

Outdoor Experiential Therapies: Implications for TR Practice

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The outdoor environment has a long history of being a popular venue for a variety of therapeutic recreation (TR) programs. Its potential to add a unique dimension to practice has been increasingly used by many TR programs. This article provides an overview of the basic theoretical frameworks underlying outdoor experiential therapies (OET), explores related terms (e.g., Adventure Therapy), and discusses some of the implications of including OET into TR programs. Also described are specific benefits of OET, the relationship between OET and TR practice models, types of OET, and emerging trends and issues.

KEY WORDS: *Experiential Activities, Adventure Activities, Outcomes, Conceptual Development, Therapeutic Modality*

The outdoor environment is increasingly being used as a therapeutic setting with many organizations and programs now incorporating a variety of therapeutic modalities in outdoor and wilderness experiences (Kelley, 1993; Roberts, 1988). These modalities have been referred to under a number of terms including adventure therapy, experiential therapy, challenge education, and wilderness therapy. This

article will explore some of the salient features and applications of the therapeutic uses of outdoor experiential settings. We discuss relevant terminology, types of outdoor experiential therapy (OET) programs, the various benefits associated with these programs, and some considerations in incorporating OET activities into therapeutic recreation (TR) programs.

Several assumptions have been made prior

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to this discussion. First, it is believed that this discussion is both timely and relevant to the TR profession as a number of programs utilizing outdoor experiential activities are now embedded in a variety of TR programs. To date, there has been little written about the overall impact of these types of modalities in TR settings (see Austin, 1999; Groff & Dattilo, 2000).

Second, it is readily acknowledged that using experiential activities in outdoor settings is only one of many types of modalities that the therapeutic recreation specialist (TRS) can use effectively. There also are times in which the TRS may find the use of outdoor settings and specific adventure activities to be inappropriate, or not fully effective, depending on the situation and the client population.

The third assumption has to do with the nature of the term "therapy." Historically, many therapeutically-related programs using outdoor settings and activities have served people who have no medically diagnosed disability or functional limitation. Examples of these types of programs might include those serving at-risk youth or adults in transition (e.g., divorce, loss of employment, etc.). As a result, some readers may question the use of the term "therapy" with these types of populations. This criticism is based on the assumption that therapies are limited to a "deficit-reduction" role, and can offer nothing to people seeking to enhance or optimize their leisure functioning or overall health. Another perspective suggests that therapeutic programs can also be used with people to improve functioning or seeking greater physical and/or psychological challenges regardless of the presence or absence of a medically-diagnosed problem. Austin (1999) referred to this as the "actualizing" component of high-level wellness. Similarly, both Gass (1993) and Crisp (1998) have identified a concept in "adventure-based practice" that they termed "enrichment." The basic premise of these types of programs proposing therapy continues to be having a clearly delineated program purpose, goals, assessment, planning, and on-going

evaluation for the population being served. Thus, the assumption made in this paper is that professional therapy programs featuring adventure and/or outdoor activities and utilizing carefully planned assessments and interventions can be used for both the amelioration of a disability or limitation, as well as for the optimization of overall functioning and improved health.

Defining Outdoor Experiential Therapies and Related Terminology

A number of terms have emerged regarding the different types of therapeutic interventions in an outdoor setting (Crisp, 1998). A partial listing of these terms are described as follows:

Adventure Therapy

Adventure therapy frequently utilizes the components of adventure (e.g., real or perceived risk, uncertainty of outcome, and personal decision-making) as part of its curriculum structure. *Adventure therapy* refers to therapeutic interventions that utilize experiential and risk-taking activities, that are both physically and emotionally challenging, and usually involve an outdoor setting. It should be noted, however, that not all adventure therapeutic programs contain significant levels of risk and danger or take place in undeveloped outdoor settings. For example, indoor climbing walls and ropes courses have become an increasingly popular venue for some adventure therapy programs. This point will be discussed in more detail later in this paper.

Crisp (1998) suggested that adventure therapy is effective because it employs the "dis-equilibrium" principle, as described by Nadler and Luckner (1992). That is, clients are faced with novel situations in which they need to develop new ways of thinking and acting. For example, people who use wheelchairs and have no prior experience being lowered down a one-hundred foot cliff, will need to develop ways to deal with this novel situation. This approach emulates the widely ascribed Out-

ward Bound process, as originally described by Walsh and Golins (1976), in which the participant is placed in novel physical and social settings and is encouraged to develop a new set of skills and behavior in order to master the situation.

Wilderness Therapy

Friese (1996) identified over 500 programs that currently operate in the United States and use "wilderness-type" settings for therapeutic purposes. In addition, Cooley (1998) found that over 10,000 adolescents were being served on an annual basis by wilderness therapy programs constituting over 33,000 user days on the public lands and generating over \$60 million in annual revenues. Although wilderness therapy has traditionally been associated with remote and relatively isolated natural settings, Davis-Berman and Berman (1994) suggested that *any* outdoor environment may offer a suitable location for therapeutic applications. Remote areas, in particular, are often more amenable to offering a sense of change from "normal" living.

Crisp (1998) suggested that programs using a wilderness-therapy orientation utilize the concept of "adaptation" or coping with change, either in the individual's social environment or physical setting. Moreover, like adventure therapy, wilderness therapy can involve the use of a residential or base-camp facilities, small group dynamics, and group psychotherapy. Given these components, program outcomes often revolve around personal change and social development.

Outdoor Experiential Therapy

More recently, outdoor experiential therapy (OET) has emerged as an umbrella term that encompasses the different, but related modalities of wilderness therapy and adventure therapy. Inherent in the term, OET, is the implication that this type of therapeutic modality generally utilizes an outdoor setting and direct experience but does not mandate that these types of therapeutic interventions auto-

matically involve adventure (i.e., the deliberate inclusion of risk or danger) or require wilderness-like environments (Ewert, McCormick, & Voight, 1999). For example, taking a group of people who have developmental disabilities on a backpacking trip can precipitate a variety of beneficial outcomes without involving a high degree of risk or using a wilderness-like environment. Within this context, outdoor experiential therapy (OET) is defined in the following way:

A treatment modality which utilizes or emulates an outdoor setting or natural environment for the purposes of rehabilitation, growth, development, and enhancement of a individual's physical, social and psychological well-being through the application of structured activities involving direct experience. (Ewert et al., 1999)

A point in common with all three of the previously described therapy programs is the utilization of "direct experience" for therapeutic interventions. Direct experience involves the components of participant-centered therapy, cognitive dissonance, reality-based outcomes, and assessment and program structure (Gass, 1993; Gillis & Bonney, 1986).

Participant-Centered Therapy. Clients are often required to take action rather than simply serve as spectators. This action is often holistic in the sense of involving physical, social, and cognitive personal resources. Thus, whether it be participation in an adventure-based activity, moving down a quiet trail, or engaging in a group discussion regarding how to accomplish a particular task, the client is exposed to situations in which he or she is encouraged to take some form of personal action in an outdoor setting. In addition, the individual is often faced with a specific challenge such as canoeing across a lake or hiking down a trail.

Cognitive Dissonance. In OET, cognitive dissonance or the discrepancy between two individually-held phenomenon, such as perceived abilities versus anticipated challenges,

is often manifested by such issues as uncertainty of outcome, the need to take risks, and resolving progressively more difficult tasks (Cooper & Fazio, 1984). Usually the underlying purpose of instituting cognitive dissonance in an OET situation is to create opportunities for personal growth, team-building, enhanced communication, and contrast to one's everyday life (see Walsh & Golins, 1976).

Reality-Based Outcomes. In the OET setting, outcomes are often perceived by the client as being "real." That is, if the individual does not perform to a given standard or engage in a behavior that successfully achieves the objective, he or she will often experience direct and immediate consequences (e.g., no supper because the stove wasn't started). Bacon (1983) suggested that these types of programs serve as metaphors for life and as such, allow the participant to learn how to contend with them. Moreover, the challenges and consequences facing the individual are systematically designed to achieve the therapeutic goals of the program. Further, these challenges and consequences are based on the physical and psychological status of the client, the desired therapeutic intentions of the program, and the physical environment in which the program is conducted.

Assessment and Program Structure. Physical activities are not simply "stand-alone" events with little connection to treatment plans or individual needs. Rather, outdoor experiential therapy programs use assessment techniques to link clients' needs with specifically designed physical as well as social activities (Gillis & Bonney, 1986). The therapist is often directly involved with the clients and engaged in the same activities and circumstances as the client. Gass (1993) suggested that this increased accessibility to the therapist, combined with the informal setting, can serve to enhance client/therapist interaction, communication patterns, and levels of "trust." Inherent in these types of programs are the techniques of group facilitation, individual feedback, personal accountability, and individual risk-taking. In addition, OET programs often strive to

increase levels of trust, teach clients how to cope with anxiety and fear, and deal with unpredictable and uncertain outcomes in order to yield specific benefits and enhance personal growth and development (Nadler & Luckner, 1992).

Comparing Attributes of OET and TR

Not surprisingly, there are similarities and contrasts among the various attributes common to both TR and OET. However, a clearer picture may be seen by a direct comparison of these attributes as is depicted in Table 1. First, the two approaches can be compared in terms of the structures within which they are traditionally practiced. OET has historically been a component of agencies whose primary mission is providing outdoor experiences. As a result, these programs have been associated with outdoor centers, camps, and adventure programs.

In contrast, TR has historically been provided through health and human service agencies. As a result, TR typically exists within organizations possessing a complex and hierarchical administrative structure, whereas OET programs have historically been located in agencies with fewer layers of administration. Consequently, TR programs are often more likely to be integrated with other services such as social work or occupational therapy, whereas OET programs continue to be more "stand-alone" and episodic.

Moreover, length of contact in traditional OET programs has tended to be of a longer duration than is commonly seen in TR. Client contact lasting 24 hours per day for one to three weeks is not uncommon in OET programs. As a result, working conditions in OET programs typically require program staff to work non-traditional schedules. Finally, the type of clients served in the two types of programs may differ. Although practice models in therapeutic recreation do not restrict services to any particular population, most therapeutic recreation specialists generally work with clients who have identified or diag-

Table 1.
Attribute Comparison of OET and Therapeutic Recreation

ATTRIBUTE	OET SETTING	TR SETTING
<i>Structure</i>		
<i>Location/Facility/Setting</i>	Outdoor-based Camps/Climbing Walls/ Ropes Courses	Primarily health and human service agencies
<i>Integration with other programs</i>	More typically "stand-alone"	Usually more integration with other therapies
<i>Work Schedule</i>	Longer workday/e.g., 10 days on, 4 days off, etc.	Typically 8 hour workday
<i>Clients</i>	Often clients w/o identified disability; may include youth-at-risk, or other special interest groups	Typically clients with identified disabilities
<i>Duration of client</i>	Often longer duration (e.g., several hours/days or weeks of continuous contact	Typically shorter duration (1-3 hours); usually during workday
<i>Process</i>		
<i>Instructor training</i>	Variety of skills and training needed (e.g., search and rescue, risk management)	CTRS minimum desired qualification
<i>Intervention</i>	Outdoor activity is the primary	Outdoor activities are one modality of a variety of possible modalities
<i>Locus of decision-making</i>	Student/Instructor/Therapist	Client/TRS/Medical Team
<i>Use of Risk</i>	Real and perceived risk used extensively as a learning vehicle	Used less intensively and often with traditional TR interventions

nosed disabilities. In contrast, OET programs often focus their service on clients without identified disabilities, such as individuals desiring a greater ability to work as a member of a group.

In addition to comparisons of structural attributes (e.g., work week, location, clients), process attributes such as staff qualifications can also differ. While training and credentialing in TR is relatively uniform, with a national certification program (NCTRC), OET staff often come from a variety of backgrounds. These may include both "outdoor leadership" train-

ing as well as training in a variety of helping professions such as counseling, psychology, and social work. As a result of this variety, when compared to TR, OET staff do not have a uniform set of education, experiential, and credentialing backgrounds.

Another comparison is seen in terms of the nature of interventions. Typically, OET programs exclusively use outdoor activities, combined with elements of risk and/or challenge as the primary modality. In TR practice, intervention modalities are usually more broadly based, with outdoor activities as only one

treatment approach among many. Consequently, while the elements of physical risk and challenge may be used in TR settings, they are typically not as integral or structurally-central to the treatment approach as they are in OET programs.

Benefits of Outdoor Experiential Therapy

Most benefits associated with OET programs stem from three major behavioral domains: sociological, psychological, and physiological. The following section provides a closer look at these three domains in relationship to participation in outdoor experiential therapy programs.

Social Outcomes

The Group Process. One of the most important components of many OET programs is the "group process" (Gillis, 1998; Schleien, McAvoy, Lais, & Rynders, 1993). Most OET programs will use a group situation as a therapeutic intervention to enhance the learning of specific social skills. It is during a group process that therapeutic interventions may enhance social skills, refine either participant-identified or externally-defined personality issues, and demand expository thinking to solve group problems. In some specific instances, the group process may also be used to redirect socially inappropriate behaviors and expose group members to certain consequences based on a sequential decision-making process. For example, the *Full Value Contract* component of Project Adventure sets specific goals to guide group decisions when confronting difficult tasks or challenges (Schoel, Prouty, & Radcliffe, 1988). "The *Full Value Contract* means that group members agree, in advance, to work together toward group goals, adhere to safety and appropriate group behavioral guidelines, and both give and receive constructive feedback (positive and negative)" (Smith, Austin, & Kennedy, 1996, p. 208).

Adolescents and OET. OET has been particularly effective with emotionally disturbed adolescents, youth offenders, and teenagers with substance abuse problems. As the literature suggests, a vast majority of outdoor experiential programs have been specifically designed for these populations (Davis-Berman & Berman, 1994; Kimball, 1980; Schleien et al., 1993). According to Miles (1993), exaggerated or misguided feelings of inadequacies, worthlessness and lack of self-esteem often lead these individuals to rebel against, or retreat from, society. Adolescents who are not strongly connected to positive role models, often feel they have no significant place or role in society, which may lead to feelings of uselessness (Kimball & Bacon, 1993). Proponents of OET feel that this type of treatment approach can offer an effective modality for adolescents through a process of personal growth and development. Miles (1993) elaborated on this belief in his statement, "The concreteness of challenges posed by wilderness experiences can allow delinquents, who usually fail to meet abstract challenges, to enjoy success and consequent enhancement of self-image and confidence" (p. 54).

In particular, the group process utilized in many OET programs facilitates socially favorable circumstances for group cooperation, team building, group contributions, and leadership. In a study by Witman (1993), helping and assisting others in a group outdoor adventure activity was cited as being the most important to adolescents in treatment. Not surprisingly, one important social benefit derived from the group process commonly used in outdoor experiential programs is the opportunity for positive leadership roles to emerge. For many adolescents, particularly girls, perceptions of a leadership role may not always be regarded as important or even feasible (Witman, 1993). But through OET activities, the opportunities to perform leadership roles in outdoor experiential groups can have a positive impact on self-esteem and self-confidence, especially for females (Levitt, 1994; Humberstone & Lynch, 1991). Women as

leaders and teachers in outdoor settings "generally bring a broader, perhaps more sensitive and democratic approach to the experience" (Humberstone & Lynch, p. 29).

Another important element when working with groups in outdoor activities is the opportunity for individuals to make a positive contribution to the group. Skilled, professional leadership can encourage the recognition of everyone's effort and value to the group (Schoel et al., 1988). When appropriately structured, an OET activity can allow all persons in the group to contribute solutions to problems or to achieve mutual group goals. These goals are frequently very basic, uncomplicated endeavors such as finding shelter, helping cook the evening meal, or providing simple words of encouragement to a frustrated fellow group member. Caution should be taken to eliminate "token" contributions, where, for example, a person with a physical or mental limitation is continually given small or inconsequential tasks to perform. An example of this type of token contribution would be to give a person a lit match to toss on a pre-laid bundle of brush and kindling, and told he or she has now built a fire. Genuine use of a person's "ability," not patronization or presumptions of "disability," is an effective way to ensure a meaningful and productive relationship with group members (Schleien et al., 1993).

The unique challenges presented with group adventure or challenge activities (i.e., initiative tasks, trust activities, etc.) allow the opportunity for participants to establish relationships and earn the respect of fellow group members (Witman, 1993). Many activities cannot be accomplished without cooperation from everyone in the group. Recalcitrant participants often learn to accept that their involvement is essential to completing necessary tasks and accomplishing group goals.

Group Decision-Making and Communication. Two additional benefits associated with OET in a social context are group decision-making and effective communication. During outdoor experiential or group challenge activ-

ities, participants are compelled to learn the art of listening to others. They come to understand that they can offer their *own* opinion toward resolution of the group's problems, but they must also accept that others in the group have convictions to which they must listen and evaluate, as well (Schoel, Prouty, & Radcliff, 1988). Learning to express opinions and propose compromises are parts of a developmental process that plays a pivotal role in effective communication and decision-making within any group situation.

Psychological Outcomes

A fundamental process of self-analysis and introspection will often take place for participants in outdoor experiential therapy activities. The nature of OET activities, such as wilderness trekking or camping, may initially bring about the evocation of long-established coping mechanisms (i.e., retreating, yelling at people, and/or physically fighting with someone). When these familiar, or long-held coping techniques no longer "work" for an individual, because of the challenge, perceived fears, and group dynamics presented by the activity, a change or modification of "old" coping responses and behaviors must occur (Kemp & McCarron, 1998). For example, the individual may subjugate her old coping mechanisms (such as yelling when she wants to eat but is not getting her way) to the needs of other group members (e.g., waiting, without yelling to eat, until everyone is in camp and in shelter). This fundamental shift, from old to new, or modified patterns of behavior, in response to the demands of the OET challenge, often result in significant change and growth for an individual. The following examples briefly describe several psychological benefits that may result from participation in OET.

Positive Impacts for Mental Health. Using outdoor experiential activities may challenge pre-established convictions of personality traits. Participants are often faced with evaluating discrepancies between their *self-concept* and *ideal self*. Positive changes affecting self-esteem, self-confidence, self-determination,

and increased self-efficacy may occur as a result of group accomplishments, reflection upon personal efforts, and contributions to the group's success (Schleien et al., 1993; Tate & Ellis, 1997). Other studies have indicated increased levels of self-actualization and increased perceptions of personal change as a result of participation in an outdoor adventure program (Vogel, 1988/89).

In particular, properly directed therapeutic interventions can help resolve group problems, or personal performance issues, resulting in what may be perceived as "first time" personal achievements. Opportunities for solitude and reflection, not often readily available for many individuals, may also greatly enhance or bestow a more positive self-image. When changes take place in these psychological areas, the individual gains a greater sense of self-control and self-empowerment over his or her world. Several outdoor and/or challenge programs report such findings: Project Pride (New Haven, CT) "brings adventure based learning to the school setting . . . focusing in self awareness, self-esteem and building communication skills" (Davis-Berman & Berman, 1994, p. 96). Working with automobile accident victims, "the Challenge Rehabilitation program teaches clients to trust, to take risks again, and to gain a sense of control over their world . . . engaging in activities which serve to enhance their self-confidence, and problem solving abilities . . ." (Davis-Berman & Berman, p. 99).

Shifting Locus of Control. Internal versus external focus of control refers to the predisposition of an individual to have or *not* have control over the events that transpire in his or her life (Iso-Ahola, 1980). Internal locus of control (or stable attributions) refers to a person's belief that he/she controls the events in his or her life, good or bad. Persons with an external locus of control (or unstable attributions) believe the events in their lives occur due to luck, fate, or chance, whether they are good or bad outcomes. Several outdoor experiential activities, as well as some therapeutic recreation programs, utilize specific therapeutic

interventions (i.e., group decision-making, cognitive retraining) to help redirect external, unstable attributions, or locus of control, toward more stable, internal attributions (Dieser & Voight, 1998). Davis-Berman & Berman (1994) described the relationship of OET activities and the shift of locus of control for adolescent participants:

One of the most often discussed changes participants experience as a result of outdoor adventure pursuits is an increased feeling of responsibility for the events in their lives . . . Many of the adolescents who are participants on a wilderness therapy trip might be described as having an external locus of control in that they feel they are not responsible for the outcomes of their actions; that is, whether or not they get rewards is a function of luck, fate or powerful others. Hopefully, participation in wilderness therapy changes their locus of control so they come to believe that the outcome of their actions is a function of effort, skill, personality or other internal factors [internal locus of control]. (p. 118)

Increased Awareness/Appreciation for the Natural Environment. When challenge activities take place in a natural environment, the opportunity to develop an individual relationship with the outdoor world often transpires. The outdoors can allow for personal reflection without the distraction of modern devices. These activities can foster a first time bonding with the environment that, heretofore, could not have taken place in a familiar, more traditional therapeutic atmosphere. The opportunity to feel a sense of belonging to an outdoor or natural setting is often very difficult to achieve in our constantly changing and extremely fast paced world (Kaplan & Kaplan, 1989). For those who have never had the opportunity to be in an environment that can't be readily changed or manipulated, the out-

door setting may help to recapture a sense of being a part of nature (Ralston, 1991).

Knowledge Acquisition. While there is much discussion and debate regarding the psychological benefits that may be attributed to involvement with OET programs, there is another related area that is often overlooked. Outdoor experiential therapy activities may provide an ideal laboratory for learning about the natural setting as well. The outdoors provides a myriad of opportunities to learn about things in nature, including botany, ethnobotany, ethology, orienteering, survival skills, and ecology. "Here, the individual will extend his or her normal functioning to greater levels of achievement based on a spontaneous learning process, which is determined by the interaction of the individual with experience" (Crisp, 1998, p. 60). While OET's basic premise may be therapeutic, its inherent opportunity for knowledge acquisition should be considered an important by-product, shown in studies to improve school performance, achievement test scores, and creativity (Cordell, 1999; Breitenstein & Ewert, 1990). It may also provide an avenue for continued interest and involvement in the outdoor setting on an independent basis after completion or discharge from an OET program.

Physiological Outcomes

When individuals become involved with OET programs, whether they are in an indoor or outdoor setting, a natural consequence of these activities can be an overall improvement in physical health. Related studies have researched the positive benefits associated with physical participation in recreation and leisure activities, such as cardiovascular improvement, reduced glucose levels, reduced fat in body mass, and increased bone and muscle mass (Paffenbarger, Hyde, & Dow, 1991). Inherent in many outdoor or adventure activities, such as indoor climbing centers, ropes courses, and wilderness experiences, is the increased demand for physical involvement resulting from unique confrontations with specific tasks and challenges that can often con-

tribute to increased, overall physical fitness. Specifically, the physiological benefits of participation in OET activities may include *potential* increases in strength and endurance, cardiovascular output, orthopedic fitness, immune system functioning, endorphin levels, and catecholamine levels. Additionally, participation in OET programs may facilitate decreases in weight, anxiety and stress, sleep disturbances, hypertension, cholesterol levels, and incidences for disease (Breitenstein & Ewert, 1990). Carefully planned interventions with clients would be warranted when seeking these types of benefits, as well as medical clearance.

Further research will be necessary to examine the length of programs related to the sustainability and long term effects of these benefits. As indicated by Ulrich, Dimberg, & Driver (1991), involvement in outdoor recreation activities or challenge activities may have positive impacts of stress reduction and physical health, but . . . "there is a need for research that investigates longer term psychophysiological influences of leisure, including challenge programs" (p. 87).

In sum, it can be seen that given the structure and components usually present in OET programs, the benefits gleaned by involvement in these activities transcend a broad spectrum of physical, social, and psychological-based outcomes. The recognition of these potential benefits have induced more and more traditional treatment programs to provide OET structured activities for their clients. These have included, but are not limited to, cancer patients and their families, people with brain injuries or severe physical and mental disabilities, and rape victims (Asher, Huffaker, & McNally, 1994; Bluebond-Langer et al., 1990; Herbert, 2000; Nichols & Fines, 1995; Sahler & Carpenter, 1989; Witman & Preskenis, 1996). Well-planned programs, coupled with skilled and experienced leaders pursuing specific therapeutic interventions are the most likely means of achieving beneficial outcomes (Datillo & Murphy, 1987; McAvoy, 1987). Careful consideration and planning for a par-

ticular client or group of clients with regard to the philosophy and tenets of a specific OET program will be essential.

OET Program Structures

While OET programs and modalities widely vary, they can generally be characterized along two dimensions. The first dimension is that of the inclusion of OET in the overall system of services. At one pole of this dimension, OET may serve as an adjunct to other therapies. A typical example of this would be the provision of OET in traditional health care settings where clients simultaneously receive other therapies, such as vocational counseling, occupational therapy, physical therapy, etc. At the other end of the same continuum would be those programs in which OET is the primary therapy and the comprehensive framework through which services are provided. Examples of this end of the continuum would be programs such as Catherine Freer Survival School and the Wilderness Therapy Program (Davis-Berman & Berman, 1994).

The second dimension of this characterization model is represented by the nature of the environment within which programs are offered. The inclusion of this dimension recognizes that although natural environments have traditionally been the core of outdoor experiential therapies, aspects of the outdoor experience can be emulated, or replicated from the natural environment, and provided in human-created environments, thus achieving many of the same benefits previously described. For example, Nadler and Luckner (1992) noted that the *adventure-based learning process* requires physical environment characteristics such as novelty of setting and the presence of unique problem solving situations. Neither of these elements inherently requires a remote or wilderness-type environment. Another example would be high-ropes courses. Although many ropes courses are located in natural settings, the ropes course itself is a human-created structure and also can be found on hospital grounds and college campuses. In one

sense, however, ropes courses can be considered abstractions of the more familiar forms of adventure activities such as rock climbing, caving, and mountain-climbing. As a result, this dimension can range from totally human-created environments, such as indoor climbing walls, to complete wilderness settings in which the influence of humans is minimized.

Integrating OET into TR Practice

In the following section we identify how OET programming might be employed in TR settings. Although there are a number of similarities between the two, their attributes are not identical. TRSs working in settings where some of the components typical of OET programs, such as risk-taking, are being employed, may experience conflict with practice parameters and efforts to integrate the two approaches. For example, administrators may fear increased liability due to the perception of risk typically associated with OET-type activities. Moreover, in some settings, off-grounds excursions are coming under question by third-party payers and administrators, thus making the "outdoor" component of OET more difficult to justify.

OET and TR Practice Models

Recently, there has been increased discussion within the TR literature regarding the development and use of practice models. Voelkl, Carruthers, & Hawkins (1997) stated that the influence of a practice model is such that it guides the overall definition of service, appropriate interventions, and intended outcomes. However, as OET has developed separately from TR, there may be some confusion as to its "fit" within therapeutic recreation practice. Although a variety of practice models have appeared in the literature, two of the more widely known models are the Leisure Ability Model (Peterson & Gunn, 1984; Stumbo & Peterson, 1998), and the Health Protection/Health Promotion Model (Austin, 1998, 1991). The following section will focus on the potential of integrating OET with these two practice models.

Leisure Ability Model. One of the most widely known practice models in therapeutic recreation is the Leisure Ability Model (Stumbo & Peterson, 1998). Due to the model's explicit focus on leisure functioning, integrating OET into practice based on the Leisure Ability Model is challenging, at best. With this in mind, it would appear that the "best" fit of OET would be in the "treatment" component of the Leisure Ability Model. Stumbo and Peterson stated that the intent of treatment "is to eliminate, significantly improve, or teach the client to adapt to existing functional limitations that hamper efforts to engage fully in leisure pursuits" (p. 89). Many of the potential outcomes of OET are focused on personal and social development that would likely enhance the abilities of clients to successfully engage in leisure pursuits. However, enhancing leisure functioning is not typically the intent of OET. Despite this point, certain theoretical foundations of the Leisure Ability Model are consistent with OET programming. For example, Stumbo and Peterson listed the constructs of learned helplessness, mastery, and internal locus of control as underlying the model. In addition, they stated that these constructs are related to therapeutic recreation "in that the ultimate goal of an individual's satisfying and independent leisure lifestyle entails being intrinsically motivated, having an internal locus of control, and feeling a sense of personal causality" (p. 86). OET programs often directly address improving these and similar attributes (see section on benefits of OET) and is relatively consistent with the Leisure Ability Model.

Health Protection/Promotion Model. Another well known practice model of therapeutic recreation is the Health Protection/Health Promotion Model (Austin, 1998; 1991). In this model, OET may fit within either the "prescriptive activity" or "recreation" components. Austin stated that prescriptive activity is used to energize clients who are in a state of illness. In the prescriptive activities component, OET might be used to directly address threats to health such as learned helplessness, depres-

sion, or self-destructive thoughts. Many of the previously discussed benefits of OET are directly related to an increased sense of mastery and control. By comparison, the recreation component of Austin's model connotes the re-creative aspect of activity, in which "clients begin to regain their equilibrium disrupted by stressors so that they may once again resume their quest for actualization" (p. 113).

Based on Austin's (1998) description of this recreation component, many of the activities within this component are designed to enhance clients' social and personal functioning through learning new skills, behaviors, and insights. Thus, OET may be used to facilitate what Austin termed "actualization." One of the therapeutic keys in OET is the discussion or "processing" of activities (see previous discussion on social benefits). The intent of processing activities is to enhance clients' knowledge and skills related to personal and social functioning. As a result, OET activities that are intended to enhance such qualities as personal insight, values, or interpersonal interaction would ideally fit into this component of the Health Protection/Health Promotion Model. However, to the extent that OET is considered a therapeutic intervention, which enhances personal and interpersonal functioning as opposed to leisure functioning, it would appear to fit best within practice models that strive to improve overall individual functioning as a final goal.

Integrating OET into TR Practice

For any type of therapeutic intervention to be successful, such as group interaction, one-to-one therapy, counseling, leisure education, behavioral modification, cognitive retraining, or role modeling, an experienced and well-trained staff is of paramount importance in achieving desired outcomes. Moreover, while perceptions of risk and challenge may be at the heart of outdoor experiential therapies, the specialist must at the same time ensure that clients are not placed in situations where their welfare is seriously endangered. As a result, there are critical implications in terms of man-

aging risk when programs of this nature are considered. Managing and minimizing risk has come to be seen as a necessary attribute of successful programs and instructional practices (Voelkl, 1988). Therefore, the specialist interested in instituting OET intervention strategies needs to develop adequate plans to ensure the safety of the clients. Three basic elements in safely managing OET are (a) the development of program standards, (b) injury/incident reporting and investigation, and (c) clinical privileging.

Program Standards

Increasingly, treatment protocols (cf. Ferguson, 1997; Grote, Hasl, Krider, & Mortensen, 1995) are being employed to help establish standards that guide the provision of services. The value of treatment protocols is that they set specific criteria (standards) for conducting an intervention. For example, the model of a program protocol offered by Grote et al. (1995) includes elements such as (a) rationale for program, (b) referral criteria, (c) key risk management concerns, (d) protocol criteria, and (e) staff qualifications. Through the development of clear statements of expected procedures for providing OET, the specialist can ensure that programs are conducted with the highest standards of quality and safety. In addition, while standards of practice for therapeutic recreation (cf. American Therapeutic Recreation Association, 1993; National Therapeutic Recreation Society, 1995) provide general guidelines for developing TR interventions, protocols for OET programs may be best developed using information related to adventure and experiential programs, such as those available from the Association for Experiential Education (Gass, 1998).

Incident Reporting and Investigation

Another key to maintaining high quality and safe programming is through the continual monitoring and reporting of incidents that are inconsistent with routine practice (Scott, 1994; Vana-

gunas, 1997). Although the most obvious incident would be a case in which a client, staff member, or volunteer was injured, other incidents in which actual practices deviate from standards should also be reported. Given the inherent risk involved in OET programming, careful recording of incidents provides the CTRS with information that can be used to (a) document the safety of his/her programs, and/or (b) provide data to investigate incidents and take steps to minimize risk of future incidents.

Clinical Privileging

Connolly (1991) stated that clinical privileging must be embraced in order to assure quality care in therapeutic recreation service. The process of clinical privileging (usually conducted on an institutional basis) grants therapists permission to provide client or patient care services within well-defined agency limits, and is based upon the professional qualifications, competence, and abilities of the therapist. Similarly, the role of clinical privileging in an OET setting is to create standards of competence for staff conducting OET programs. Given the nature of OET programs, the competency "mix" needed by the specialist to conduct OET will involve not only the components of therapy but also necessitate the need for various outdoor skills such as emergency procedures, site management, and hazard identification. Although, at present, there are no universal standards for conducting OET programs, a variety of training programs are available through universities and/or private entities such as Project Adventure, National Outdoor Leadership School, Outward Bound, and the Association of Experiential Education.

The inclusion of OET with traditional health service programs should be integrated with current facility risk-management plans. Although such plans should already be in place for agencies, particularly those conducting off-facility trips, the inclusion of OET into programming will require that existing plans be reviewed and revised. Particular attention should be paid to policies such as transportation, evacuation (especially if remote areas are

used in programming), medications, side effects from natural environments (e.g., heat and cold stress, dehydration, and physical exertion), and first aid in the event of injuries. Through the use of risk management practices, OET can be safely integrated into TR programming while still maintaining high standards of client safety.

Issues and Trends in OET

A number of trends and issues that are now impacting the OET field also have a direct relationship to TR. A sample of these include therapist or instructor training and skills, risk management, the ethical use of risk and danger in the intervention and application, third party payment, and demonstrated benefits and outcomes from participation in OET programs.

Training

The types and level of training therapists/instructors need in order to be effective is highly dependent on the specific situation. For example, how much and what type of outdoor skills training should the TRS receive? While part of this question is dependent on the type of program being implemented, there is also a developing framework of medical, technical, and group management skills providing a standardized framework for therapist/instructor training. To a certain extent, regardless of the program and situation, the therapist/instructor will need certain qualifications in outdoor technical skills, group and individual facilitation, emergency response, risk management, and medical training in addition to specific therapeutic-based training.

Risk Management

Because of the nature of the OET programming and setting, the TR specialist will need to implement effective risk management procedures specific to that situation, client, and program. This entails understanding the components of client/group coping, effective decision-making, hazard identification, emergency

response, search and rescue, evacuation techniques, and other technical skills.

The Ethical Use of Risk and Danger

Havens (1985) pointed out that there are a number of ethical issues related to working with clients in an outdoor setting. A sampling of these issues includes the use of danger and risk, pressures to participate, the safeguarding of confidential information, moral and legal standards, responsibility to the client, and the welfare of the client (e.g., dealing with anxiety, group confrontation, student fears, etc.). For example, despite the potential for personal growth and a sense of achievement, how much challenge and exposure to risk are appropriate for an individual client?

Third Party Payment

Just as TR continues to be faced with challenges associated with the third party payment, OET programs will experience the same dilemma until both areas are recognized as being able to effectively deliver specific outcomes and benefits. The necessity to prove a cause and effect relationship related to improved overall functioning must transpire before either is likely to become a part of insured and/or mandated treatment services (Shank, Kinney, & Coyle, 1993). In addition, the use of OET in an actualizing or preventative situation, such as with populations "at-risk," may pose some of the greatest challenges. This issue will continue to pose difficulties as long as health care payment structures continue to be tied to pathology, as opposed to prevention.

Demonstrated Benefits and Outcomes

As previously described in this article, the literature suggests that there are a number of benefits and positive outcomes that can be accrued from participation in outdoor experiential programs (Ewert & McAvoy, in press). However, these beneficial outcomes are predominantly derived from a "self-system per-

spective" (i.e., self-concept, self-esteem, intrinsic motivation, and locus of control), as opposed to a physiological system. Based on the research literature, little has been studied on therapeutic outcomes such as increased motor control, reduction in deviant behavior, or enhanced physical performance. Perhaps the true value of OET types of programs is that they are effective at impacting self-systems and affective performance, but less so in altering physical parameters.

Conclusions

Outdoor experiential therapy programs have continued to grow in popularity and have moved into the realm of normative therapeutic practices. Ultimately, the role that these types of experiential treatment modalities will serve in the overall scheme of TR is yet to be determined.

While OET programing is not a panacea nor useful in all situations, the range of its applications suggests that these types of treatment modalities can be useful in a variety of settings and with a broad spectrum of clients. Several critical issues, such as staff training, risk-taking and challenge in outdoor environments, and the integration of TR program objectives with OET practices, are still to be fully resolved. Moreover, how the medical community will regard OET approaches remains unanswered but probably will vary with the institution and situation.

This article has discussed a number of theoretical and practice-based issues that currently surround OET. Continued clarification of these and related issues will serve to better identify the role that OET can play in enhancing the rehabilitation, functioning, and overall wellness of the client.

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