself on before you do that same thing? I always

> do a session which with every new raft guide, because finding queer raft guides is not the easiest thing to do…

Indigenous culture. Indigenous culture was another component of diversity that was shared in many interviews. Two providers described that their programs work exclusively with Indigenous clients; another provider stated that their program works primarily with Indigenous young people. Many other providers described working with many Indigenous youth, but not exclusively. Providers described working with populations of Indigenous young people that included Native Americans, Canadian First Nations, Australian Indigenous People, Maori youth in New Zealand and Indigenous people in Guam and Hawaii. Providers described building their programs with input from tribal leaders, spiritual leaders, and Indigenous cultural practices. One provider described using storytelling as a key component in their program to fit with local Indigenous approaches to teaching young people. Another provider discussed how diversity, equity, and inclusion is different in Native American cultures and they described Native American approaches to inclusion and acceptance of LGBTQ identified clients. They explained:

> …traditionally a lot of tribes…had traditional roles of gay people…they had a particular role in the culture and they were honored and respected and stuff. So we really try to approach it from that point of view that, you know, the dominant culture may or may not look kindly on those kind of people, but in traditional native cultures, they were respected and honored and had roles to play.

They continued to describe that young people have often internalized homophobia from majority culture, which must be challenged and replaced with Native teachings of acceptance and inclusion.

Challenges, insensitivities, and microaggressions. Although most providers interviewed described working towards improved diversity, equity, and inclusion in their programming, some also made comments that could be considered insensitive or microaggressions. These included comments that overgeneralized LGBTQ identified clients and racial minority clients by describing their cultures and behaviors stereotypically. For example, one White-identified provider described their self-appointed membership in a minority racial demographic due to their affinity for foods that are sometimes stereotypically associated with that culture. In another example, a male-identified participant described that their program does not make accommodations to promote inclusion of those from diverse backgrounds. They said that instead diverse clients grow from adjusting and assimilating into the program's culture and curriculum. Lastly, another participant, who identified as a male, described LGBTQ clients as "men who act more like women and women who act more like men."

Themes for Sub-Question 3: Training and Evaluation

How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services? The third, and final, sub-question was used to gather information about how ABP providers described training and preparation for ABP as well as evaluation and research of their services. Five themes emerged from the data: three were related to training and two were related to evaluation. The training themes were mentorship, providers' lived experiences, and education and training. The evaluation themes were program/outcome evaluations and adventure-based prevention research.

Training

Mentorship. A common theme across about half of the interviews was mentorship in ABP. Providers shared experiences receiving mentorship in their workplaces, in professional

organizations, and from mentors they sought out in the world of ABP practice. Many providers described becoming connected to mentors in the Therapeutic Professionals Adventure Group (TAPG). Providers from across North America often named the same field leaders as the mentors who provided them with the most support. Additionally, some female-identified providers described the importance of receiving mentorship from field leaders who are women. One provider elaborated, “I practiced under amazing professionals. I've had so many mentors. There's so many amazing women in this field.”

Providers detailed important mentorship relationships in their workplaces as well. Some of them described being mentored in specific aspects of ABP such as technical skills in outdoor activities like white water rafting. Others discussed receiving mentorship from clinical supervisors about how to integrate adventure into their clinical practice. Another provider described a reciprocal mentoring relationship with a peer with whom he bonded. He spoke of forming a strong bond with mentoring support that allowed them to both pioneer and experiment with new ABP interventions as co-mentors.

Providers’ lived experiences leading to adventure-based work. Every person that was interviewed spoke about their lived experiences, outside of formal education, that directed them toward work in ABP. Experiences that were shared included time working and participating in outdoor camps, adventure recreation, volunteering, and working in the social services and related fields. Many providers shared anecdotes about how their experiences as a young person in outdoor and adventure settings influenced them to seek employment in this field. One provider stated:

> For me personally, …I grew up in the rain forest, on acreage, had the rainforest in my backyard. So just knowing how amazing that was for me as a child…that spontaneous

> interaction with flora and fauna that you just can't replicate anywhere. And just knowing how good it was. So…I've got that bias and wanting to probably, a little bit selfishly…to do a job that…I got to do that and got paid for it.

Other providers shared their experiences working in similar fields and using these experiences to get connected to ABP. For example:

> So I came became part of that team as a volunteer, because I was a professional whitewater rafting guide…and that kind of opened my eyes to this whole new world of adventure therapy work. And so kind of based on those experiences, I decided that's what I wanted to do for a career. And so then I went and got my master's in community counseling to get my license.

Another person stated, "I came into the field of equine work, which led to the greater field of adventure…there's a lot of transfer between the two." Also, many providers spoke of experiences in summer camp programs, or outdoor adventure activities when they were children. They described how these lived experiences encouraged them to seek careers doing similar work with young people.

Education and training. Providers described a variety of educational and training paths to ABP when discussing their preparation to do ABP work. Many shared their experiences receiving more general education in the helping professions, such as a master's degree in social work or counseling, and then later getting training in specific activities used in adventure programming. Some providers also said that they were trained as outdoor educators first and learned the therapeutic skills on the job. Others described attending programs that were designed to prepare providers for adventure therapy-related fields. Programs described included those at University of New Hampshire, Prescott College, University of Michigan, and unspecified

colleges and trade schools. Some providers also shared seeking outside skills to support this work, including yoga/meditation instructor training, martial arts instructor training, and specialized training to instruct adventure activities such as climbing, hiking, rafting, and ropes and course facilitation.

Those interviewed also shared seeking training for risk management and wilderness medicine to respond to emergencies in remote settings. These included specialized training such as wilderness first responders (WFR) and wilderness first aid (WFA). One provider even described seeking volunteers and employees having specialized medical training, such as physicians and nurses, to support clients with specific medical needs in the field.

In addition to outside training, some ABP providers described trainings offered in their place of employment or organization. One shared:

> We do monthly group trainings, two-and-a-half-hours at a time every month that everybody attends, and they are always experientially led. So we're not doing PowerPoints. Now, I do often follow up with that secondary learning process of here's an article that I want you to read or…here's an article to read prior to our experience, but primarily, it's afterward. We talked about neuroplasticity, here's the article, please review that, here's a TED talk, please review that…that gets followed up in our individual supervision. So if we had group and we were talking about neuroplasticity, and I asked them to review this TED Talk, their next individual session will bring up the, what was happening for you in that group piece. What did you learn about from the TED talk? How did that influence how you're thinking about that? How does that influence how you're going to teach that?

Many ABP providers described attending professional conferences to receive additional training in ABP techniques. They described attending trainings from The Therapeutic Adventure Professionals Group, The Wilderness Therapy Symposium, and The International Adventure Therapy Conference. They shared how these conferences provided opportunities for learning new adventure-based skills as well as networking with other professionals in their field. Providers described going to these conferences early in their careers and then returning multiple times, often as teachers, to continue to learn and to support the learning of others.

Evaluation/Outcome Assessment

Program/outcome evaluations. Every person interviewed for this study shared methods that they used in their practice or programs to evaluate their ABP work. Many described formal methods that they used such as scales/questionnaires, exit interviews, and academic or community data. One program administrator shared, "So we have some measurement tools of baseline emotional scales and then we're using the ATES: Adventure Therapy Experience Scale, and that's done pre/post and then three months out." Others discussed informal methods that they used that included listening to teachers, youth, and parents, and watching the local news. One school-based worker explained, "…administration…their discipline referrals have decreased. Their attendance in school is increased…things like that, they graduated whereas before they had zero credits. Very…salient simple things that they…will point to all that happens because of this." They even included specific anecdotes of news reports of criminal activities in which they were able to identify clients with whom they have worked. Some providers said that they were funded by grants and that collecting ongoing program data was a stipulation of their grant funding. Others said that they collected data to demonstrate to their organizations' administration that their programming was worthwhile and should continue. One elaborated, "it's

good to evaluate because then it brings credibility to your program, and you can get added resources." A few providers also described wanting to do more evaluation, but being limited by resources and funding, which made these practices challenging.

Those interviewed shared specific scale-based measures that they used in their outcome evaluations. These included resilience scales, well-being scales, mental health scales, The Positive Youth Development Inventory (Arnold, Nott, & Meinhold, 2012), The Adventure Therapy Experience Scale (Russell & Gillis, 2017), and scales that they had developed specific to their programs or organizations. These scales were described as being administered in different ways, including single point measurements, as pre/post measures, and less commonly, longitudinally with clients.

Providers described some positive client outcomes that they witnessed from data collection. One provider shared experiences measuring suicide data while working in schools that were identified as facing a high level of suicide risk. They reported that in this five-year program across five schools, they had zero suicides:

> We did a five-year project. We had zero suicides…some of the outcomes from that project were that there was a dramatic improvement in the relationship between the community and the police because we were collaborating with the…police on this. And then also there was a dramatic decrease in juvenile crime and arrests and zero suicide attempts.

Another ABP provider described monitoring bullying data in their school program and finding a reduced rate of bullying incidents in students who had participated in their program. Another provider described seeing reduced rates of juvenile justice involvement in those who had participated in their program.

Adventure-based prevention research. About a third of those interviewed for this study shared ways in which they also participate in ABP research. Some providers described doing their own data collection and research report development. While other providers described working with groups that included the Outdoor Behavioral Healthcare Research Collaborative and the National Association of Therapeutic Schools and Programs who analyze and publish findings from their data. Two providers also described working with large, federally funded projects to share their data with scientists and healthcare professionals. Other providers shared their experiences doing ABP research while completing graduate degrees in the field. Providers described quantitative outcome studies, qualitative research on participant experiences, and mixed methods reports. Many providers also spoke of the need for increased research in the field of ABP to demonstrate the effectiveness of this type of work.

CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

This chapter includes: (a) how the findings appear to answer the research question and sub-questions; (b) the extent that the findings seem to align or not align with the qualitative research sensitizing constructs drawn from *risk and resiliency theory*; (c) the extent that the findings *compare and contrast with key literature* about prevention-based adventure therapy; (d) *new prevention-based adventure therapy findings* drawn from this study; (e) *implications and recommendations* for practice, policy, research, and social work education; (f) *study limitations* and *strengths*; and (g) a study *summary*.

This study used qualitative applied thematic analysis techniques as described by Castleberry & Nolen (2018). This research was informed by theory and sensitizing constructs rooted in risk and resilience theories (Masten, 2014; Rutter, 1993). The study data were drawn from 21 interviews (with one 3-person group interview) with 23 ABP providers, scholars, and program administrators. Each of these interviews were transcribed, coded, , and analyzed to develop themes to provide insight and information that may answer the research question and sub-questions.

The over-arching research question that guided this study was: "***How are adventure therapy techniques reportedly used by prevention services providers in adventure-based prevention programs for young people?"*** The three sub-questions were: "***(1) How do adventure therapy prevention providers describe specific interventions that they utilize in their programs?, (2) How do adventure therapy prevention providers describe how they integrate ethics, equity, and inclusion into their adventure-based prevention services?, and (3) How do adventure therapy prevention providers describe training and evaluation in their adventure-based prevention services?"***

How Findings May Answer the Research Questions

This study offers the practice perspectives of 23 individuals who have worked within the field of ABP. These perspectives were summarized in 13 themes that provide insight into work done across ABP programs. Interview participants described trying to prevent behavioral health challenges in young people who face increased levels of risk. These programs are intended to prevent a variety of behavioral health conditions, including mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm. Providers reported working with people from an array of groups, including general populations, racial/ethnic minorities, LGBTQ identified youth, Indigenous youth, youth with refugee statuses, and those experiencing homelessness.

The 13 themes that identified how these programs may serve at-risk young people included five themes about how ABP providers' described specific interventions; three themes about how ABP providers integrate ethics, equity and inclusion into their practice; and five themes about how ABP providers utilize training and evaluation in their practice (*Table 3*). The five themes about specific **interventions** were, "engagement;" "connecting;" "reflection, processing, and metaphor;" "building resilient kids: to do better in life;" and "program and intervention structure." The three themes about **ethics, equity, and inclusion** were "ethical approaches/ethical challenges;" "collaboration and oversight;" and "diversity." The five themes about **training and evaluation** were "mentorship;" "providers' lived experiences leading to adventure-based work;" "education and training;" "evaluation;" and "adventure-based prevention research." Certainly, the recommendations offered herein can be applied to this sample of ABP providers. However, they cannot be generalized to the wider population of all ABP service providers. Additionally, if the findings from of this study were to be supported with similar

findings in subsequent, rigorous studies, with representative sampling, the data may offer the field new insights into how ABP interventions are delivered, how providers integrate ethics, equity, and inclusion, and how they utilize training and evaluation in their programming. The findings from this study should be considered a starting point in working toward developing subsequent studies.

Alignment with Risk and Resilience Theory

Risk and resilience theory offers descriptions of how exposure to high levels of biopsychosocial childhood adversity may lead to the development of future mental health conditions and how resiliency-promoting supports may buffer the effects of adversity (Greene, 2013; Masten, 2014; Rutter, 1987, 1993; Zimmerman, 2013). Risk and resilience theorists and adventure therapy researchers have described how ABP may help to increase resilience in young people by teaching them coping skills to use when they encounter challenge and adversity (Booth & Neill, 2017; Ungar, Dumond, & McDonald, 2005). They describe the development of resilience as an ongoing process that is supported through activities and events that encourage healthy psychosocial development in young people. The findings from this study offer insight and information about how ABP providers described delivering services that may promote resilience against behavioral health challenges in young people.

The findings from this study appear to align with risk and resilience theory, first providers described offering targeted ABP services to young people who faced increased levels of adversity and risks for behavioral health disorders. Providers said that their clients experienced risks that included exposure to substance abuse, exposure to community violence, poverty, homelessness, severe physical illnesses, systemic racism, and gang involvement. They also described offering services to young people in the general population that were designed to

combat common behavioral health risks that included bullying, substance abuse, suicide, and mental illness.

Next, the providers described how their programs may be used to increase resilience and reduce risks in young people. Mechanisms that the providers described to support resilience included youth coping skill development, autonomy development, life skill development, social skills acquisition, empowerment, perseverance, and rehearsal. Providers also described prescriptively matching ABP interventions to the developmental stages of clients to help promote healthy development. They also explained how participation in their programs helped clients learn how to overcome challenges and utilize social supports when facing increased levels of adversity. Providers also detailed how their services targeted resilience by empowering youth. An example of youth empowerment came from a provider who described celebrating the culture of Indigenous clients throughout the course of their program. Providers offered examples of activities that promoted resilience through social skills acquisition when young people collaborated with their peers to solve complex problems during challenge activities (such as completing a high-ropes obstacle course activity or planning a multi-day canoe expedition). Providers also explained how their programs reduced exposure to adversity by encouraging young people to stay "out of trouble" so they could participate in adventure activities. They described how the prevention-based adventure therapy programs provided young people respite from risky environments such as time spent on the streets by taking them into the natural world with supportive adults for ABP programming. They also described facilitating adventure and challenge activities in parks and locations in the community close to their clients. Additionally, the term building resilient kids: "To do better in life" was an in-vivo theme that emerged from the actual words of those interviewed. In this theme, providers described ways in which their

programming supported the development of resilience in young people that they served. This theme is explored further under *specific interventions.*

How Themes Compare and Contrast with Key Literature

It is important to position this work within what is currently known about ABP practice by comparing these findings to key selected literature from ABP and AT literature. In this section, key findings are compared and contrasted with knowledge from this literature base. This alignment is organized by the themes emerging from the interviews.

Sub-Question One: Specific Interventions

"Engagement: Everyone buys into it voluntarily." The findings from this study may build upon previous adventure therapy literature that has described adventure programming as a useful tool to engage young people in mental health services (Bowen et al., 2016 Tucker, 2009; Tucker, Norton, Itin, Hobson, & Alvarez, 2016). This research expands upon previous discussions of adventure as a tool for engagement by also discussing its merits for encouraging engagement of *providers* in this work. It also is the first study found by the researcher to document descriptions of how ABP may lead to long-term engagement of clients who reportedly returned to participate in programs as staff and volunteers later in their lives.

The findings of this study related to engagement contrast with findings from one form of adventure therapy, wilderness therapy. Scholars have described these programs as involuntary treatments that young people are forcefully taken to by secure-transportation services (Dobud, 2019; Mooney & Leighton, 2019; Pfaffendorf, 2019; Tucker et al., 2016). In contrast, many of the providers interviewed in this study described young people as being actively engaged and choosing to participate in ABP programming. They discussed the importance of informed consent and young people's desire to participate in ABP programming.

Connecting. The data collected from this study align with previous literature that described adventure-based prevention as a tool for youth connecting with others, including peers, mentors, and supportive adults (Beightol et al., 2012; Ritchie et al., 2014). It also aligns with literature that discussed connections with the natural world that are facilitated through the use of nature-based programming and therapies (Annerstedt, & Wahrborg, 2011; Pretty et al., 2005; Townsend & Weerasuriya, 2010). An important implication of this finding is that ABP may be a good fit for clients who have trouble connecting with providers in other forms of prevention programming. It may also be useful to help clients foster connections with the natural world. Connecting with nature might be useful for young people who have limited access to mental health resources but live near natural areas or parks. This could include young people in underserved rural areas or those who reside near urban parks. These young people may benefit from prevention programming that includes the use of these natural areas that are in their communities.

Reflection, processing, and metaphor. The adventure therapy literature frequently refers to reflection, processing, and metaphor as therapeutic tools utilized in practice (Alvarez & Stauffer, 2001; Dobud & Harper, 2018; Gass et al., 2012, Russell & Gillis, 2017). Adventure-based prevention programs also have discussed the use of reflection, processing, and metaphor in their practice (Beightol et al., 2012; Carter et al., 2007; Ritchie et al., 2014; Sveen & Denholm, 1998). The findings of this study support the notion from previous literature that reflection, processing, and metaphor are tools from AT that are described as commonly utilized in ABP practice.

Providers offered descriptions of reflection, processing, and metaphor as ingredients that may encourage resilience in young people participating in in ABP programs. Providers described

young people in ABP programs participating in activities and experiences in which they overcome challenges to succeed (such as going through a challenge course or navigating a wilderness trail). They also described how youth ABP participants were able to use reflection, processing, and metaphor to generalize learning experiences during ABP programing to challenges in their lives outside of the program. For example, the ABP providers who participated in interviews said that young people who completed an ABP challenge cooperatively oftentimes reflected upon on how they used social support from peers or adults to work through challenging situations, such as a high ropes course activity. Providers explained how this reflection process may help program participants to reflect on the need to use similar skills when encountering new challenges in their home and community environments. Reflection, processing, and metaphor were described as cornerstones of ABP practice.

Building resilient kids: "To do better in life." The activities and programming described by the providers in this study had many conceptual crossovers with resilience-promoting buffers described by risk and resilience theorists. These activities included coping skill development, autonomy development, social skills acquisition, supportive relationships with peers and adults, empowerment, perseverance, challenge activities, life skills activities, and rehearsal (Greene, 2013; Masten, 2014; Rutter, 1987, 1993; Zimmerman, 2013). Additionally, providers described helping young people to increase their resilience by connecting with the natural world, which was consistent with literature from eco and nature-based therapies that encourage connections with the natural world (Davis, 2011; Roszak et al., 1995; Scull, 2008; Townsend & Weerasuriya, 2010). Ecotherapy providers have detailed the importance of building increased connections with the natural world to help clients improve their overall mental health (Roszak et al., 1995). Providers described how they facilitated connections with the natural world by delivering

programming in wilderness settings away from electronics and lights so that their clients could become more in-tune with the natural environment. This research offers insight into how prevention programs and ABP programs may use experiential activities to offer situations in which young people could strengthen their developmental resiliencies. For example, many providers described models in which young ABP participants overcame difficult challenges, such as going through a challenge course or climbing a rock wall, with support and input from adults and peers. This may offer a model for rehearsing the use of youth social supports to overcome challenges in a safe and supportive environment.

Program and intervention structure. A small collection of examples of ABP programming were found in the current research literature (Beightol et al., 2012; Carter et al., 2007; Ritchie et al., 2014; Sveen & Denholm, 1998). These included school-based anti-bullying curricula (Beightol et al., 2012), mental illness and suicide prevention programs for Indigenous youth (Carter et al., 2007; Ritchie et al., 2014), and criminal justice involvement prevention for Australian teens (Sveen & Denholm, 1998). These programs described using activities that included canoeing, rock climbing, wilderness expeditions, challenge courses, social skills curricula, psychoeducation, and cultural learning to prevent behavioral health challenges in the young people involved. Similarly, those interviewed in this study described a similar mixture of adventure activities, psychoeducation/education, and skill development.

Previous literature describes programs that delivered in a mixture of wilderness settings, such as expeditions (Ritchie et al., 2014), as well as in urban locations such as schools or community centers (Beightol et al., 2012). The findings from this study fit with these blended locations. Programs were described as being delivered in wilderness settings such as the peaks of Rocky Mountain National Park or the Australian Bush. They also were described as taking place

in urban locations such as Michigan's Detroit metropolitan area or San Antonio, Texas. An important implication of this research is demonstrating that ABP interventions are reportedly done in an array of locations that include wilderness, rural, suburban, and urban areas. Descriptions of programming and interventions from interviews had many similarities with previous literature, but also added new perspectives and program types that were not previously described.

Sub-question 2: Integrating ethics, equity, and inclusion

Ethical approaches/ethical challenges. Although scholars have described ethical practice in prevention science (Sloboda & Petras, 2014) and in adventure therapy (Gass et al., 2012; Harper 2017; Tucker & Norton, 2013), no literature was found that offered in-depth descriptions of ethical approaches used in ABP work. This study offers insight into how some ABP providers describe their perceptions of ethical practice in their programs. The study also offers descriptions of ethical challenges that providers described encountering in their ABP programs.

Collaboration and oversight. Many ABP practices in this study were described to be within organizations such as schools, community centers, tribal governments, and social services agencies. Providers shared the importance of building their ABP practice with collaboration and oversight from community partners, tribal elders, administration, and families. This is consistent with previous literature that discusses seeking input from tribal government and community when developing interventions (Ritchie et al., 2014). However, there is limited literature describing this phenomena further in ABP practice.

Diversity, equity, and inclusion. Adventure therapy has repeatedly been critiqued in the research literature for a failure to deliver services that are culturally informed and inclusive of marginalized groups (Gray, 2016; Hoffert, 2008; Karoff et al., 2018; Mitten, 1994; Orren &

Werner, 2007; Whittington & Mack, 2010). However, in contrast, most of the providers in this project described ways that they were working to adjust their approach to increase diversity, equity, and inclusion in their programs. These included descriptions of diversity, equity, and inclusion trainings in programs and attempts to hire a more diverse staff. Although those interviewed in this study were mostly White-identified (69.75%), there were also providers who identified as queer, indigenous, people of color, and/or Latinx. Additionally, almost half (43.48%) of the sample identified as female. Although this was not a representative sample, this may demonstrate that some programs in ABP are now being offered and developed by those from more diverse backgrounds.

It is also important to describe the contrasting findings on diversity, equity, and inclusion contained within this study. Some interviews contained examples of stereotyped beliefs, insensitive language, and microaggressions toward racial minorities and LGBTQ identified clients. These emerged when some providers described their work on diversity, equity, and inclusion. This demonstrates that ABP providers and programs may still have work to do toward making their services more equitable and inclusive. This work should be considered an ongoing journey that should be built into the framework of staff and program development in ABP. Also, these contrasting findings highlight a need to do increased research on diversity, equity, and inclusion in ABP practice to better understand these phenomena in this field.

Sub-question 3: Training and Evaluation in ABP

Education, training, & mentorship. No research literature was found describing the educational and training paths to becoming an ABP provider. This appears to be a major gap in the research literature on both AT and ABP practice. These findings offer some introductory information about the educational paths that some providers may take before working in this

field. A common path that was described across interviews was early lived experiences in the outdoors, undergraduate training in outdoor education or social sciences, a graduate degree in outdoor education, a therapeutic field (social work, counseling, psychology), and then further mentorship and informal training after graduate school. These paths also included seeking outside training and certification in wilderness skills such as a wilderness first responder or training to guide clients on rivers, rock walls, and in technical outdoor environments. Some providers also described enrolling in programs that offer specialties in adventure therapies or nature-based therapies.

Many of the people interviewed shared their experiences of developing adventure-based programs before they knew this field formally existed. Providers described seeking training and guidance on the job, which led them to connecting with other providers. This finding may provide insight and guidance for those who are interested in working in this field, or already working in this field, that were not able to access university training in ABP. These findings may highlight the importance of offering additional education and training to those who are early in their careers providing adventure-based services.

Evaluation. Adventure therapy has been described in the literature as needing to move toward the use of ongoing data collection and routine outcome monitoring to assess the effectiveness of services (Bowen & Neill, 2013; Dobud, Cavanaugh, & Harper, 2020). An early study found that less than 1% of programs collect outcome data (Neill, 2003). However, a surprising finding of this study is that *all* ABP providers who were interviewed described using some form of outcome evaluation. Since ABP has a relatively small research literature, it is possible that this subfield of AT may be more effective in its use of ongoing evaluation tools than other parts of AT. However, it is also possible that not enough is known about evaluation in

ABP practice to understand the field's use of evaluation tools. It is also possible that these findings could be related to social desirability bias and overreporting of outcome monitoring. It is also possible that this finding is due to this select sample using increased levels of outcome monitoring. More research is needed to understand how the entire field of ABP utilizes evaluation.

Providers also offered some insight into ways that those delivering ABP services can evaluate their programs. They described how they utilized standardized scales, academic outcomes of clients, observational data, qualitative reports from young people and adults in their lives (such as parents and guardians), and community-wide data from where their clients reside. Client outcomes were described as a reduced rate of suicides, a reduction in bullying behaviors, and improved performance in schools. Community-wide data included a described reduction in community crime levels. Standardized scales that were described included the Adventure Therapy Experience Scale (Russell & Gillis, 2017) and the Youth-Outcome Questionnaire (Wells et al., 1996). This finding provides insight into how researchers, and others, who are interested in ABP outcomes may be able to further evaluate ABP interventions.

Adventure-based prevention research. Prior to this study, only a small amount of research into ABP programs was found in the literature (Beightol et al., 2012; Carter et al., 2007; Ritchie et al., 2014; Sveen & Denholm, 2007). However, approximately one third of providers who were interviewed described engaging in some form of research data collection in their programs. Many providers described working on research in their programs in partnership with organizations that included the Outdoor Behavioral Healthcare Research Cooperative (OBHRC) and the National Association of Therapeutic Schools and Programs (NATSAP). In these organizations, mental health researchers at universities work with interdisciplinary research

teams to support research across the field of AT (Outdoor Behavioral Healthcare Center, 2018). This demonstrates that there may be opportunities for programs that are not currently engaged in research to partner with others, to share their program data witin ABP research studies. The findings of this shared research could support the development of a stronger body of knowledge about how ABP programs work and their client and program outcomes. It may also lead to further recognition of ABP as a distinct sub-field of AT and prevention.

New Adventure-Based Prevention Findings Drawn from this Study

What happens in adventure-based prevention practice. This is the first known study to describe how ABP practice is conducted, as described by multiple providers. This finding is important because it helps to identify many ways that providers have described combining adventure therapy and prevention practice. A common aspect of this finding is providers describing how they have facilitated a variety of adventure activities, described as the “grab bag of activities,” and how they applied these activities therapeutically through the guidance of a model such as *the experiential wave* (Lung et al., 2008). The described activities included hiking, camping, primitive skills (such as fire building), paddle sports, archery, games, and challenge course activities. These activities were described as being matched to the clients’ presenting needs to promote the development of resilience. This also included a description of how ABP activities were intentionally sequenced by providers.

Ethics, equity, and inclusion in adventure-based prevention. An important finding of this study is that ethical practice in ABP is described by providers as including two primary components: a) ethical practice towards clients and b) conservation ethics while practicing in the natural world. This is consistent with TAPG’s guidelines for ethical practice for adventure professionals (AEE, 2019). Some providers stated the need to follow clearly described guidelines

from the helping professions, such as the National Association of Social Worker's *Code of Ethics* (NASW, 2017), as well as following ethical guidelines to protect natural areas such as *Leave No Trace* principles (Griffin, 2004). The NASW code provides clarity and guidance in how social workers should practice ethically in regard to topics such as client confidentiality, dual relationships, and promoting social justice (NASW, 2017). *Leave No Trace* principles provide guidance on how to protect natural spaces and minimize human impact in the wilderness. As ABP and AT continue to grow during a time of increased challenges from both climate change and complex social justice issues, it will benefit the profession to utilize both sets of principles.

Another promising finding from this research was that *every* participant interviewed shared ways in which they integrated diversity, equity, and inclusion into their practices. This may demonstrate that some ABP practices are heeding the call to move adventure practices away from the White, male-centric paradigms of the past. The providers interviewed offered advice that they described may help improve ABP practice in this regard. This included hiring a diverse staff that is more representative of their clientele, creating spaces where these topics can be discussed in their practice, challenging microaggressions of clients and staff, and encouraging providers and staff to "check their privilege."

Pathway to adventure-based prevention practice. The literature on AT and ABP does not appear to contain much information on how to become a provider in the fields of AT and ABP. This study offers information from providers about their pathways to ABP practice. These findings likely will be helpful for both ABP and general AT providers as most providers work in both the greater AT field and the more specialized arena of ABP. The most important aspect of these findings may be how most providers described using a combination of lived experiences in

the outdoors, university education in the helping professions, mentorship from other providers, and conference-based learning to build their knowledge and experience. Another important component of this is how many providers described finding their pathway to work in ABP by attending the TAPG conference and developing a network of adventure professionals. A key takeaway from this finding is that it may illuminate a pathway for aspiring providers to plan their training in ABP.

Outcome evaluations in adventure-based prevention. A surprising finding from this study was the frequency with which providers described using outcome evaluation in their ABP practice. A recent paper criticized the field of AT for limited use of routine outcome monitoring in its practice (Dobud, Cavanaugh, & Harper, 2020). However, in this study, every provider described some form of outcome evaluation that they have utilized in their ABP practice. The use of evaluation strategies included informal feedback from clients and staff, standardized scales, such as the Adventure Therapy Experience Scale, (Russell & Gillis, 2017), and measures of success such as academic outcomes, reduced instances of bullying, or a reduction in suicides. It is possible that ABP providers have developed ways to engage in ongoing evaluation of their programs that could be shared so as to increase their data informed practices across particular forms of adventure practice. It is also possible that there is outcome data from these programs that could be further analyzed and used to develop new research on the efficacy of various ABP programs.

Implications and Recommendations: Practice, Policy, Research, and Education

This study offers important introductory findings about ABP based upon this sample of ABP providers. This provides a starting point from which the field of ABP may start to be

understood. These implications and recommendations should be considered in the context of this sample, and future work that is more representative should also be pursued.

Social work practice. The findings from this study may offer a starting point for those developing ABP programs to inform their practice with perspectives from providers who reportedly practiced in the field of ABP. This may also be helpful to non-adventure prevention programs whose staff may wish to infuse experiential activities into their work. Areas that may be of particular interest are the descriptions of how providers from different programs conduct their practice, evaluate their work, and try to assure their practice is done in an ethical fashion.

Interventions. Providers interviewed for this study shared descriptions of the practices that they have used across their ABP programs. These practices include having knowledge and training in a "grab bag of activities" that can be matched to their clients "in the moment" during ABP practice. Those interviewed explained that ABP providers should be ready to use a number of interventions that can include group challenge activities, ropes course activities, outdoor sports (mountain biking, climbing, hiking, paddling, etc.), and games to engage their clients in prevention content. They explained that these activities can be used to match the presenting needs of their clients by encouraging social skills, personal reflection, perseverance, and teaching life skills. These activities also should be planned to fit within the available practice environment. For example, a nature hike may be used by a provider near a park or wooded space while an activity such as ball-passing game may be more fitting for an urban school-based program. This "grab bag" was described as being paired with a model such as *The Experiential Wave* that describes how providers can match adventure interventions to a client's life challenges (Lung et al., 2008). Although the activities can be selected and changed during the session, using

a consistent model, such as *The Experiential Wave*, provides consistency that could help ABP providers evaluate their outcomes to move toward an evidence-based practice.

Recommendation number one is that providers and programs should work to identify both their grab bag of activities and the theoretical model that they use to implement them. An array of unique adventure-based activities were described by providers. It could become easy to get lost in this sea of interventions. It could be beneficial for ABP providers to begin to clearly identify which activities are chosen, the reasons they are selected, and how the selections are guided by theory. These descriptions could help to advance ABP knowledge and provide guidance to new providers while they are first exploring ABP interventions. This also could contribute to future manualized interventions that could be used in the development of ABP evidence-based practices.

Community collaboration and oversight. Providers interviewed in this project described ways in which they said their programming was improved through the use of community collaboration and oversight. In consideration of these findings, those developing ABP programs may consider collaborating with community stakeholders for oversight in their programming. By integrating this oversight and the perspectives of community stakeholders, ABP programs may be able to better integrate *community perspectives* and *client/family voice* into their work.

Evaluation. An important practice implication described in the data was the need to evaluate ABP programming. Every participant described different forms of evaluation they used in their practice or programs. The practice of ABP evaluation was described as useful in communicating the effectiveness of this intervention style to organizational administration, funders, and the clients participating in programming. Evaluation data also were described as useful in subsequent outcome evaluation research.

Subjects who reported conducting evaluation also described partnerships with researchers and outside evaluators from organizations such as The Outdoor Behavioral Healthcare Research Cooperative, The National Institute of Mental Health, and various research partners from universities and grant administrators. *Recommendation number two* is that those engaged in ABP programming should strive to follow this lead and develop and implement strategies to evaluate their programming. Evaluation of ABP could also be strengthened by adopting strategies from *feedback informed treatment* to continuously monitor client outcomes engaged in ABP services (Dobud et al., 2020). These strategies could be supported through developing relationships with organizations, such as OBH, that can help them with evaluation of their practice and programs. This could help to improve their practice and understanding of the impact of their ABP programming.

Ethics. Most providers described receiving ethical guidance on how to conduct ABP practice from sources that include professional boards and organizations (such as the National Association of Social Workers), adventure therapy communities (such as the Therapeutic Adventure Professionals Group), and their agencies. This is consistent with adventure therapy literature that encourages adventure providers to seek ethical guidance from both their profession's code of ethics and those of adventure therapists offered by the TAPG (Gass et al., 2012: Tucker & Norton, 2013). Findings from this study demonstrate that ABP providers consult these ethical guidelines to support their practice similarly to those who offer other forms of adventure therapy services.

Providers reported challenges they encountered, such as client confidentiality, when running prevention groups in public spaces. The National Association of Social Workers mandates that providers must protect client confidentiality when delivering services (NASW,

2017). Some providers described being mistaken for outdoor recreation groups and having people in parks demand permits. They had to juggle their responsibilities of protecting client confidentiality while offering mental health services in public areas. Other providers described establishing agreements with guide companies and recreation facilities to assure the protection of confidentiality during their practice. This research offers information for providers and program developers to consider related to ethical challenges as well as the solutions offered by ABP providers. ABP providers described navigating ethical challenges successfully by seeking guidance from their profession's code, engaging in best practice standards set by the TAPG, and by consulting with qualified mentors.

Recommendation number three is that ABP providers should be prepared to use both their profession's code of ethics as well as the ethical guidelines of the TAPG to provide the support necessary to navigate the ethical challenges that they may encounter in their ABP practice. Also, ABP organizations should clearly describe the ethical standards that they follow and describe how they support their providers to assure that they practice in an ethical manner.

Social work education, training, & mentorship. Providers interviewed in this study reported a variety of different paths to becoming trained to provide ABP services. These findings that demonstrate an array of paths to AT and ABP offer two primary takeaways: (a) there are multiple ways to become a proficient ABP provider; and (b) there is a need for increased access to professional preparation to provide adventure-based services. One of these that was described as under development is an adventure therapy certification program offered through the TAPG.

Important implications for education are highlighting the often unclear path for people who are interested in pursuing a career in ABP. Prospective ABP providers may attend one of the few social work programs that offer specialized graduate education in adventure therapy. As only

three of these programs are known to exist in the U.S., access to this education may be a challenge for many social work students. These programs are known to be offered at University of New Hampshire, the University of Michigan, and Texas State University. Also, other graduate programs in adventure therapy that are outside of social work are offered at Naropa University and Prescott College. These programs may offer opportunities for current social workers who desire to go back to school and learn skills specific to ABP, or the greater field of AT. Other pathways to preparation as an ABP provider included seeking training in either outdoor education and being trained on the job as a prevention provider or seeking education in the helping professions and then seeking additional training in outdoor adventure activities. A key component of this outside training was attending professional conferences, such as those offered by TAPG and NATSAP. Providers described the importance of developing mentoring relationships with more experienced providers while at these conferences to further develop skills.

Another implication that may be important for social workers seeking education and training in ABP is the possibility of future certification as an adventure therapist. A few people interviewed described a certification program that is being developed through TAPG and AEE. They described this as a certification to demonstrate competency as an adventure therapy provider. Details related to this certification were limited, as it was described as still in development. If this certification is developed, it may provide another training pathway for those pursuing a career in ABP.

Recommendation number four is for both social work educators and schools of social work to increase student access to formal education and mentorship in ABP and AT. Social work educators should consider conducting internal needs assessments to evaluate the level of student

interest at their schools in education for adventure modalities. Based upon student interest, programs to train AT and ABP providers should be developed. These programs could be supported by seeking consultation from academic programs such as University of Michigan, University of New Hampshire, and Texas State University that already have models in place. Programs could offer electives in adventure modalities or they could consider developing graduate certificates to demonstrate preparedness for this work in their students. These programs also could include a mentorship component whereby students interested in adventure modalities could be connected with seasoned providers for guidance. Social work programs should also work on building relationships with ABP and AT providers to have available field placements opportunities for students with interests in these areas. This would create learning opportunities for students interested in these modalities, even if the school does not have resources to offer its own programming. Social work programs may also consider adding continuing education units (CEUs) to teach providers in their areas about adventure-based interventions. These CEUs could be crafted collaboratively with field experts from organizations such as the TAPG, NATSAP, and OBH to include their expertise.

Recommendation number five is for licensed clinical social workers, and other providers, who specialize in ABP to offer formalized mentorship and supervision to providers who are interested in ABP. Pre-licensure social workers may struggle to find licensed social workers to provide supervision in this specialized area. Those interested in offering these services may consider engaging in outreach to organizations such as TAPG, as well as ABP providers in their area. It is likely that building a stronger network of supervisors having experience providing ABP services will lead to improved training for new ABP providers.

Recommendation number six is for early career social workers who are interested in the fields of ABP and AT to attend conferences hosted by organizations such as TAPG and NATSAP. Providers widely touted TAPG as instrumental in their development in their careers in ABP. They described these conferences as places to learn about the field and meet a large number of practicing peers. They also described opportunities to meet field leaders and build mentoring relationships within these organizations. It is possible that early career social workers will benefit similarly from attending these conferences.

Policy needs and recommendations. Two of the biggest challenges described by ABP providers in this study are limited funding for ABP programs and insufficient access to ABP services for clients. Overall, AT is a young field. Furthermore, ABP is a newer form of AT and appears to have much less research. Many providers described finding funding to maintain their programs as an ongoing challenge. Additionally, providers described prevention funding overall as being challenging to access. It appears that greater funding is needed, especially for prevention of behavioral health disorders. Research participants also described limited access to ABP interventions for many clients. They described waiting lists for services and an inability to serve all of the clients who were interested in their services. This may be related to a lack of funding, providers, and/or ABP programs.

Recommendation number seven is that policy advocacy is done to promote increased funding of experiential, adventure-based interventions in prevention practice. This policy advocacy should be for federal and state grants to develop and support ABP services. It should also include advocacy for public and private mental health insurance providers to pay for ABP services that may not have previously been covered. Supports for strengthening funding of ABP services would include widely disseminating the benefits of the services and developing

additional evidence-based practices (EBPs) in ABP. The need for EBPs is described further in research implications and recommendations.

Recommendation number eight is that policy advocacy is done to encourage the development of new ABP programs in geographic areas that do not currently have access to these services. This policy work could focus on large urban centers, such as Detroit, MI where young people may not have access to activities in nature. It can also focus on underserved rural and remote locations, such as Michigan's Upper Peninsula, that have limited service providers but have close access to nature and wilderness areas. Creatively developed ABP programming could bring nature to urban clientele with park walks, summer camp programs, gardening programs, and other forms of nature-based curricula. Additionally, policy could be written to provide opportunities for ABP programs to be developed within schools and other publicly-funded service settings in underserved areas. In order to staff these programs, partnerships could be developed with organizations such as the TAPG and universities, such as University of Michigan, University of New Hampshire, and Texas State University to refer job-seeking social workers to work in these underserved areas.

Recommendations for future research. This study offers an overview of the work being done by many ABP service providers. This study should find itself positioned next to other introductory works that describe ABP programming (Beightol et al., 2012; Carter et al., 2007; Epstein, 2004; Neill & Dias, 2001; Ritchie et al., 2014). This is the first known study to offer a descriptive overview of multiple programs and providers across the field of ABP. This study could provide a starting point for additional research describing ABP programs as a distinct form of AT services that can support young people who face increased risks of behavioral health challenges. *Recommendation number nine* is that future research should be conducted to further

describe ABP services and to evaluate the effectiveness of these services. This research should include qualitative studies to capture participant voice and build theory. It should also include quantitative studies to understand how ABP may lead to short and long-term changes in participants.

Youth and family voice qualitative research. *Recommendation number ten* is that future research in ABP should include more qualitative studies that provide additional insights into this work from the perspectives of clients and their families. This research should focus on capturing youth and family voice about the merits and challenges of using adventure activities in prevention programs. Research into prevention programs should include the voices of young people describing their experiences of overcoming adversity and challenge (Gladstone, Boydell, & McKeever, 2006). This study offered providers' perspectives of how these programs may help young people. However, it is recommended that future research provide descriptions from young people and their families outlining their perspectives about participating in ABP programming. This research should be empowerment-based and focused on listening to the perspectives of the most disenfranchised clients who participate in ABP services. Future qualitative research should also include the use of methods that aim to develop theory describing how and why ABP works. Methodologies such as *grounded theory* could be beneficial in helping ABP providers develop theory that describes the mechanics of ABP practice

Diverse perspectives. *Recommendation number eleven* is that future research on ABP must include the perspectives of both clients and providers from diverse backgrounds. This should include people from countries whose first languages are not English, those who are racial and ethnic minorities, LGBTQ identified people, female-identified people, and marginalized individuals. During interviews, many ABP providers also described the need to increase diversity

in this field. Researchers should strive to conduct research that captures the perspectives of providers from diverse backgrounds describing their experiences working in this field. It should also include interviews with young people from diverse backgrounds describing what it is like to participate in ABP services. Researchers should seek to elicit perspectives about ABP from those outside the dominant culture. Future researchers may identify successful pathways and blind spots that enhance and hinder diversity, equity, and inclusion in the field of ABP.

Quantitative outcome evaluations. *Recommendation number twelve* is that research initiatives in ABP should include more quantitative outcome evaluations of programs that can contribute additional information about the efficacy of this type of intervention. It is recommended that research should include longitudinal studies that follow young people who participated in ABP for an extended period of time to learn what may actually be prevented by participating in ABP programs. Quantitative outcome research also should include randomized controlled trials that compare outcomes of young people in ABP programs to outcomes of both control groups and those who are in more traditional, didactic prevention programs. Outcomes in these studies should be assessed by comparing longitudinal life outcomes that include levels of mental illness, substance abuse, and criminal justice involvement of those in ABP programs to those in control and comparison groups. Additionally, this research should utilize measures such as *The Resilience Scale* to assess if participation in ABP programs leads to measurable changes in levels of resilience in participants (Waginald, 2009). Research should also examine if there are specific factors unique to ABP programming that are most beneficial to participants. Additionally, researchers without the resources to conduct longitudinal studies should consider

Currently, only two evidence-based programs in are known in ABP: Project Venture (Carter et al., 2007) and Adventures in a Caring Community (Beightol et al., 2012). These

programs offer hope that additional EBPs could be developed in ABP with additional research. It is recommended that ABP providers partner with research organizations, such as the Outdoor Behavioral Healthcare Research Cooperative, to work toward developing their curricula into an EBP. To develop these EBPs, ABP programs will need standardized intervention manuals, training materials, common measures to assess participant outcomes (such as the ATES), large representative samples, and eventually, randomized controlled trials. It is also recommended that individual researchers who are interested in AT explore research opportunities in ABP programming to support this segment of the field. Adventure-based prevention research likely will benefit from quantitative outcome research to assess the effectiveness of this type of programming.

Limitations and Strengths of this Study

This study has limitations and strengths. One limitation of this study is the use of a non-random sample of ABP providers. Due to the use of a non-random sample, these findings cannot be generalized to the greater population of all ABP providers. However, the providers in this study were purposively chosen due to their expertise and knowledge in the field of ABP. A purposive sample is considered to be appropriate within exploratory qualitative research (Padgett, 2008). Since those interviewed were all providers and/or administrators of ABP services, they were well-suited to describe activities taking place in the field.

Despite the presence of some diverse perspectives in this sample, the majority of providers reportedly identified as being White (69.75%) and all reportedly identified as cisgender. Additionally, providers in this sample were all English-speakers who reside in North America and Commonwealth nations. Future research should include more providers that are people of color and transgender/non-binary identified persons. However, it is noted that the number of

female-identified persons within the sample was higher than is common in adventure therapy research, with 56.52% male-identified and 43.48% female-identified in comparison to 62% male-identified and 38% female-identified in Bowen and Neill's (2013) meta-analysis of 197 studies and 73.4% male-identified and 23.6% female-identified in Tucker, Smith, & Gass's (2014) database study (n=1058). It is recommended that future research exploring ABP services strive to sample a more diverse array of providers and program participants.

Another sampling limitation is that this study only included the perspectives of ABP providers. It is also important to capture youth and family voice in research about social work interventions. Future research on ABP should include interviews with youth and their families to understand their perspectives of how these treatments work and are delivered. However, a strength of this sample was that these providers represented a large number of program administrators, published researchers, and scholars having a depth of experience in the field of ABP.

Another limitation of this study is the use of self-report data from providers that is not verified by other sources such as observational field notes, healthcare databases, program manuals, case notes, or other source comments/records, e.g., parents, youth participants, educators, or caseworkers from community services agencies - such as child welfare and mental health agencies. Therefore, it could be helpful for future researchers to collect additional types of data. Future researchers should consider going into the field to collect observational data while ABP programs are being conducted. This research also could be supported with future quantitative and mixed-methods research that collects outcome data from ABP programs. However, a strength of this current study is that it contains descriptions of ABP programs as explicated by those administering and delivering them. Future researchers may build on the

knowledge collected by early ABP research studies. Since little currently is known about ABP services, the data drawn from speaking with providers and administrators seems to have offered a good first step in exploring ABP program delivery.

A final strength of this study was the number of methods utilized to increase the rigor of the qualitative data analysis. This study used six strategies to attempt to increase the trustworthiness of the data. These strategies were: researcher reflexivity, memoing, intercoder reliability, triangulation, in-vivo coding, and member checking (Creswell, 2013; Padgett, 2008; Saldaña, 2016). Researchers engaging in the interpretation of textual data must work to reduce the likelihood of biased data analyses. Creswell (2013) recommends qualitative researchers use at least two strategies to attempt to increase the trustworthiness of their data, so six strategies clearly exceeds the expected number of qualitative research trustworthiness strategies.

Summary

This chapter provides a description of the findings from this study as well as the implications for social work practice, policy, education, and research. First, this chapter describes how the findings from this study appeared to answer the research question and the three sub-questions. Next, this chapter offers descriptions of how the findings aligned with risk and resilience theory. This chapter also explores how each of the 13 themes aligned with previous literature on AT and ABP. Following the discussion of alignment, this chapter outlines new findings about ABP that were drawn from this study. This chapter also contained 12 specific recommendations that could be considered for future practice, policy, research, and social work education. For example, this study offers recommendations for mentorship and education for those who are interested in pursuing a career in ABP. Additionally, the recommendations include a call for the development of ABP research to build an understanding of how ABP may help to

reduce risks for vulnerable young people. This chapter finishes with a discussion of limitations and strengths of this study. Strengths include both new findings related to ABP as well as rigorous qualitative methodology. Limitations include a non-generalizable sample and the limitations of self-report data.

This qualitative research study offers introductory information about how ABP providers report conducting their practice. This study was focused on three key areas: how providers report delivering ABP interventions; how they integrate ethics, equity, and inclusion in their practice; and training and evaluation used in ABP practice. This study attempted to answer the research question by conducting an applied thematic analysis of data drawn from semi-structured interviews with purposively-selected ABP providers and administrators (n=23). While not generalizable to the greater population of all ABP providers, the study does target an important knowledge gap and may be useful to guide future research with larger samples, more rigorous designs, and a broader inclusion of stakeholders.

APPENDICES

APPENDIX A

Prevention and Adventure-Based Prevention Terminology

The following definitions of terminology utilized in this paper are offered to increase clarity for the reader.

Adventure-based prevention (ABP): This term is used to describe programs offering services to young people before the onset of a behavioral health condition. These programs aim to increase an individual's resiliency while counteracting risk factors with the hope that they may prevent future behavioral health conditions. These programs can be compared and contrasted to *adventure therapy* programs that are delivered after the onset of a condition. These programs can be considered as a blend of prevention programs and adventure therapy programs.

Adventure therapy (AT) programs: According to Alvarez and Stauffer (2001), "adventure therapy is any intentional, facilitated use of adventure tools and techniques to guide personal change toward desired therapeutic goals" (p. 87). These are programs that integrate experiential challenges, often offered in the outdoors, into mental health and substance abuse treatment. Adventure therapy is offered in many settings including nature parks, schools, therapy offices, challenge courses, and the wilderness. Adventure therapy is an overarching term that includes more specific forms of adventure therapy such as wilderness therapy, outdoor behavioral healthcare, and adventure-based counseling.

Behavioral health conditions: this term refers to risks that include or are related to: mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm, all of which are maladaptive behaviors and/or risk factors that are treated by mental health clinicians. This term encompasses

conditions found in the *Diagnostic and Statistical Manual, 5th ed.* (American Psychiatric Association, 2013) as well as dysfunctional human behaviors that comprise the symptoms of disorders included within.

Internalizing/externalizing behaviors: These are behaviors that are often symptoms of mental health disorders. Internalizing behaviors are common with anxiety disorders or depression and include self-doubt, isolating, catastrophizing, or depressed thoughts. Externalizing behaviors are what people associate with "acting-out" and include physical aggression, impulsivity, blurting out at inappropriate times, and hyperactivity. These behaviors are common associated with disorders such as ADHD but can also be common with depression and PTSD in young people.

Experiential education: "Experiential education is a teaching philosophy that informs many methodologies in which educators purposefully engage with learners in direct experience and focused reflection in order to increase knowledge, develop skills, clarify values, and develop people's capacity to contribute to their communities" (Association of Experiential Education, 2019, para. 1). Experiential education includes all forms of adventure therapy: adventure-based counseling, outdoor behavioral healthcare, and wilderness therapy, as well as: wilderness experience programs, outdoor education, service learning, field education and other forms of learning by doing.

Outdoor behavioral healthcare (OBH): is a type of wilderness therapy program that has undergone strict training and safety certification standards by a third-party accrediting body (Russell, 2003). These programs are evaluated by a research board that strives to use ongoing assessment and evaluation to build an evidence based for their services. The majority of OBH programs are wilderness-based residential treatment programs.

Prevention programs: Prevention programs aim to use techniques and theory from prevention science to prevent the development of human disease or dysfunction. This may include mental illness, physical illness, crime, violence, or other maladies which society would like to prevent. Prevention programs describe within this dissertation are focused on behavioral health promotion and behavioral disorder prevention.

Prevention science: Coie et al., (1993) describe prevention science as, "The goal of prevention science is to prevent or moderate major human dysfunctions… Preventive efforts occur, by definition, before illness is fully manifested, so prevention research is focused primarily on the systematic study of potential precursors of dysfunction or health, called risk factors and protective factors, respectively" (p. 1013).

Psychoeducation: According to Lukens and MacFarlane (2004), "Psychoeducation is a professionally delivered treatment modality that integrates and synergizes psychotherapeutic and educational interventions" (p. 206). This is an evidence-based intervention that combines teaching about mental health with the delivery of interventions that promote psychological well-being.

Risk and resiliency theory: Risk and resilience theories are popular in prevention and adventure-based prevention programs. These theories describe how exposure to high levels of biopsychosocial childhood adversity may lead to the development of future mental health struggles and how resiliency promoting supports may buffer the effects of adversity (Masten, 2014: Rutter, 1993). These theories describe how activities, such as learning to cope by spending time in nature, may provide a buffer against psychological distress that could lead to the future development of a behavioral health condition.

Wilderness experience programs (WEPs): Wilderness experience programs are outdoor education programs that utilize challenge and adventure to teach participants about activities in the outdoors. These programs can be educational, therapeutic, and/or recreational in nature. They are contrasted from adventure therapy in that they do not utilize trained mental health professionals and treatment goals in the delivery of their services. These include programs such as Outward Bound, Girl Scouts, and Boy Scouts.

Wilderness therapy (WT): is type of adventure therapy that is offered in remote outdoor locations. Wilderness therapy utilizes natural settings, group work, natural consequences, and metaphorical processing to drive therapeutic change. This treatment is often provided in group expeditions (Gass et al., 2012: Russell, 2001). Many wilderness therapy programs are long-term residential style programs for youth with severe mental health and or behavioral concerns.

APPENDIX B

Informed Consent and Study Purpose

Informed Consent Form: Michigan State University School of Social Work

Seeking consent for research: You are invited to participate as a **research subject in a study.** I will ask you to engage in about a 45-55 minute interview. The research study focuses on the use of adventure-based prevention techniques in your practice.

Research project purpose: The primary purpose of the project is to learn how adventure therapy techniques are used in prevention programs for young people.

This project aims to develop knowledge about how these programs work and practitioner perspectives of the programs. If you decide to participate, you will be interviewed about your experiences delivering adventure-based prevention programming and/or developing prevention programming using adventure therapy techniques.

Voluntary participation: Your participation in this project is entirely voluntary. You may choose to not participate in the project. You may also choose to not participate in certain parts such as answering specific questions. If at any point in time you decide to discontinue your participation, we will, at your request, remove your responses from our research study.

Benefits: It is possible that you could benefit from sharing your perspectives on the program(s) that you have worked within. This may give you an opportunity to reflect upon your experiences and feel your perspectives have been shared with the greater adventure therapy community. You may also benefit the field of adventure therapy by increasing knowledge about adventure therapy-based prevention programs. There is no financial compensation for participation in the project.

Risks: It is possible that you may experience some discomfort discussing the program(s) you have worked with over your career. Additionally, it is possible, but highly unlikely, that someone, such as your employer or colleagues, may assume your participation in this study based on this research. There could be associated professional consequences if this were to occur. To protect against this risk, all data will be deidentified and changed to protect participant identity.

Confidentiality: Your confidentiality will be protected to the maximum extent of the law. If you participate in the program, data about you will be collected. Any data about you, your program, and/or your clients will be kept strictly confidential. No information shall be released that can identify you or anyone associated with your program. If the information that you provide can identify you or anyone associated with your program, it will be changed to protect confidentiality. Any information about specific individuals or groups will only be shared in an anonymous format.

Limits to confidentiality: One exception to confidentiality includes suspected or actual reports of child abuse or neglect. As social workers and helping professionals we are legally-mandated reporters. This means that we are required by law to report such allegations. Another exception takes place when a person threatens to harm himself, herself, or another person. These incidences must be reported. It is also possible that staff from the Human Research Protection Program of Michigan State University could audit the project files for compliance with ethical research standards. The data will be kept for at least three years after the project closes at MSU.

Contacts: If you, your colleagues, or your supervisors have concerns or questions about this study, such as scientific issues, how to do any part of it, or to report a research-related injury (i.e., physical, psychological, social, financial, or otherwise) please contact the researchers:
Daniel Cavanaugh, LMSW
Graduate Student Researcher
Email: cavana63@msu.edu
Direct Phone: 503-890-2830

Dr. Joanne Riebschleger, Ph.D., MSW
Primary Investigator
School of Social Work
Michigan State University
254 Baker Hall
East Lansing, MI 48823
Email: riebsch1@msu.edu:
Fax: 517-353-3038 (Attn: Daniel C. & Joanne R.)

If you have questions or concerns about your role and rights as a research participant, would like to obtain information or offer input, or would like to register a complaint about this study you may contact anonymously, if you wish:

Human Protection Programs
Michigan State University
4000 Collins Rd., Suite 136,
Lansing, MI 48910
E-mail: irb@msu.edu
Work Phone: 517-355-2180
Fax: 517-432-4503

Please sign below to indicate your voluntarily agreement to participate in the study:

____
(Please print your name)

_______________________________________ ________
Signature/Date

APPENDIX C

Semi-Structured Interview Protocol Questionnaire

Introduction: Thank you for agreeing to participate in this study about adventure-based prevention practice in behavioral health. Adventure-based prevention is a term used to describe programs that use techniques from adventure therapy to increase resilience and prevent the onset of a variety of behavioral health conditions that include or are related to: mental illness, substance abuse, exposure to traumatic events, bullying, criminal justice involvement, internalizing/externalizing behaviors, and suicide/self-harm. I am going to ask you some basic demographic questions followed by 10, open-ended questions about your experiences working in adventure-based prevention programming. I understand that you may have worked in both direct service delivery as well as in program administration. I am interested in hearing both perspectives. Additionally, throughout the interview, I will summarize and repeat my understanding of your responses to help me attempt to record your perspectives more accurately.

Demographics

To begin, I am going to ask you some basic demographics questions to get a better sense of who is represented in my interview sample:

Age:_________________________________

Gender Identity:________________________

Race/Ethnicity:_________________________

Role and Responsibility in Organization:

____

Degree/Field:__________________________

Time Practicing Adventure-Based Prevention:

____

Transition: Next, I will ask a general question just to learn a little bit more about the work activities that you do. After this, I will ask other questions related to programming, evaluation, training, and outcomes.

Warm up question:

Question 1 (Path to Adventure): What led you to work in the fields of adventure therapy, prevention, and adventure-based prevention?

Possible probes:

a. How did you become interested in this work?
b. Please tell me a little bit more about that.
c. What are some examples of that?
d. What did you do before this work?

Transition: For the next question, I am going to ask you about the adventure-based prevention program that you work in or adventure-based prevention programs you have worked in previously. I will be looking to gain an understanding of what your program does and how your program works.

Question 2 (Program: Overview): How would you describe your current adventure-based prevention program or adventure-based prevention programs that you have previously worked in? Also, please give me an overview of the work that you do or have done in this area.

Possible probes:

a. Please describe your adventure-based prevention model.
b. How does this model guide the activities you use?
c. Who do you offer services to?
d. How long are your programs? How many sessions do the clients receive?
e. Please describe the demographics of the clients that you serve in your adventure-based prevention program.
f. Where are your services delivered?
g. Please describe that a little further.
h. Can you provide a case example?

Transition: For our next question, I would like to go a little bit deeper into your specific programming. I would like to learn about the nuts and bolts of the interventions you are offering to your clients and how they are conducted.

Question 3 (Program: Interventions and Techniques): Please describe the adventure interventions, techniques, and theoretical model you and/or your program use in your prevention programming? Also, please describe how activities and interventions are sequenced in your program.

Possible probes:

a. How does your program blend prevention and adventure?
b. Please describe how theory guides the interventions you use?
b. What locations and settings do you do this work in?
c. What materials and equipment do you use with these interventions?
d. What are some examples of specific interventions?
e. How did you pick that intervention? How does it work to encourage prevention?
f. Please describe how these activities encourage resilience in youth.
g. What are some examples of that?

Transition: The next question I ask is going to be about ethical practice in your program. I will ask about your organization's and/or profession's ethics and how they informed the development of the programming that you offered.

Question 4 (Program: Ethical Practice): How do you or your organization assure that the ABP programming that you are offering to clients is being delivered in an ethical manner? Please describe any ethical code or code of conduct that your organization utilizes.

Possible Probes

a. Describe any ways that these ethics have been challenged in your practice.
b. Please describe any oversight offered in your organization to encourage ethical practice.
c. Please tell me a little bit more about that.
d. Please describe that further.

Transition: Next, I will ask you about the mechanisms of how you believe adventure techniques may work in prevention programming for young people. This question will help me to learn how you understand ABP works with the clients you serve.

Question 5 (How ABP Works): How would you describe your perceptions of how your adventure-based programming may prevent future behavioral health challenges in young people?

Possible probes:

a. What are the mechanisms that make that work?
b. What do you believe is prevented by this type of programming?
c. How do your interventions foster prevention in your clients?
d. Please tell me a little bit more about that.
e. Please describe that further.
f. Could you provide a case example?

Transition: The next question will be about how you and your organization evaluate your adventure-based prevention services. Please think about how you evaluate and assess the services that you are delivering.

Question 6 (Evaluation): How do you evaluate the effectiveness of your adventure-based prevention programs?

Possible Probes

a. What outcomes do you measure? How do you measure them? Who do you measure them with?
b. What initial assessments do you use with your clients? How do you assess outside challenges and assets in the young person's systems?
c. How do you measure outcomes? How long do you track outcomes?
d. How else do you determine that your adventure-based prevention services are effective?
e. What do you do with your outcome data?
f. Please tell me a little bit more about that.
g. Please describe that further.

Transition: The next question will help me to learn about your training to provide adventure-based prevention services to your clients. I am interested in learning about education, training, and mentorship that helped you to develop as an adventure therapy provider. I am

also interested in learning anything else you would like to share about your journey to becoming a professional in the world of adventure therapy.

Question 7 (Training/Education): How did you learn to provide adventure-based services?

Possible probes:

a. Where did you receive training in these models?
b. What are the educational requirements of your organization?
c. Please describe any degrees or certificates you have in this type of work?
d. Please describe any mentorship you have in this area.
e. Please describe any additional training in adventure-based prevention that you have received through your organization or in other locations.
f. Please tell me a bit more about that.
g. What are some examples of that?

Transition: We have made it through our evaluation, education, and training section. Our next question will be about the rationale for using adventure-based prevention services in your organization. The next question I will ask is for your perspectives on the pros and cons of using adventure techniques in prevention programming.

Question 8 (Why use ABP?/Pros and Cons): Why did you or your organization decide to blend adventure therapy and prevention services? What are some of the benefits of using adventure techniques in your prevention programming? What are some drawbacks or difficulties?

Possible probes:

a. How do you assess those benefits and/or drawbacks?
b. How is your adventure-based program different from other prevention programs?
c. What do the clients and families describe as most beneficial?
d. What do they describe as the biggest drawback?
e. How did you overcome these barriers?
f. Please describe that a little further.
g. What is an example of that?

Transition: Next I am going to talk about diversity, equity, and inclusion in adventure-based services. I will ask about how your adventure-based programming works with people from an array of different backgrounds.

Question 9 (Diversity, Equity, & Inclusion): What are the demographics of the clients that you serve in your adventure-based prevention program? I am interested in learning about the age, gender, culture, race, and other demographic factors of the clientele you work with.

Possible Probes

a. How have you adapted your program to work with these diverse clientele? Please describe specific adaptations.
a. How do you recruit a diverse clientele?
b. How do you and/or your program increase cultural sensitivity to your clientele?

c. How can this field recruit a more diverse clientele?
d. Please tell me a little bit more about that.
e. Please describe that further.

Transition: The next question is our last. I will be asking if there is anything that we did not cover in our interview that you would like to share.

Cool down question 1:
Question 10 (Closing Question): What else would you like to share? Is there anything we asked about that you would like to discuss further?

Possible Probes
a. Is there anything else that you'd like me to know?
b. Is there anything that you would like to discuss a little further?

Transition: Thank you so much for participating in our interview today. Please contact us if you have any future questions about any aspect of this interview or research project. Take care.

APPENDIX D

Additional Materials

When people responded to me with interest in the study:

Dear ______,

You are invited to participate as a research subject in a study about adventure therapy based prevention services. You will be asked to participate an interview lasting about 45-55 minutes.

The purpose of this project is to learn about your perspectives about the use of adventure therapy services in the delivery of prevention programming to young people (ages 5-25). We want to understand how you, or the programs where you have been employed, have used adventure therapy techniques in prevention programming.

The name of this research project is, "An Exploration of Adventure-Based Prevention Programs for Young People" The primary investigator for this project is Associate Professor Dr. Joanne Riebschleger, PhD. at the Michigan State University School of Social Work. The PhD. student investigator is Daniel Cavanaugh, LMSW a doctoral candidate in the School of Social Work at Michigan State University.

This study will be used to try to further knowledge development of how adventure therapy techniques may be used in prevention service delivery. This data may also be used to gain a greater understanding of what types of prevention programs are being offered by adventure therapy providers across the U.S. The researchers also hope that the knowledge gained from this study may contribute to learning what happens in adventure-based prevention programs including some information about participant outcomes.

If you would like to hear more about this project or are interested in participating in this research, please contact me at cavana63@msu.edu or (503) 890-2830. It would be helpful if you could include days and times that are convenient for an interview.

Thank you for your time,

Daniel Cavanaugh, LMSW

APPENDIX E

Reflexivity Statement

I am a straight-identified, cisgender, able-bodied, White male that was raised by professional parents in an upper middle-class household in the Midwest region of the United States. Additionally, I am college educated and hold a bachelor's degree and master's degree in the behavioral sciences (psychology and social work). These identities and experiences represent positions of privilege that almost certainly lead to biases in both my clinical work and the research process in this project. Additionally, I have developed further biases about mental health practice, research, and knowledge creation that I will attempt to elucidate further.

I am a professional social worker and believe strongly in the dignity and the worth of the clients we serve and of all marginalized people. Due to my work as a social worker, and a social work research, I have developed strong beliefs about the resilience and strength of our clients. I believe that preventative interventions that foster resilience in young people may prevent future negative outcomes (such as mental illness or incarceration). This favorable professional bias towards preventative research may have an effect on the outcomes of my research on this subject matter.

Next, I believe that much of our current research on psychotherapeutic interventions and mental health is overly reductionistic and may miss the importance of individual human perspectives. I operate under an assumption that psychological wellness is constructed within individuals, families, and communities. Due to my postmodern and constructivist leanings, I will most-likely take a critical viewpoint of research that is strongly positivist and does not incorporate post-modern methodologies.

Next, I have work experience as a community mental health clinician providing preventative and intervention-based services to economically disadvantaged young people. I have also worked as a mental health researcher doing research specifically on marginalized young people and their families. Due to these work experiences, I probably look upon these types of interventions in a more positive light. These experiences have led me to subjectively pursue the creation of knowledge that favors programs that I personally believe are helpful to young people and their families.

I am an avid-outdoorsperson and I spend the majority of my recreational time doing activities such as snowboarding, climbing, cycling, hiking, etc. I believe strongly that these experiences have positively favored my personal development and the development of those around me. Also, work in the outdoors and outdoor recreation has been a component of my personal and professional life as long as I can remember. I was a Boy Scout as a child, and later, I became involved with activities such as snowboard club, and competitive skateboarding. I have also worked in ski and snowboard shops and taught private skateboarding and martial arts lessons. Later, I blended this passion and began to integrate adventure therapy techniques into my social work practice in community and school-based mental health. I am now active in professional organizations such as the Therapeutic Adventure Professionals Group, The American Alpine Club, and The Mazamas (a regional climbing club). I am, undoubtedly, an insider in both recreational and therapeutic adventure. My love for these experiences may lead me to view them with rose-colored glasses. Since the research matter that I am studying, adventure-based prevention, often includes these activities, I may, inadvertently, fail to notice negative aspects of this work.

This statement is my attempt to acknowledge these biases and to share them openly so that I may be transparent about sources of my subjectivity. I have almost certainly missed areas of bias that will affect my research. I will continue to evaluate my bias and work to increase my reflexivity throughout this project through reflexive memoing and research supervision.

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