DOCUMENT RESUME

ED 342 584 RC 018 574

AUTHOR Gillis, H. L.; And Others
TITLE Family Adventure Questionnaire: Results and Discussion.
PUB DATE Oct 91
NOTE 12p.; In: Proceedings of the International Conference and Workshop Summaries Book of the International Association for Experiential Education (19th, Lake Junaluska, NC, October 24-27, 1991); see RC 018 571.
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Adventure Education; *Family Counseling; *Family Programs; Mail Surveys; Outdoor Activities; Personnel; Program Descriptions; *Recreation; *Therapy
IDENTIFIERS *Rope Courses

ABSTRACT

This article presents the results of a survey conducted with 44 adventure programs working with families. Results of the survey show that the majority of families served by family adventure programs are step families. The source of the programs' primary referrals were mental health or medical staff. Programs reported that they worked almost exclusively (90%) in a multi-family format. The average family adventure program had been in existence for a little more than 3 years. Most family adventure programs worked with a specific hospital or treatment center (69%). Most of the programs (70%) characterized themselves as being therapeutic in function. The majority of adventure sessions are between 1 and 4 hours in length and last for only one session. Sixty percent of the total program time was spent on ropes course activities. The top three goals of the programs were increasing communication skills, gaining insight into family dynamics, and building trust. An average of 39% of the clients paid an extra fee for participation in the adventure portion of the program. Of the programs surveyed, 81% reported staff with at least master's degrees. Only 14% of the programs reported that research had been conducted on their program. Four program formats emerged from the survey. These categories are: (1) recreation; (2) enrichment; (3) adjunctive therapy; and (4) primary therapy. A major concern resulting from the survey is that "cross training" of staff in family therapy and adventure programming is questionable. (KS)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL IN OTHER THAN PAPER COPY HAS BEEN GRANTED BY
Karen Warren
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

ED342584

FAMILY ADVENTURE QUESTIONNAIRE: RESULTS AND DISCUSSION[1]

H. L. (Lee) Gillis, Ph.D.
Georgia College, Milledgeville, GA

Michael A. Gass, Ph.D.
University of New Hampshire

Scott Bandoroff
University of South Carolina

Sue Rudolph Ed.D.
University of Northern Colorado

Cindi Clapp, MSW
The Family Challenge, Boston MA

Reldan Nadler, Psy.D
Family Bound Santa Barbara, CA

Abstract

This article presents the results of a survey conducted with 44 adventure programs working with families. To chart a course for the future, a map of the current landscape is constructed. The following four program formats are offered as landmarks: recreation, enrichment, adjunctive therapy, and primary therapy. The discussion presents a dialogue amongst the authors about the state of the field with recommendations offered to guide research and practice in family adventure programs.

Introduction

The use of adventure activities has been growing within the therapy field (Bacon & Kimball, 1989; Gass, 1991a, 1991b; Gass & McPhee, 1990; Gillis & Bonney, 1986, 1989; Gillis & Gass, 1991; Schoel, Prouty, & Radcliffe, 1988). One such area of growth has been in the use of adventure programming with families. Gass (1991) has outlined how adventure strategies integrate with strategic and structural approaches to family therapy. Gillis and Bonney (1989) have discussed how adventure activities can fit within a psychodrama format. Gerstein and Rudolph (1989) and Gillis and Bonney (1986) have documented the use of strategic family approaches for adventure curriculum, while Mason (1987) has acknowledged the influence of Whitaker's family therapy approach in her work.

As Gillis and Gass (1991) have observed, those who first used adventure activities in marital and family therapy found this integration to show promising potential. Information is lacking, however, regarding the current scope and practice of professionals who work with couples and families in adventure settings. Where do adventure activities best "fit" in the therapeutic process? Are adventure activities being used more as tools for enrichment, as an adjunct to traditional marriage and family therapies, as a technique in traditional therapy, or as a whole new perspective on therapy??

Gass and McPhee (1990) surveyed adventure programs working with chemically dependent populations and identified referral sources for clients as well as describing program characteristics, financial arrangements, staffing characteristics, and program research. Their procedure proved useful for determining the state of the field with regards to work with chemically dependent clients. A similar approach has been adopted for this survey. The purpose of the survey is to answer questions about the various formats (e.g., hours, one-day, weekend), environments (e.g., ropes course and wilderness), and populations (e.g., enrichment and therapeutic) currently being used by practitioners working with couples or families. It is hoped that from this information a map of the field can be constructed with recommendations to guide further study and practice.

---

[1] This survey was funded in part through funds provided by the Adventure Counseling Research fund of the Georgia College Foundation, Georgia College, Milledgeville, GA 31061

BEST COPY AVAILABLE

Method

Subjects.

Forty-four programs in the United States were identified as using aduenture experiences with families. This group was targeted through a compilation of lists that were acquired through Gass & McPhee's (1990) survey, provided by several agencies involved in adventure treatment programming, generated by practitioners, and collected in family adventure related workshops conducted at the annual convention of the Association for Experiential Education (AEE). A master list exceeding 300 programs was developed and each was sent a cover letter, a four page questionnaire, and a self addressed envelope. From that mailing, 44 programs returned questionnaires identifying themselves as working with families. Two of those questionnaires contained incomplete.data and were not included in the final sample.

Questionnaire Development

The Gass and McPhee (1990) survey was used a basis for developing the family adventure questionnaire. Information was gathered on client population, program, finances, staff, and research. In most cases, respondents were asked to report answers in percentages so each category would add up to 100%. Figures are provided to highlight major findings of the survey.

Results

Client Information

As noted in Table 1 below, the majority of families served by family adventure programs are step families followed by single parent families, intact families, parent-child dyads, and couples. Those who responded to the "other" category described their clients as adoptive or foster parents. Figure 1 illustrates these percentages by mean scores.

Table 1
Average Percentages Reported for Clients Served

Client population	Mean	Std. Dev	N
Step Parent Families.	26.98	(22.35)	42
Single Parent Families	21.64	(20.74)	42
Intact Families (never divorced).	19.12	(18.71)	42
Parent-Child Dyad	16.24	(24.02)	42
Couples	9.21	(17.57)	42
Other:	1.38	(5.21)	42

Figure 1

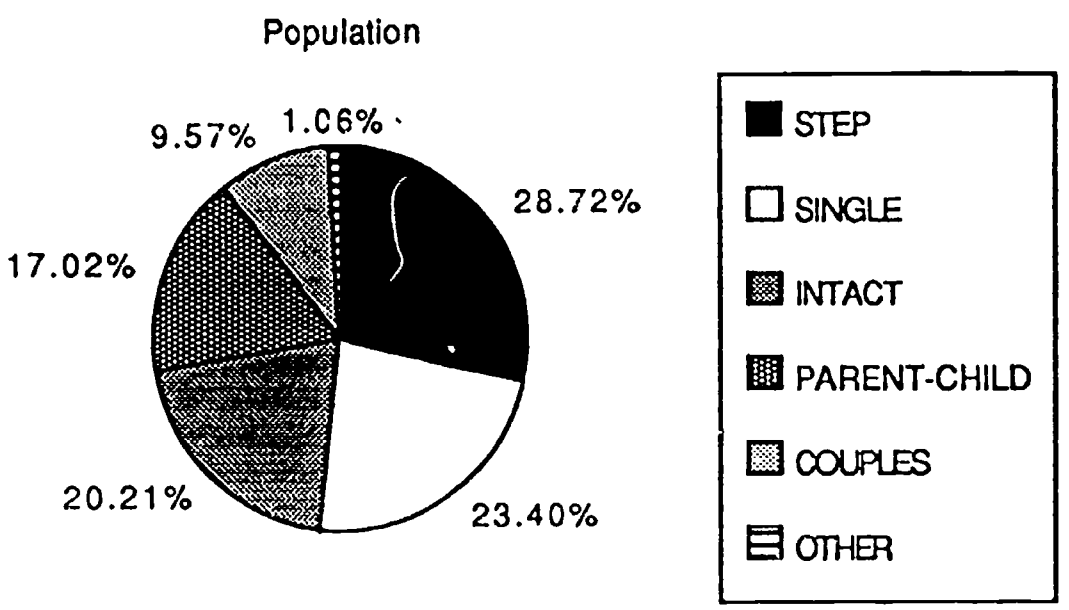
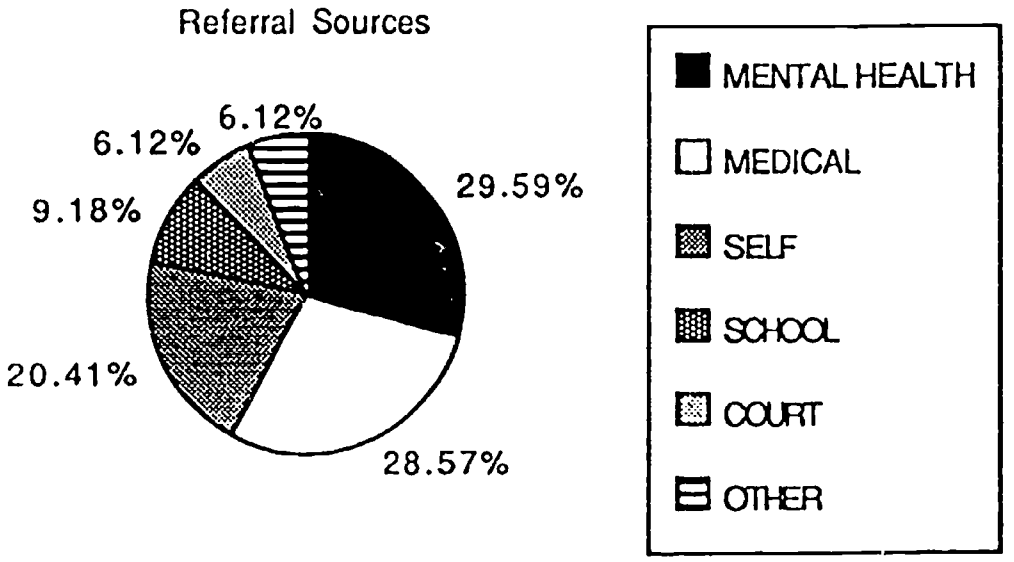


Figure 2 represents the source of referrals reported in the survey. As noted, the source of programs' primary referrals were mental health or medical staff. This reflects the fact that most family adventure programs spent the majority of their time in specific hospital or treatment centers through inpatient programs.

Figure 2



Programs reported that they worked almost exclusively (90%) in a multi-family format. More than one half of these programs (59%) grouped families based on specific characteristics. Clients were grouped on substance abuse issues (81%), conduct disorders (31%), age (19%), and abuse or violence issues (15%).

The ages of the youth in the programs ranged from 9.6 to 21 years while adult ages ranged from 24.4 to 57.2 years of age. Eighty percent of the respondents screened for physical or psychological limitations. The primary method of screening used was a verbal interview with the family (30%). Other methods listed

included a review of the medical chart (15%) or a questionnaire completed by the family (15%).

Program Description

Location. Respondents were found in the following states: Texas (10), followed by Colorado (4), California (3), Florida (3), North Carolina (3), Georgia (2) Louisiana (2), and Ohio (2). One response each was received from programs in Connecticut, Idaho, Indiana, Massachusetts, Missouri, Maryland, Minnesota, New Jersey, Oregon, Tennessee, Wisconsin, South Dakota, and Utah.

Length of program. The average family adventure program had been in existence for a little more than three years (3.02). Seven of the programs had been operating for less than one year, while nine had operated from 1 to less than 2 years, eleven for 2 to less than 3 years, ten for 3-4 years, six for 5-8 years and two programs reported to have been in existence for 12 and 14 years respectively.

Characteristics. Most family adventure programs worked with a specific hospital or treatment center (69%). Fifteen percent responded to the "other" category and listed outside referral sources, educational institutions, outdoor programs, and miscellaneous groups (e.g., church, youth service, and probation) as the source for their clients. Programs reported the majority of their work was being done with inpatients (61%) while outpatients accounted for an average score of 35%.

Most of the programs (70%) characterized themselves as being therapeutic in function with only 25% describing themselves as preventive or serving an enrichment function. The majority of the families served (79%) were in traditional counseling/therapy in addition to the family adventure program.

The family to staff ratio reported by in the survey was 4.1 families to 1.6 staff. When asked for the number of participants to staff, the ratio was 11.4 group members to 2.7 staff members.

Length, number, and content of sessions. Table 2 lists the average percentages reported for the length of each session and the total number of sessions. Note that the majority of sessions are between one and four hours in length and last for only one session. The reader is alerted to the wide variation of scores (i.e., standard deviation) in each column.

Table 2
Average Percentages Reported for Length and Number of Sessions in Family Adventure Programs

How long do your family adventure experiences last?

Each session :	Mean %	SD
1 hour	3.64	(15.25)
>1 hr - <4hrs	49.79	(45.68)
> 4 hr to a full day	34.95	(41.67)
overnight	11.60	(27.28)

Total number of sessions

	Mean %	SD
1 session total	36.50	(43.62)
2-sessions total	16.83	(30.24)
3-5 sessions total	29.05	(37.13)
6-10 sessions total	13.45	(28.64)
More than 10 sessions total	2.74	(15.47)

Respondents were asked to compare time spent indoors, outdoors (not ropes course), on ropes course activities, and in wilderness settings. The majority of total program time (60%) was spent in ropes course activities. When asked to compare time allocated to specific outdoor activities such as rock climbing,

backpacking, hiking, boating, solo experience, or ropes course, again the vast majority of time (85%) was spent on the ropes course. When asked how time was allocated in session, respondents reported that an average of 23% of the time was spent in skill training (e.g., teaching communication skills), 46% of the time was employed participating in adventure activities, and 33% of the time was spent debriefing or processing the experience. Breaking down the ropes course portion of the program, respondents spent an average of 21% of their time in warm-up activities, 58% of their time on low ropes, and 18% of their time on high ropes. The rating of activities is presented in Table 3.

One half of the respondents reported that they followed up families in their adventure program. When asked what method was used, the largest percentage (38%) reported informal contact while 17% used questionnaires or surveys.

Table 3

Activities used by Adventure Programs Working with Families

This table indicates the percentage of programs that identified activities as useful in their program

	%
Warm-ups:	
Tag games (hug, blob etc)	46
Name game	24
Stretching	22
Group juggle	17
Various "New Games"	12
Trust circle/progression	10
Low ropes/initiatives	
Trust fall/sequence	32
Nitro crossing/acid river	27
Spider's web	24
Knots	22
TP shuffle	17
Trolleys	17
Wild woosey	17
Trust walk	15
Prouty's landing	12
Mohawk walk	12
Wall	12
Swinging log	10
High ropes	
Cat walk	46
Dangle duo	32
Pamper pole	17
2-line bridge	12
Climbing wall	10
Burma bridge	10

Goals. The survey asked respondents to list the top three goals of their program. These goals are listed in Table 4. Note that increasing communication skills, gaining insight into family dynamics, and building trust are the top three goals of most programs.

Table 4

Goals for Adventure Programs working with Families

This table indicates the percentage of programs that identified each goal as a focus of their program

	%
Increase communication skills	62
Insight/understanding of family dynamics	24
Establishing/building trust	21
Learning and/or acting out effective problem solving	19
Provide opportunity for families to relax and have fun together	17
Increase/facilitate family support for each other's contributions and skills	17
An opportunity to identify and act out new and different roles	12
To build relationship network with other families	9
Develop more effective life/family skills	9
Team building/cohesiveness/cooperation	9
Identify control issues: understand need to relinquish control / manipulation /codependency	9
Increased level of mutual understanding/respect	9
Practice/reinforce issues identified in family therapy	9
Safety: emotional, physical, personal, environmental	7
Provide family enrichment activities	7

Financial Arrangements

Respondents reported that an average of 39% of their clients paid an extra fee for participation in the family adventure portion of the program. The amount of the fee was a difficult question to answer since the responses varied widely in format. For example, 20 of the 42 (48%) reported no charge for their program. Of those who charged, the lowest fee was $20 per person per day and the highest fee was $120 per hour for a 15 hour course over three days (totaling $1800). There was very little agreement among the 22 who did charge as to the amount or structure of the fee.

Staffing Characteristics

When asked about the level of education attained by the staff, 26% reported staff with a doctorate degree, 81% reported staff with a masters degree, 71% reported staff with an undergraduate degree, and 33% reported staff with a high school degree or attending college. From the data gathered concerning degree areas, the predominant undergraduate degrees were in psychology, social work, and therapeutic recreation. The predominant masters degrees were in social work, psychology, therapeutic recreation, and counseling. The predominant doctoral degree listed was in psychology.

An average of 7.5 years of training was reported in adventure programming with the range of responses from 0 to 41 years. Respondents were not asked about specific family therapy training, but they were questioned about the family orientation that guided their program. Of those who responded, five listed themselves as Structural, four as Behavioral, and two each as structural/strategic, Ericksonian, and Satirian.

Program Research

Only 6 (14%) of the 42 programs reported that research had been conducted on their program. Four of those six reported that they were processing their data and had no results at this time. One respondent reported that families rated the family component highly and frequently cited it as the most important part of their overall treatment.

Discussion

The use of adventure programming with families has increased tremendously since the first documented program (Mason, 1981). Most of the programs identified by the survey have been operating for less than four years. The majority of programs are hospital based and used as part of the patient's stay at the treatment facility. The results of the survey offer a descriptive view of the field's current status. The results raise several issues that must be considered in order for family adventure programming to gain more acceptance for therapeutic application.

Recreation, enrichment, adjunctive therapy, or primary therapy?

Seventy percent of the programs describe their mission as therapeutic. However the level of therapeutic intent or duration probably occurs at a variety of levels. From the results of the survey, four distinct categories seem to have arisen. These categories are (1) recreation, (2) enrichment (3) adjunctive therapy or (4) primary therapy. These program formats are not mutually exclusive. The differences noted in the categories generally relate to (1) the level to which an adventure activity is tailored to address a particular problem a family is experiencing, and (2) the extent to which the adventure activity is the primary therapeutic modality. A brief description of each format is presented below.

Recreation. This format often typifies an engaging "one-shot" family adventure program that would use a "family day" or "family hour" format to complete its task in a single session. It would appear that the goal for such a brief experience would be to have families participate in activities so that they leave the experience with a "good" feeling. While it might be assumed that most of the families in a program with recreation as a goal might be the most non-clinical of the four formats mentioned here, this may not always be the case. The true goal of this approach, however, is not therapeutic in nature but is recreational. Generally steps are not taken to frame activities as metaphors related to any family issue. Whatever therapeutic benefits might occur would be related to the family.participating in the adventure activities.

Enrichment. This format would be characterized by structured sessions over multiple days that purposely address common relationship and/or family issues/problems selected from a predetermined agenda. The goal would be to use topic-focused skill building sessions (e.g., communication, trust, and problem solving) augmented by related or "isomorphic" adventure activities (Glass, 1991b) more specifically related to the skill being taught than tailored to a specific family's issue. The families in an enrichment adventure have chosen an experience in order to improve their relationships. The topic-focused sessions may run over several weeks allowing for integration of the material learned from session to session. A good example of the enrichment format is the first part of The Family Challenge (Clapp & Rudolph, 1990) since it teaches skills in communication and trust using didactic and experiential methods. The latter part of The Family Challenge, however, focuses more on using adventure activities tailored to specific issues the individual families are addressing in their traditional family therapy sessions. Since this approach would be an adjunct to traditional treatment, it would also be classified under the next category.

Adjunctive therapy. This format includes 1-4 day adventure experiences in conjunction with a more traditional treatment approach. Traditional treatment could include an individual's stay in an inpatient facility, an extended wilderness treatment program for an identified patient (IP), or family therapy in an office setting. The goal of this approach is to address family systems issues. An advantage of this approach is to have family members experience some of what the IP has experienced in treatment or possibly to have the family participate in an adjunctive adventure experience to get them "unstuck". One reason why families may attend this type of therapy is that a member of their family (IP) is in treatment. An example of this format in conjunction with treatment of adolescents is represented by Bandoroff (1992), Bandoroff and Scherer (1990), and Gillis and Simpson (1991). Like Bandoroff's Family Wheel program for conduct disordered adolescents, Gillis and Simpson's family weekends for chemically dependent youth and their families, and the latter part of Clapp and Rudolph's (1990) Family Challenge, the therapeutic interventions in the adjunctive therapy format are planned to parallel treatment goals of a larger program or traditional treatment format. The goal of adjunctive therapy is not necessarily to correct family distress during the adventure experience, however often the unbalancing that takes place can be used by traditional therapists as a catalyst for change. These programs also can augment or enhance the attainment of treatment goals set forth in the primary therapeutic modality. A well framed adjunctive therapy adventure

experience can unbalance an unhealthy family system requiring a restructuring that leads to a healthier, more functional balance. In such a case, the therapeutic application of the adventure experience would make this format closer to the next category.

Primary therapy. This format of intervention could be part of a single therapy session, but is more likely multiple treatment sessions best recognized by the level of distress of the family (or families) involved, the specificity of the intervention for a particular family's problem, and the use of the adventure activity or sequence of activities as the primary change agent. It is possible to undertake this type of therapy in a traditional office setting although, the use of the outdoors and a low ropes initiative course can also be used. If using a multiple family format, the intensity of this intervention would likely require a one-to-one family to therapist ratio and families would need to share a very similar problem.

The following areas are suggested for defining a primary family adventure therapy program: (1) the goal(s) of the therapists are to make a lasting systems change in the family using adventure activities as a primary therapeutic modality, (2) the level of assessment done prior to the family therapy adventure experience attempts to narrow the focus to specific family issues, (3) the framing done prior to participating in a naturally isomorphic adventure activity is therapeutically intense (Gass, 1991b), (4) the sequencing of isomorphic activities by the therapist is focused in order to achieve lasting systems change in the family, and (5) the debrief is used by the family adventure therapist to punctuate the metaphor or to reframe inappropriate interpretations of the experience; the primary therapy has taken place while participating in the activity (Gass, 1991b). An example of a therapist attempting to achieve the level of intensity and specificity described here while keeping the experience with adventure activity as the primary therapeutic modality can be found in Gass (1991a).

Although 70% of the respondents in the survey described their program as more therapeutic than enrichment or assessment in focus, using the proposed differentiations might change their classification. This primary therapy format may be more of a goal than a reality at this point. As the data indicate, the majority of families in the programs surveyed are also in traditional family therapy, thus adventure activities are not being used as the primary therapeutic modality in these programs. Training and experience with family therapy and adventure therapy are both needed to reach the intensity of treatment discussed here.

Training in family adventure programming

A positive finding in the survey is that respondents reported an average of 7.5 years of adventure training among staff, however, the type of training and quality of training in therapeutic uses of adventure programming remains unclear. It is important to note that a majority of the programs reported their staff had advanced degrees in fields associated with mental health. However the availability of staff "cross-trained" in marriage and family therapy and adventure programming is still questionable. While the value and number of programs using family adventure therapy seems extensive, training in both the fields of adventure therapy and marriage and family therapy is difficult to find (Gillis & Gass, 1991). The "cross training" of both these fields seems to be lacking in academic settings or in institute formats. Most therapists that are trained in this manner have put together their own training programs through a combination of academic training in traditional family therapy and adventure education formats and experience with a number of families. In this light, it is possible that many persons in both adventure and family therapy fields do not take the "cross training" issue seriously enough. Marriage and family therapists are warned not to assume competence as adventure therapists from mere exposure to this field during a 1-5 day workshop on adventure counseling techniques as adventure leaders are also warned not to venture into family therapy without adequate training. One of the concerns with single event approaches to family adventure programs with distressed families, and without adequate follow-up, is that adventure leaders may do more harm than good. This is certainly a risk when a minimally trained adventure leader is conducting a family recreation experience with a clinical population under the guise of "therapy." Adventure activities can be powerful tools and can have both positive and negative consequences for clientele (Creal & Florio,1986). Adventure leaders are urged to adopt ethical stances of recognizing the boundaries of their competence and not venturing into therapeutic issues for which they are unprepared.

Activities useful for family adventure programs

It appears that the majority of family adventure groups spend their time on a ropes course, specifically

low ropes course or initiative course and with the remainder of the time teaching relationship skills or processing the adventure activities. It is uncertain if this is the most efficacious treatment or simply the easiest to implement. Perhaps the ease of access to and training with ropes courses make them the most frequently used adventure activity of this survey.

It remains unclear which activities work best with which populations. As viewed in Table 3 it does not appear there are a particular set of adventure activities for working with families that are different from those used when working with adjudicated adolescents, addicts, psychiatric inpatients, or executives. Several respondents noted that any adventure activity could be used successfully with a family (or by implication, any population) depending on how it is framed. Perhaps practitioners have developed introductions to activities that are naturally isomorphic to family issues, but at this point, with the exception of Gass & Dobkin's (1991) publication, they have not been shared.

Other questions about activities need to be addressed. Are there activities that can bring up family issues too fast (Creal & Florio, 1986)? Are there populations or diagnoses for which family adventure is contraindicated (Gillis & Gass, 1991)? From the few, but varied, responses to the question of family orientation, research is also needed to discover which theoretical orientations are best suited for adventure programming with families or if family adventure programming is a theoretical approach in and of itself.

From this data it would appear that a family adventure program could be conducted with an initiative course or a "bag of tricks"/warm-ups (Rohnke, 1984, 1988, 1989, 1991). Much more work can be done to find ways to augment traditional family therapy with the action-oriented methods of adventure therapy and to use these methods in traditional group/family therapy treatment rooms (Gillis & Bonney, 1989).

Recommendations

The purpose of this paper is to describe the current status adventure programs working with families. A number of the results of this survey are encouraging. Respondents are reporting success with difficult and distressed families and the opportunity to expand this success to outpatient families and non-clinical populations is exciting. The task now is for the field to continue to evolve and for practitioners to continue to share their experiences. To that end, the following recommendations are offered:

1. Are the formats of recreation, enrichment, adjunctive therapy, and primary therapy adequate to describe the current state of the field? . What are the benefits and liabilities of categorizing programs in this way? Are there categories that are missing or mislabeled? Further investigation can include identifying programs that fit into the various categories discussed and identifying programs which might not be represented in this survey or in these categories.

2. It is exciting to see that the majority of staff in the field have a background in mental health. More "cross-training" academic programs and workshops are needed, however, to teach the skills of both approaches in an evolving manner. In addition, writings from the adventure therapy field need to be shared with the family therapy practitioners.

3. The relationship between traditional treatment staff and adventure staff in the family adventure programs located in hospitals needs further investigation. How well do the programs interface? What positive interaction and/or problems occur and are they hospital/clinic specific or universal? How can the interfacing of adventure therapy and other treatment modalities in hospitals be most productive? What is the best way to inform treatment facilities and the public of the benefits and utility of family adventure programming?

4. More research is needed to determine if there are adventure activities that are contraindicated for work with specific family groups or specific family dynamics and diagnoses. More sharing is needed to determine if there are natural isomorphic activities (Gass, 1991b) that "fit" family adventure and framing techniques that are useful when working with particular issues. Additional research and writing is needed to determine if family adventure programming has a better fit with one of the major family therapy theories (e.g., strategic, structural, transgenerational, communication or experiential).

5. The survey raises questions about the structure of family adventure programming. Is there an ideal session length? How many total sessions are beneficial? Might the length of sessions and total number of sessions be dependent upon the format used? What processing techniques might be most effective with family adventure programming? Are single family or multiple family techniques more indicated for some

formats? Are particular processing techniques (e.g., fishbowl technique, writing, or videotape) more effective with certain family dynamics (Nadler, & Luckner, 1992)?

6. It is encouraging to see that some follow-up procedures are being used in family adventure programs although the type and extent of such procedures remains unclear. How many follow up sessions should there be, at what intervals, and of what type (e.g., booster sessions, phone calls or questionnaires)? Practitioners are asked to share their positive findings and failings to determine how effective adventure activities are with families.

7. Some mechanism must be found within each aspiring family adventure therapist to reward a willingness to be challenge in an attempt to move their work to a higher, more effective level. It is clear that to do family adventure programming well in any format in the way outlined requires hard work at these levels. Will the reward be monetary? Will therapy be briefer but more effective and lead to greater job satisfaction? Will colleagues recognize the "job well done"? Each must find their own internal or external reason to move toward the level of competence in this field.

8. More discussion is needed on the use of adventure activities as primary therapy. Is the field of family adventure programming developing a set of techniques that are useful in conjunction with a particular family therapy theory? Is family adventure programming as primary therapy developing into a philosophy of treatment in and of itself?

This article has attempted to construct a map of the field of family adventure therapy. Readers are invited to join in the map making with comments, suggestions, recommendations, and criticisms. It is only through sharing that this adventure avenue will discover if our bearings are accurate or need further refinement.

References

Bacon, S. B. & Kimball, R. (1989). The wilderness challenge model. In R. D. Lyman, S. Prentice-Dunn, and S. Gabel (Eds.) *Residential and inpatient treatment of children and adolescents*. NY: Plenum Press.

Bandoroff, S. (1992).*Wilderness family therapy: An innovative treatment approach for problem youth.* (Doctoral Dissertation, University of South Carolina, 1992).

Bandoroff, S. & Scherer, D. (1990). The family wheel. In R. Flor (Ed.) *Proceedings Journal of the 18th Annual AEE Conference:* Boulder, CO: Association for Experiential Education, pp. 87-89.

Clapp, C. & Rudolph, S. (1990). The Family Challenge Program. In R. Flor (Ed.) *Proceedings Journal of the 18th Annual AEE Conference.* Boulder, CO: Association for Experiential Education, (pp. 71-73).

Creal, R. S. & Florio, N. (1986). The family wilderness program: A description of the project and its ethical concerns. In M. Gass & L. Buell (Eds.) *Proceedings Journal of the 14th Annual AEE Conference: The season of ingenuity: Ethics in Experiential Education.* Boulder, CO: Association for Experiential Education, pp. 47-55.

Gass, M. A. (1991a). Adventure therapy for families. In M. A. Gass (Ed)*Therapeutic applications of adventure programming*. Boulder, CO: Association for Experiential Education.

Gass, M.A. (1991b). Enhancing metaphor development in adventure therapy programs. *Journal of Experiential Education, 14(2),* 6-13.

Gass, M. A. & Dobkin, C. (1991). *Book of metaphors: A descriptive presentation of metaphors for adventure activities.* Published by the authors.

Gass, M. A. & McPhee, P. J. (1990). Emerging for recovery: A descriptive analysis of adventure therapy for substance abusers. *Journal of Experiential Education, 13*(2), 29-35.

Gerstein, J. & Rudolph, S. (1989). *Taking family adventure programming one step further: Utili ng a strategic perspective*. Paper presented at the Association for Experiential Education, Santa Fe, New Mexico.

Gillis, H. L. & Bonney, W. C. (1986). Group counseling with couples or families: Adding adventure activities. *Journal for Specialists in Group Work. 11*(4), 213-219.

Gillis, H. L. & Bonney, W. C. (1989). Utilizing adventure activities with intact groups: A sociodramatic systems approach to consultation *Journal of Mental Health Counseling. 11*(4), 345-358.

Gillis, H. L. & Gass, M. A. (1991) *An overview of adventure experiences used in marriage and family therapy*. Article submitted for publication.

Gillis, H. L. & Simpson, C. (1991). Project Choices: Adventure-based residential drug treatment for court-referred youth. *Journal of Addictions and Offender Counseling. 12*(1) 12-27.

Mason, M. J. (1981). Relationship enrichment: Evaluating the effects of a couples wilderness program. (Doctoral dissertation, University of Minnesota, 1980) *Dissertation Abstracts International, 42*, 161B.

Mason, M. (1987). Wilderness family therapy: Experiential dimensions. *Contemporary Family therapy, 9*, (1-2), 90-105.

Nadler, R. S. & Luckner, J. L. (1992). *Processing the adventure experience.*. Dubuque, IA: Kendall Hunt Publishing Company.

Rohnke, K. (1984). *Silver bullets*, Hamilton, MA: Project Adventure, Inc.

Rohnke, K. (1988). *Bottomless bag*, Dubuque, IA: Kendall Hunt Publishing Company.

Rohnke, K. (1989). *Cowstails and cobras II*, Hamilton, MA: Project Adventure, Inc.

Rohnke, K. (1991). *Bottomless baggie*, Dubuque, IA: Kendall Hunt Publishing Company.

Schoel, J., Prouty, D. & Radcliffe, P. (1988). *Islands of healing: A guide to adventure based counseling*. Hamilton, MA: Project Adventure, Inc.