

Adventure Counseling as an Adjunct to Group Counseling in Hospital and Clinical Settings

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Adventure counseling has been thought of as a highly specialized application of group counseling skills in a wilderness environment. In fact, adventure counseling is based on a developmental theory of group, can be useful for a variety of clients, and can be thoughtfully integrated into clinical and hospital settings. This article describes the overlap between group counseling and adventure counseling, the stages and characteristics of adventure counseling, research supporting the efficacy of adventure counseling, and suggestions for implementing strategies of adventure counseling into clinical and hospital group counseling.

Keywords: *group counseling; adventure counseling; clinically based counseling*

Adventure counseling has a long history as an effective counseling intervention, but it has been underutilized (Fletcher & Hinkle, 2002; Nicholson, 1986). Williams (2000) suggested that adventure counseling might have accidentally been discovered after the 1906 San Francisco earthquake destroyed the buildings at the Agnew Asylum. He described how patients were forced to live in tents, set up on the asylum grounds, and assist in the reconstruction of the city. The staff was surprised to find that many of the patients showed immediate and remarkable changes in their behavior.

Camping and therapy also have a long history. Perlman stated in 1947 that camp might become the therapist's most valuable tool. Specialized camps, like the University of Michigan Fresh Air Camp, offered controlled experiences, creative learning opportunities, real

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living situations, and excitement without the client resorting to anti-social behavior (Morse, 1947). Such camps also provided therapists an opportunity to observe clients for a continuous period of time.

Adventure counseling, as it is utilized today, evolved from the Outward Bound tradition (Russell, 2001). Outward Bound, a term used to designate the leaving of a safe harbor for a journey into the unknown, originated with educator Kurt Hahn to promote inner qualities of survival (Hahn, 1960). Hahn sought to accomplish this by enhancing emotional and physical abilities in order to deal with stressful events. Beginning in the 1960s, hospital personnel experimented with adventure counseling as an adjunct modality (Williams, 2000). Adapting adventure counseling into group clinical settings held the promise of (a) engaging the client quickly as an active participant in therapy, (b) providing real activities with natural consequences that promote functional change for the clients, and (c) utilizing reflection as a critical element in the therapeutic process (Gass, 1993).

Ashby and DeGraf (1998) stated that a cornerstone of adventure counseling was the development of small group functioning. Adventure counseling most often takes place outside of normal institutional settings, but the adventure counseling process does not require an outdoor setting. According to Gass (1993), many adventure counseling experiences take place at the hospital or clinical setting. In these environments adventure counseling is an integrated part of the entire in-patient or out-patient therapeutic process, accomplished with trained professionals who have an understanding of the adventure and counseling perspectives (Gass, 1993; Williams, 2000).

Adventure counseling is based upon developmental theories of groups. McPhee and Gass (1993) proposed a five-step adventure counseling model based upon Garland, Jones, and Kolodny's (1973) five-stage model for group development. McPhee and Gass's group development model included the following stages: (a) pre-affiliation, (b) power and control, (c) intimacy, (d) differentiation, and (e) separation. McPhee and Gass stated that these five developmental stages could be infused with adventure counseling applications in order to aid clients in the acquisition of therapeutic goals.

Russell (2001) stated that adventure counseling groups could be broadly assembled into the following stages: (a) cleansing, (b) personal and social responsibility, (c) transition, and (d) aftercare. These stages could be applied to in-patient care as clients in these settings go through a phase of psychological and physiological disengagement, or cleansing, before beginning to engage in necessary therapeutic activities focusing on personal and social responsibility. Likewise, transition preparation and actual transition into aftercare are therapeutic goals for many patients.

Successful adventure counseling programs also include the following factors: (a) focus on a target group, (b) promotion of long-term change, (c) opportunity for the learning of new coping skills, (d) strengthening of interactions with home, school, and community, and (e) collection of rigorous analytical data (Gillis & Simpson, 1991). According to Russell (2001) adventure counseling should be therapeutically based, use careful selection techniques to determine participants, be integrated into individual treatment plans, occur under the direction of skilled leaders, provide accomplishments that are concrete, and allow the client to reflect after the moment of interaction. Therefore, hospitals and clinics become an excellent environment in which to utilize adventure counseling.

The use of adventure-based counseling in hospitals and clinics is well-documented (Fletcher & Hinkle, 2002; Gillis & Simpson, 1991; Nassar-McMillan & Cashwell, 1997; Ragsdale, Cox, Finn, & Eisler, 1996). Adventure-based counseling has been noted to reduce feelings of hopelessness, guilt, and shame, and to increase empathic responses among adults in psychiatric hospitalization (Ragsdale et al., 1996). Gillis and Simpson (1991) reported that outcomes of adventure-based counseling in out-patient and residential programs were often attributed to the development of new coping strategies, the formulation of a new experience by the client, and the strengthening of support from the group, community, school, or family setting. For example, Gillis and Simpson (1991) found that 87 percent of the participants in a residential alcohol treatment program that integrated adventure and traditional group counseling successfully completed all phases of treatment and that clients also showed a significant increase in self-esteem. Finally, Gilliam (1993) reviewed the experience of staff and patients engaged in adventure counseling activities at five psychiatric hospitals and treatment centers. Gilliam stated that when adventure counseling activities were accepted as having clinical, and not just recreational use, they were incorporated into multiple clinical populations and used as a part of an overall, valid treatment strategy. Adventure counseling counselors utilize traditional counseling skills, understand and employ group facilitation skills, understand and choose appropriate activities, and assist clients in transferring their experience (Glass & Meyers, 2001).

However, implementing adventure-based counseling in hospitals or clinics may be problematic. First, according to Davis-Berman and Berman (1994), the way that clinical time was viewed in hospitals and clinics was a concern. Group counseling occurred in specified periods of time in hospital and clinical settings. For instance, a 50-minute session for a group may be a fixed part of the client's schedule.

However, staff members who utilized adventure-based counseling opportunities required more time, or more flexible time, in order to provide the clients with an opportunity not only to participate in an activity, but to process the activity adequately. Second, it is common practice in hospitals for clients to be assigned to group counseling or activities without any screening. Nicholson (1986) identified screening and recruitment strategies as vital components if adventure-based counseling was to be effectively utilized. Interviews with clients were necessary to assess motivation and identify appropriate participants. According to Nicholson, client screening should include the client's level of motivation to (a) take physical risks, (b) take risks related to emotional expressiveness, and (c) self-disclose. Additionally, the client's level of physical fitness may need to be assessed in order to accomplish specific tasks.

WHAT EVERY COUNSELOR SHOULD KNOW ABOUT ADVENTURE COUNSELING

The processes and stages of group development are basically the same in institutional and adventure settings (Williams, 2000). According to Russell (2001), adventure counseling utilizes group theory, uses challenges with high perceived risk, takes place in an unfamiliar environment, and employs therapeutic techniques. Adventure counseling activities are planned, coordinated, and presented in incremental stages to promote cooperation while meeting specific needs of clients (Herbert, 1998). The stages of adventure programming include assessment and screening, integration of treatment plans, ongoing assessment of appropriate interventions, group closure, and appropriate follow-up (Gillis & Ringer, 1999). Fletcher and Hinkle (2002) reported that the integration of an adventure component into group counseling resulted in enhanced self-confidence, self-concept, and well-being. Glass and Benshoff (2002) stated that another benefit of using adventure counseling included increased group cohesion.

Differences between adventure counseling and clinically based group counseling lie in content, intensity, and duration—in other words, in the amount of time spent in an activity, the interrelationship between clients and counselors, the development of the group, and the type of activities (Williams, 2000). Adventure counseling removed clients from their familiar social contexts and provided unfamiliar activities that promoted change (Glass & Meyers, 2001). Primary care staff that utilized adventure counseling engaged clients in a nurturing and caring manner and employed the use of natural consequences

including ceremony and ritual (Russell, 2001). Adventure counseling also utilized a therapeutic style other than verbal, thereby capturing the attention of clients who struggled to respond orally in clinical group settings (Williams, 2000).

Ashby and DeGraf (1998) described adventure group counseling as supporting three basic concepts that are familiar to any clinical group counselor: (a) a working therapeutic alliance, (b) transference, and (c) real relationships. These three concepts relate to Yalom's (1995) therapeutic factors of (a) corrective recapitulation of the primary family group, (b) group cohesiveness, and (c) catharsis. The working alliance included an emotional bond between members and leaders, shared goals for the group, and shared understanding of the group tasks. In adventure counseling, the group tasks are easy to recognize. Therefore, a strong working alliance developed and supported the less recognizable goals, such as social skills and improved interpersonal relationships.

Ashby and DeGraf (1998) stated that transference in an adventure counseling setting was complicated by the fact that it occurred with group members, not just the leader. However, this allowed the group and the leaders additional opportunities for understanding the group process, as well as an opportunity to explore attitudes, feeling, and responses. Real relationships, a final aspect of the adventure counseling relationship according to Ashby and DeGraf, were defined as open, honest interactions. Real relationships are based on accurate perceptions and feelings of the clients and counselors. Clients build group cohesiveness and a collaborative working atmosphere, because members are engaged in situations where they communicate, negotiate, and assist each other in order to accomplish overt goals.

EXAMPLES OF ADVENTURE COUNSELING

One method of adventure counseling, known as Adventure Based Counseling (ABC), was first utilized as a counseling modality with an outpatient therapy group (Schoel, Prouty, & Radcliffe, 1988). ABC differed from traditional counseling due to differences in the setting, use of perceived risk, and the need for additional experiential skills (Fletcher & Hinkle, 2002). However, like traditional institutional group counseling, ABC included a complete assessment of the group, activities that promoted change, and processing techniques that allowed clients to integrate learning and offer a sense of completeness to the activity (Fletcher & Hinkle, 2000). Hammel (1993) stated that processing during adventure counseling (a) included

adequate time to reflect on the experiences, (b) related directly to the activities, (c) included questions appropriate for the level of learning integrated into the activity, and (d) offered support for each client's goals and objectives.

Perceived risk, one of the principle factors of ABC, provided clients with the illusion of danger, thereby engaging the clients in higher levels of cognitive and emotional arousal (Fletcher & Hinkle, 2002). Perceived risk took participants out of their comfort zones by simply moving them to a different environment. This shift allowed for growth by the client, as well as transference to real-life situations (Fletcher & Hinkle, 2002). Gass (1993) stated that clients in unfamiliar environmental situations enhanced therapy since there were few preconceived expectations for success. The use of unfamiliar environments, or activities that promoted perceived risk in clients, also provided situations that contrasted with the client's current reality. Yalom (1975) referred to the use of perceived risk and unfamiliar environments as one of the two symbiotic tiers for the here-and-now focus. The first was immediate ahistoric group discourse, which facilitates client involvement in the group. The second tier, according to Yalom, was the illumination of process, similar to the group processing used in ABC. Finally, group leaders who integrated ABC into traditional group counseling had to be aware of factors created when engaging in adventure counseling outside, such as weather conditions and other specific skills required when performing the activities, including knots and safety gear (Fletcher & Hinkle, 2002).

In another study, Glass and Benshoff (2002) examined clinically based group counseling in conjunction with a specific type of adventure counseling activity—a 1-day low-ropes challenge courses. Low-element group courses last only a few hours and focus on cooperation while moving a client to confront his or her emotional and physical comfort zones (Glass & Meyers, 2001). Low-element challenge courses are group-oriented, focus on shared responsibility by client participants, and encourage cooperative problem-solving. Glass and Meyers stated that low-element group courses have proved to be successful when proper equipment was used, appropriate activities were utilized, and staffs were well-trained. Glass and Benshoff (2002) reported that participation by adolescents in therapeutically focused low-ropes activities (a) promoted group cohesion, (b) provided the group members with structured experiences, and (c) allowed the group members to take responsibility for success in the group activities. In addition, group members were able to find ways to transfer the learning from the program to their everyday lives.

SUGGESTIONS FOR IMPLEMENTATION IN AGENCIES AND HOSPITALS

In order for adventure counseling activities to be successfully integrated into agency and hospital counseling groups, the following should be strongly considered. First, the reason for inclusion of adventure activities must be determined. Adding activities to a group because it is interesting to the leaders, the facility has purchased adventure materials, it sounded good at the workshop, or because the group is struggling in its current format are not good reasons for integrating adventure counseling. Program change should only occur after careful examination of the current program. Gilliam (1993) argued that only a congruent vision between the use of activities, group counseling, and treatment goals would encourage the integration of adventure counseling in a facility. Gilliam found that when a hospital regarded adventure counseling as merely a means for adolescents to burn off energy, it was of limited use. However, at hospitals and clinics where adventure counseling was viewed as a valid treatment strategy, it was more likely to be utilized by a variety of populations.

Once a hospital or clinic has decided that utilization of adventure counseling techniques is important and that these activities can be seamlessly integrated into the current group counseling format, then, according to Davis-Berman and Berman (1994) the following should occur: Individual clients should be screened to determine if their participation is warranted. Special attention should be given to individual treatment goals, ability to interact with a group, and potential harm to self or others by increasing the perceived risk to a client. In addition, staff members should be carefully screened and trained in order to assure that they are prepared to deal with the emotional ramifications of adventure counseling activities on their clients and themselves (Davis-Berman & Berman, 1994). Gilliam (1993) stated that hospital staffs were more comfortable making client referrals to adventure-based group counseling when facilitators possessed adequate group processing skills, understood patient diagnosis, and had the necessary skills to relate activities to therapeutic goals and objectives.

Finally, a reputable adventure counseling provider should be hired to consult, train, or manage the program. There are many adventure counseling programs currently operating in the United States and abroad that successfully utilize adventure therapy. However, hiring adventure-based counselors who understand the needs of a particular hospital or clinic settings should be undertaken with care. Adventure counselors should have a strong background in the technical skills

required to create a safe environment for staff and clients. In addition, they should have a clinical background that assists them in finding common ground with the hospital or clinic while co-creating group activities. Gilliam (1993) recommended that hospitals and clinics recruit staff that not only have mental health training and experience, but also have documented experience in providing adventure-based counseling with the specific population. Gilliam also stated that staff orientation was a useful tool for integrating new and existing staff into adventure counseling groups. On the other hand, Davis-Berman and Berman (1994) suggested a bifurcated staff at the minimum, with some staff supervising and implementing the adventure-based counseling techniques while other staff focuses on the group counseling components in order to capitalize on the therapeutic moments.

IMPLEMENTING ADVENTURE COUNSELING: A CASE STUDY

While ropes courses and outdoor activities have been used quite successfully with adventure-based counseling (Gillis & Ringer, 1999; Glass & Benschhoff, 2002), such activities can be extremely costly and not conducive in agency and hospital settings. However, adventure-based strategies may still be incorporated into the therapeutic milieu of hospitals to create a meaningful intervention for the clients without costly equipment or outdoor experiences, even when clients may be a danger to self or others or may be restricted to their unit. The following case study provides an example of adventure counseling in a hospital setting.

Initially the group leader identified the ground rules for the group, including goals for the group exercise, boundaries for each activity, and the importance of working as a team in order to accomplish the task. Group members were expected to identify group and personal expectations and the group leader introduced the full value contract. The full value contract required group members to respect each other, provide a safe environment for self-disclosure, give and receive feedback, and work together toward group goals (Millard, 1995). "By establishing this agreement initially, behavior and group participation is structured for group members—achieved through peer pressure and the awareness of the expectations by all group participants" (Balkin & Leddick, 2005, p. 212).

Group work, especially with new groups, began with a warm-up activity to promote working together and group cohesion. The warm-up activity used in this case was group juggle (Rohnke, 1984). While the members stood in a circle, the leader began by calling out a group

member's name and tossing a tennis ball to him or her. The group member was instructed to call out another group member and toss the ball to him or her. In turn each group member eventually had his or her name called out and received the tennis ball. Once the pattern was established, the group leader asked the group to set a goal; for instance how quickly can the ball be tossed to each group member? It was important to promote an initial discussion concerning the group goal and that the group agrees with the goal set. The exercise continued until the goal was met. The group then agreed to adjust their goal and the challenge increased by incorporating two, three, or more tennis balls. Such an exercise introduced goal setting, team dynamics, and group communication. Also, the group leader had the opportunity to observe how the group may deal with stress.

Upon completion of the warm-up activity, the group leader utilized an initiative, or higher intensity group challenge. There are numerous examples and resources for group initiatives (e.g., Rohnke, 1984, 1989; Rohnke & Butler, 1995). In this case study the group leader utilized an initiative called *Traffic Jam* (Gillis, 1983). The group was divided in half, with the first half in a single file line facing the other half in a single file line (i.e., the first half may be facing left, and the second half may be facing right). Each group member was standing on a marked spot, with one empty spot in the middle between the two groups. Working together the group had to figure out how to get each member to the other side (i.e., members on the left line need to move to the spots on the right and vice versa) with the following rules: (a) group members can move only one spot at a time, (b) a person can pass another person if the person is from the opposing line and there is an empty spot immediately behind the other person (c) if you are in the line facing left, you can only move left; if you are in the line facing right, you can only move right, and (d) after each move, everyone must be on a spot and no spot can be shared. Successful completion of the task required time to experiment and process. The group leader had the opportunity to witness how the group dealt with the problem and worked together. Typical dynamics that became apparent included frustration, conflict, and team commitment. Clients took assertive or aggressive roles in order to solve the problem, while others were more passive. Conflict arose when group members believed they were not being treated respectfully or being heard. The group leader monitored interactions and reminded members of the full value contract when necessary. Finally, the group reached a conclusion by either finding the solution or failing to accomplish the task. Regardless of the outcome, the initiative was processed.

The goal in processing the initiative was to promote transfer of the activity to the group and real world experience. Smead (1994)

proposed a model of processing activities that is appropriate to adventure counseling by posing three questions: (a) What? (b) So what? and (c) Now what? The group leader facilitates the interactions related to what happened in the initiative, what is the relevance of the initiative, and how any learned information can be applied to a different or new context (Balkin & Leddick, 2005). For example, a group member identifies a particular group role that he or she is using and how this role may be a familiar or new experience. Another group member may process frustration with the exercise, or how the initiative was reminiscent of other stressful situations such as school or family conflicts. The group leader encourages further processing of this disclosure by addressing how the client's behavior was similar or different in the initiative and what the client may be able to change. Other group members struggle with transferring the activity to any real world themes. The group leader may need to challenge members to consider their roles, feelings, and attitudes during the initiative. The group leader should work to promote interchange by addressing common experiences of group members. As group members transfer the experience of the initiative to their own issues, additional insights and methods of coping may be achieved.

CONCLUSION

The essential element in adventure counseling is the use of group counseling in order to affect change (Itin, 2001). While the integration of adventure counseling into institutional and clinical group counseling settings seems difficult, the counseling perspective in an institution is not that much different than the perspective adhered to in an adventure counseling setting (Williams, 2000). In fact, Fletcher and Hinkle (2002) stated that the integration of an adventure component into an institutional group setting has produced enhanced self-confidence, self-concept, and well-being in clients. The positive outcome of integrating some level of adventure counseling was supported by Neill (2003) who showed that high effect sizes on clinical scales were linked for participants in residential settings when participating in adventure counseling as a part of a broad intervention strategy.

Williams (2000) reported that adventure-based counseling enhanced the building of a social microcosm in groups due to the amount of time spent working together and that groups moved more rapidly through early developmental stages and were able to spend more time in later developmental stages. Adventure counseling initiatives promote therapeutic gains due to the real-world nature of exposing clients to potential conflicts and problem solving tasks. Clients

have the opportunity to experiment with new behaviors in stressful situations or identify specific situations that serve as triggers to maladaptive behaviors. In clinical settings where the number of sessions is limited, interventions that provide the opportunity for immediate meaningful insight can be essential. However, this progress would not be possible without dedicated group counselors utilizing traditional counseling skills, choosing appropriate adventure activities that directly relate to the individual and group goals, and assisting clients to transfer the experience (Bruyere, 2002; Glass & Meyers, 2001).

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