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Theoretical Orientation Beliefs Among Adventure Therapy Professionals

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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Edward C. Spaulding

M.A., Sam Houston State University, 2008

B.S., Unity College, 2001

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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Abstract

Adventure therapy as a therapeutic model for the treatment of mental health has been a growing area of psychology for more than 50 years. This quantitative study was conducted to explore the theoretical orientation beliefs to clarify the theoretical framework of this therapeutic approach using Coleman's theoretical evaluation self-test (TEST) to gather data on self-identified adventure therapy practitioners' theoretical beliefs. Data were collected from 150 participants recruited through their membership or affiliation with adventure therapy professional organizations or social media groups. Data were analyzed using a paired t-test to determine if adventure therapy professionals have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST than the domains of psychodynamic, family, biological, and pragmatic as suggested in previous research. Data were analyzed using chi-square goodness-of-fit test to determine if theoretical orientation beliefs differ depending on degree emphasis and depending on licensure among adventure therapy professionals. Analysis confirmed that adventure therapy professionals had higher scores on the cognitive, ecosystems, and humanistic domains of the TEST. However, the chi-square results indicated no difference in theoretical orientation beliefs among adventure therapy professionals regardless of degree emphasis or licensure. The findings of this research have potential implications for positive social change by being the first to identify the theoretical orientation beliefs among adventure therapy professionals, that can influence the practices and development of this field, which could lead to greater uniformity in treatment with this modality and improved patient outcomes.

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Dedication

Dedicated to the memory of honorary doctorate Karl Rohnke, who directly encouraged the pursuit of my ideas and writing. Karl taught me, as one of many young children, the joy of learning and exploration through his work with Project Adventure and challenged me to become my best self through his continued work at High Five Learning Center. My thanks to Karl and his legacy in the fields of adventure education and therapy.

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Chapter 1: Introduction to the Study

Introduction

Adventure therapy has shown promise as a therapeutic medium, especially in working with adolescent youth (Bowen & Neill, 2013). While a unanimous definition of adventure therapy remains elusive, its practice continues to expand beyond serving simply adolescent youth (Gass et al., 2012). Research on adventure therapy uses many terms, such as *wilderness therapy* (Russell, 2001), *nature-based* or *nature-assisted therapy* (Annerstedt & Währborg, 2011; Russell, 2001), *therapeutic adventure*, *wilderness-adventure therapy*, *adventure-based therapy*, and *adventure-based counseling* (Newes & Bandoroff, 2004, p. 4). According to Lynch (2005), the differing operational terms are problematic for adventure therapy. Without a unanimous definition, research cannot be compared, and any meta-analysis is of tentative value. Debate has ensued as to the factors in an adventure therapy program that influence outcomes and the populations adventure therapy best serves (Gass et al., 2012). For this study, the functional definition of adventure therapy was "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral level" (Gass et al., 2012, p. 1).

Therapeutic orientation of mental health professionals is the key to understanding the theoretical framework of their practice (Norcross & Prochaska, 1983). Groups of mental health professionals were traditionally believed to have shared theoretical orientation beliefs, aiding in group definition or shared understanding (Norcross & Prochaska, 1983). While none of the theoretical orientation beliefs have been found to be

more effective than others, past research has concluded that theoretical orientation does correlate to shared belief systems (Norcross & Prochaska, 1983). Therapeutic orientation beliefs have been the subject of multiple studies, which has led to the development and use of multiple instruments meant to distinguish differences between theoretical orientations, practitioners, students, and fields of mental health (Coleman, 2007; Halbur & Halbur, 2015; Hamilton, 2012). Previous studies of the field of adventure therapy have been focused on the practice and allowed practitioners to self-identify, resulting in an inability to research therapeutic orientations (Norcross & Rogan, 2013).

Adventure therapy practitioners have not been a population previously studied to determine their theoretical orientation beliefs. Previously this group of professionals was categorized in research through selected criteria (Itin, 2001). The previous criteria were based on education required to participate in mental health fields in general (Itin, 2001). Further, Norton (2010) proposed one of the working definitions of adventure therapy based on the similarities of practice across the field. The lack of consensus on the proposed definition of adventure therapy could be resolved through an understanding of the theoretical orientation beliefs shared among practitioners.

Coleman's theoretical evaluation self-test (TEST) instrument (2007) was previously used to determine the theoretical orientation beliefs of social work students. The instrument is broken down into seven basic theoretical orientations: (a) humanistic, (b) psychodynamic, (c) biological, (d) cognitive, (e) family systems, (f) pragmatic, and (g) ecosystems. Adventure therapy professionals have been speculated as best relating to these orientations with the highest values for cognitive, ecosystem, and humanistic

domains, that comprise Group 1 of the independent variable for Research Question 1 in this study (see Lynch, 2005). The domains predicted to be less aligned with the theoretical orientation beliefs of adventure therapy professionals are psychodynamic, pragmatic, family systems, and biological, that comprise Group 2 of the independent variables for Research Question 2 in this study.

My analysis of the theoretical orientation beliefs of adventure therapy professionals was conducted via a survey ascertaining these professionals' theoretical orientation beliefs, course of study in academia, licensure status and field, and membership to the Therapeutic Adventure Professionals Group (TAPG). These variables should indicate whether there is unanimity in the therapeutic beliefs among adventure therapy practitioners, which would lend to the development of a shared definition. Because the majority of adventure therapy professionals identify as eclectic orientation, previous self-identified studies on the practices of adventure therapy have left a gap in the knowledge of the adventure therapy field.

In Chapter 1, I explore the background of adventure therapy, including past and current definitions and the practice's origins. Included in Chapter 1 is the problem statement that addresses the lack of consensus for a definition of adventure therapy. I also address the purpose of the study, which uses theoretical orientation beliefs to help define adventure therapy. Chapter 1 includes the research questions, hypotheses, theoretical framework, nature of the study, definitions, assumptions, scope, delimitations, limitations, and the significance.

Background

The definition of theoretical orientation beliefs is key to understanding therapeutic practices in the field of mental health. Therapeutic orientation is the philosophy or set of principles that guide the therapeutic techniques therapists adhere to in their practice (Norcross & Prochaska, 1983). The theoretical orientation beliefs of practitioners have been historically valued as one of the most prominent criteria in defining a professional group in the human services fields (Norcross & Prochaska, 1983). Theoretical orientation has been defined as the theoretical framework that informs a clinician regarding the therapeutic needs of a client and a direction in addressing these needs (Poznanski & McLennan, 1995). The American Psychological Association (APA, 2022, para. 1) dictionary of psychology defines theoretical orientation as "an organized set of assumptions or preferences for given theories that provides a counselor or clinician with a theoretical framework for understanding a client's needs and for formulating a rationale for specific interventions." Coleman (2007) defined theoretical orientation beliefs as the underlying principles, values, and philosophies that define a therapeutic practice for mental health professionals. Therapeutic orientation beliefs in the field of psychology have been the subject of extensive research and discussion among social service fields for many decades. Past researchers have sought to define distinguishing variables among different theoretical orientations. The research in this area has confirmed that no single theoretical orientation is superior to any other in its effectiveness (Kottler, 2017). Instead, theoretical orientation tends to correlate to belief systems shared by practitioners of the same theoretical orientation (Walker, 2013).

Theoretical orientation has been the subject of several studies in which researchers have developed instruments for discerning theoretical orientation principles and/or beliefs held by students and practitioners (Coleman, 2002, 2003, 2004, 2007; Halbur & Halbur, 2015; Hamilton, 2012). Several researchers have developed instruments to measure theoretical orientation beliefs. Hamilton (2012) developed the Preference for Adherence to Theoretical Orientation Scale (PATOS). Coleman (2007) developed the TEST through the process of four different studies (Coleman, 2002, 2003, 2004, 2007). Halbur and Halbur (2015) have published a text with an instrument commonly used in teaching clinical theoretical orientations to graduate students of mental health. Theoretical orientation beliefs are essential in defining the outcome of therapeutic interventions. Coleman (2007) specifically breaks down the basic theoretical orientations as humanistic, psychodynamic, biological, cognitive, family systems, pragmatic, and ecosystems.

Research by Lynch (2005) suggested that adventure therapy may best relate to these basic orientations and their values for the cognitive, ecosystem, and humanistic domains. Perhaps this is because adventure therapy practitioners appear to use techniques similar to those used in the cognitive, ecosystem, and humanistic domains. Theoretical orientation beliefs of adventure therapy professionals would help in defining what core beliefs adventure therapy professionals hold to effectively practice therapeutic interventions in the field of adventure therapy. A definition of adventure therapy is “the use of traditional therapeutic techniques, especially for group therapy, in an out-of-doors setting, utilizing outdoor adventure pursuits and other activities to enhance personal

growth" (Davis-Berman, & Berman, 1994, p. 13). This view suggests that adventure therapy may utilize traditional therapeutic techniques, such as those found in other theoretical orientations and the beliefs held by their practitioners.

Despite adventure therapy existing for more than 50 years, literature on adventure therapy has yet to address the theoretical orientation beliefs of adventure therapy practitioners. By defining the theoretical orientation beliefs of adventure therapy professionals, I sought to identify the core beliefs this group has and to define the relationship of those beliefs with demographic criteria held by adventure therapy practitioners. Itin (2001) attempted to define adventure therapy professionals through selected criteria. According to Itin's (2001) criteria, adventure therapy professionals must have a master's degree in the human services field and engage in therapy with a clinical population for the purpose of concrete behavioral change and also for the purpose of addressing meta-processes. This knowledge would help define the field of adventure therapy and influence its teaching and practice toward greater effectiveness. One such definition proposed by Norton (2010, p. 1) defined "wilderness therapy as a modality of mental health treatment that takes place outdoors and utilizes challenge and adventure, group work and other structured clinical interventions." This definition is relevant to adventure therapy because adventure is contained within the definition of wilderness therapy. The study by Norton (2010) helps to inform the working definition of adventure therapy due to its similarities in practice. Adventure therapy is likely to differ in its functional definition because it is not necessarily limited to the outdoors. The theoretical orientation beliefs of practicing adventure therapists would assist in defining adventure

therapy. Past research in the field of adventure therapy has not defined adventure therapy practitioners' beliefs as a variable of a study; therefore, there is a significant gap in the knowledge of this field. Theoretical orientation beliefs have been a fundamental concern of the field of psychology since this profession became accepted in the field of science (Steiner, 1978).

Newes and Bandoroff (2004) concluded that the field of adventure therapy should not be viewed as independent or unique in the field of mental health; adventure therapy is more similar to other established theoretical orientation beliefs than different. Clarification of theoretical orientation beliefs would allow for the identification of core values that would enable adventure therapy to be viewed within the spectrum of theoretical orientation beliefs among mental health providers. Past research on theoretical orientation beliefs has indicated that opposing beliefs also correlate to conflicting theoretical orientations, whereas similar beliefs harmonize with similar theoretical orientations (Coleman, 2007). Adventure therapy research has primarily been focused on outcomes and has not included attention to definitions of adventure therapy, shared values of adventure therapy, or even the methodology of adventure therapy (Bettmann et al., 2016). This research on theoretical orientation beliefs among adventure therapy practitioners was conducted to address one of the many gaps in adventure therapy knowledge.

Adventure therapy has been viewed as both an orientation and a modality (Lynch, 2005). Perhaps this lack of clarification has led to adventure therapy's lack of definition, contributing to its lack of mainstream recognition as a viable therapy. There is currently

no APA division or other psychological or social work organization recognizing adventure therapy (APA, 2019). Nonetheless, the Outdoor Behavioral Healthcare Center was established in 2015, based out of the College of Health and Human Services of the University of New Hampshire. This center is dedicated to expanding research to understand effective adventure therapy practices and promote its viability as a treatment program. Additionally, adventure therapy as a practice grew out of a field of experiential education and has been recognized as a therapeutic practice within a subgroup of the Association of Experiential Education named TAPG. Despite having roots in experiential education, the practice of adventure therapy is executed by mental health professionals in the fields of psychology, counseling, social work, and marriage and family therapy (Gass et al., 2012). This study was necessary to gain an understanding of theoretical orientation beliefs among practitioners in the field to be applied as part of the progress toward establishing a definition for adventure therapy.

Problem Statement

The purpose of this research was to ascertain the theoretical orientation beliefs of adventure therapy practitioners. Current research in the field of adventure therapy has been focused on outcomes and has failed to address the orientation beliefs of adventure therapy and practitioners. Past studies in the field of adventure therapy did not identify theoretical orientation beliefs and have allowed adventure therapists to self-identify. In this study, I sought to explore the theoretical orientation beliefs of adventure therapy practitioners. No unanimous definition or defining set of variables currently exists that define adventure therapy. Eclectic orientations tend to dominate the field of mental health

and may muddle any efforts to define adventure therapy as a separate orientation (Norcross & Rogan, 2013; Seligman, 2001). As such, adventure therapy shall be viewed purely as a modality for the purpose of this research (see Lynch, 2005).

Purpose of the Study

This study was focused on the differences in theoretical orientation beliefs among those who practice adventure therapy by using a paired t-test and chi-square analysis of the quantitative survey results. These results should indicate whether adventure therapy practitioners share similar theoretical orientation beliefs and whether variables such as licensure and area of study affect these outcomes. This information will help to inform the practice of adventure therapy and situate the theory of adventure therapy among other therapeutic modalities.

Paramount to this study was identifying whether adventure therapy professionals have shared theoretical orientation beliefs. Without such sharing of beliefs among adventure therapy professionals, the results may have suggested there are no defining characteristics among this profession. However, if adventure therapy professionals do have shared theoretical orientation beliefs, this suggests a shared definition for adventure therapy as a therapeutic modality.

Theoretical orientation beliefs differ depending on a practitioner's course of study in academia. Rosen (2017) showed differences between the social work, clinical psychology, and counseling professions for identified theoretical orientation. If degree emphasis did not indicate a relationship to theoretical orientation beliefs in this study, then the degree that adventure therapy professionals obtain would be irrelevant to the

shared definition of adventure therapy as a therapeutic modality is. However, if a relationship between theoretical orientation beliefs and degree emphasis was found, then the degree emphasis would be important in defining the practice of adventure therapy.

Professional licensure has been found to be a significant factor (Liu et al., 2013). The modality of adventure therapy makes use of therapeutic staff for programming, who are usually unlicensed but essential to therapeutic programming (Gass et al., 2020) and were included in this study. Since the time of Freud, lay staff have made notable contributions to therapeutic modalities (Malcolm, 1982). Therefore, professional licensure has been considered a variable among adventure therapy professionals and has strong potential to influence theoretical orientation beliefs. If no difference between theoretical orientation beliefs among adventure therapy professionals and their relationship to professional licensure is found, then licensure is not significant in defining who is an adventure therapy practitioner. If a relationship was found between theoretical orientation beliefs and current professional licensure for adventure therapy professionals, then licensure would be essential in defining who is an adventure therapy practitioner. While licensure may be a factor in theoretical orientation beliefs, whether specific types of licensures may also have a bearing on theoretical orientation beliefs remains unknown in the existing literature.

The research questions for this study outline the variables involved. For RQ1 the independent variables are the domains of theoretical orientation beliefs. The independent variables are separated into two groups: cognitive, ecosystems, and humanistic = Group 1; and psychodynamic, family, biological, and pragmatic = Group 2. The dependent

variable for RQ1 is a participant's individual score on the orientation beliefs questions. The independent variable for RQ2 is degree emphasis of individual participants, and the dependent variable was the scores on the orientation beliefs domains. The independent variable for RQ33 is whether an individual participant has professional licensure in the field of mental health, while the dependent variable is the individual participant's scores on the orientation beliefs domains.

Research Questions and Hypotheses

RQ1: Do adventure therapy professionals belonging to TAPG have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST than the domains of psychodynamic, family, biological, and pragmatic?

$H_0$1: Adventure therapy professionals belonging to TAPG do not have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST.

$H_1$1: Adventure therapy professionals belonging to TAPG do have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST.

RQ2: Do the theoretical orientation beliefs differ depending on degree emphasis among adventure therapy professionals?

$H_0$2: There is not a relationship between theoretical orientation beliefs and degree emphasis for adventure therapy professionals.

$H_1$2: There is a relationship between theoretical orientation beliefs and degree emphasis for adventure therapy professionals.

RQ3: Do theoretical orientation beliefs differ depending on licensure among adventure therapy professionals?

$H_0$3: There is not a relationship between theoretical orientation beliefs and current professional licensure for adventure therapy professionals.

$H_1$3: There is a relationship between theoretical orientation beliefs and current professional licensure for adventure therapy professionals.

Conceptual Framework

An improved understanding of the theoretical orientations of adventure therapy practitioners would support increased insight into the field of adventure therapy (Newes & Bandoroff, 2004). Newes and Bandoroff (2004) defined adventure therapy as

> A therapeutic modality combining therapeutic benefits of the adventure experiences and activities with those of more traditional modes of therapy. Adventure therapy utilizes a therapeutic focus and integrates group level processing and individual psychotherapy sessions as part of an overall therapeutic milieu. (p. 4)

By surveying the current practitioners of adventure therapy, I hoped to gain an understanding of how their beliefs and actions define adventure therapy in practice. I hoped to identify a profile for the theoretical orientation beliefs of adventure therapy practitioners. The current research in the field of adventure therapy has been outcome focused utilizing differing definitions of adventure therapy (Gass et al., 2012). By focusing on the beliefs and orientations of adventure therapy practitioners, I hoped to support a more cohesive theoretical perspective on adventure therapy practice.

Theoretical Foundation

Due to the integral nature of theoretical orientation beliefs in the development of definitions in the fields of social sciences, psychology, mental health, social work, and marriage and family therapy, it is reasonable to administer this tool for use with adventure therapy practitioners (Linden & Hewitt, 2018). An improved understanding of the theoretical orientation beliefs of adventure therapy practitioners would lend to increased insight into the field of adventure therapy. Upon application of the framework of negative pragmatism to the outcome of this study, adventure therapy can distinguish what relationships are present or, more importantly, what relationships it does not have. Negative pragmatism, or method to determine the definition of a concept through the understanding of what it is not, can be applied to the population of adventure therapy practitioners through the theoretical orientation beliefs they do not hold (Stuhr, 2015).

Nature of the Study

Because theoretical orientation beliefs have been considered fundamental in defining a theoretical orientation in the fields of social sciences, psychology, mental health, social work, and marriage and family therapy, the survey design for therapeutic orientation beliefs has been a reasonable tool to administer to the field of adventure therapy practitioners (Linden & Hewitt, 2018). The outcome of this study was to understand the practice of adventure therapy by the orientation beliefs of adventure therapy practitioners. The framework of negative pragmatism (Stuhr, 2015) when applied to the outcome of this study shall define adventure therapy both by what relationships it does have and, more significantly, what relationships it does not have. The independent

variables for RQ1 are orientation beliefs on two levels: cognitive, ecosystems, humanistic (Group 1) and psychodynamic, family, biological, pragmatic (Group 2) as per Coleman's (2007) TEST instrument. The dependent variable for RQ1 was the score on the orientation beliefs questions. The independent variable for RQ2 was degree emphasis and the dependent variable was orientation beliefs score. For RQ3, the independent variable was professional licensure, and the dependent variable was orientation beliefs score. Positive findings can be obtained even if significance was not achieved, and because the level of participation conformed to the power analysis, this study provided significant demographic information regarding the profile for adventure therapy professionals and the modality of adventure therapy.

The population of interest was adventure therapy practitioners, defined as individuals who self-identify as adventure therapy practitioners, who have completed at least 1 year of practice in the field of adventure therapy, and who are active in TAPG, APA, or other professional organizations, and who attend professional conferences and/or are members of social media groups with access to the survey through electronic devices. The TEST instrument and demographic survey were administered by computer server through an online website link. The data were analyzed using the latest version of software available from IBM corporations' Statistic Pack for Social Services (SPSS), Version 28. I reviewed each submitted survey to ensure the data was uncorrupted and complete. The scores of each participant were separated into two groups: the domains of Group 1 and Group 2. The participant scores were reduced to their mean to enable comparability of scores. RQ1 required a paired t-test to determine if one group has

significantly higher scores than the other. RQ2 and RQ3 were analyzed using a chi-square goodness-of-fit test to determine if there was a relationship between the participants' theoretical orientation beliefs and degree emphasis or licensure status. The hypotheses for RQ2 and RQ3 would be accepted if the chi-square goodness-of-fit analysis demonstrated significance at the 0.05 level.

Definitions

In 2009, I self-published an evolving definition of adventure education as "integrates kinesthetic, affective, and cognitive-based learning using experiential methods" on the internet as part of my research organization founded in 2009 Northland Adventure Education & Therapy Center (NAETC; Spaulding, 2009). This later evolved into my own original definition: "adventure therapy simultaneously provides therapy through affective, kinesthetic, and cognitive domains providing for greater connection with clients suffering from trauma" (Spaulding, 2009, para. 3). This evolving definition was self-published in marketing materials and listed on NAETC's website as "the use of intentional kinesthetic, affective, and cognitive shared experiences that foster relationships and promote personal growth and change" (Spaulding, 2011). NAETC published youth–parent flyers stating that adventure therapy programs "integrate kinesthetic, affective, and cognitive-based shared experiences. Our philosophy is to promote the growth of healthy relationships and positive behavioral changes."

The adventure therapy definition accredited to Mark Ames, "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral

level" (Gass et al., 2012, p. 1) contains similarities to my own self-published and original works. The word *prescriptive* implies intentional use of adventure experiences, and the kinesthetic, cognitive, and affective domains are cited as contributing toward defining this modality. The self-published and original definitions do lack the use of specifying mental health professionals, natural settings, or behaviorism because practitioners of adventure therapy are often not trained as mental health professionals; this is addressed in the demographic data in this study. Freud often referred to the importance of lay practitioners in the practice of psychology and their importance (Malcolm, 1982). Additionally, adventure therapy practices often make use of manufactured settings like ropes courses, climbing walls, basecamps, and gymnasiums to facilitate programming; behaviorism or biological orientation has been shown one of the least shared therapeutic orientation beliefs among adventure therapy professionals.

This evolution of a definition acknowledges the experiential education origins of adventure therapy. As such, Bloom et al.'s (1956) taxonomy is the basis for the inclusion of cognitive, affective, and kinesthetic or psychomotor domains in the definition of adventure therapy. In addition, the term *behavior* is excluded as being redundant and already part of the definition of the kinesthetic or psychomotor domain (see Harrow, 1972). Ames has stated, "It's the relationship, stupid! That's why it works!" (Wasserburger, 2012, para. 5), thus contributing to the justification for the inclusion of "foster relationships" in my original self-published definition. John Dewey is often regarded as the father of experiential education, defined as a shared experience of both pupil and instructor or teacher for the purpose of gaining knowledge, the development of

skills, to clarify one's values, and/or to foster the development of community contributions (Itin, 1999). Itin (1999) cited the Association of Experiential Education's definition of experiential education as "a process through which a learner constructs knowledge, skill and value from direct experience" (p. 91) and goes on to state must be separated from the definition of experiential learning. Itin developed this definition of experiential education into a philosophy. Indeed, Outward Bound, an organization whose model is often cited as contributing to the origins of adventure therapy, is also rooted in the philosophy of Dewey's experiential education model (Gass et al., 2012; Wash & Golins, 1976). When developing definitions, it is vital to take stock of the root sources that fostered the growth of an ever-evolving field such as adventure therapy. There is a clear and continued need to further develop the definition of adventure therapy.

Because the field of adventure therapy and its definition continue to evolve through the beliefs, actions, and contributions of the practitioners or professionals in the field, I sought to not limit participation by defining who is and is not a practitioner or professional in the field of adventure therapy. Instead, survey participants were allowed to self-identify if they were a practitioner or professional in the field of adventure therapy. The survey questions were technical enough to serve as defining self-selection criteria and lead to verbal feedback from participants who chose to not complete the survey because they felt it did not apply to them. I chose to define a practitioner or professional in the field of adventure therapy as someone with at least 1 year of experience in the field of adventure therapy. Despite these aspirations of an evolving definition, for this research, the definition of adventure therapy cited by Gillis et al.

(2012) was considered the current published operational definition and the most recent advancement in defining adventure therapy.

Further, there are differences between the terms *modality* and *orientation*. An orientation is described as "an individual's general approach, ideology, or viewpoint," (APA Dictionary "Orientation," 2022, para. 6). In this study, the term *orientation* describes the theoretical orientation beliefs consisting of humanistic, cognitive, ecosystems, psychodynamic, pragmatic, family systems, and biological. A modality is described as "a particular therapeutic technique or process (e.g., psychodynamic)" (APA Dictionary "Modality," 2022, para. 1). The term *modality* would be best be applied to practices within the field of adventure therapy because it is a specific therapeutic technique or process involving adventure experiences for the purpose of therapeutic intentions.

The independent variables of RQ1 are adventure therapy practitioner orientation beliefs with scores divided into two groups: cognitive-ecosystems-humanistic (Group 1) and psychodynamic-family-biological-pragmatic (Group 2) as determined by Coleman's (2007) TEST instrument. The dependent variable of RQ1 is individual scores on the orientation beliefs questionnaire. The independent variable of RQ2 is the adventure therapy practitioner's degree emphasis, and the dependent variable is the individual participant's orientation beliefs score. For RQ3, the independent variable is professional licensure, and the dependent variable is the individual participant's orientation beliefs score.

Assumptions

In this study, a methodological and rhetorical assumption was that practitioners of adventure therapy are capable of self-identifying as adventure therapy practitioners through their professional membership to adventure therapy organizations and/or social media groups. A key rhetorical assumption was that adventure therapy is not synonymous with established theoretical orientation beliefs but is unique, although some beliefs may be shared with other established theoretical orientation beliefs. By using an established instrument, this study adhered to ontological and axiological assumptions as data were expected to be objective and unbiased. I held no position within TAPG, adhering to epistemological assumptions that I was independent from the study.

Scope and Delimitations

Preliminary data (Spaulding, 2016) have established that the membership of the TAPG consists of individuals with a social worker background, which the TEST (Coleman, 2007) had previously been used to gather data on. TAPG was originally chosen as the population for study because it is the best-known grouping of adventure therapy practitioners, but due to TAPG's inability to email their membership the survey, social media groups, professional conferences, and other groupings of adventure therapy practitioners were chosen for the study (see Spaulding, 2016).

Limitations

The field of adventure therapy research has been limited by the focus of studies, and this study was limited to those self-identifying as adventure therapy practitioners. This study may contain some bias through the survey chosen and the means of

distribution for the survey, that was limited to those with online access and a computer or personal electronic device capable of completing the study. Because adventure therapy practitioners may include those who work in wilderness settings where there is no internet access and/or computers with the capability for completing a survey, they were given ample time, 6 months, to participate in the study.

The definition of adventure therapy in past literature has varied greatly due to assumptions of what is defined as adventure therapy. This has proven true given the lack of consensus for a definition for adventure therapy and based on the myriad of definitions that have been proposed throughout past literature. The abundant use of eclectic therapeutic modalities, that may blend aspects of adventure therapy, have certainly contributed to the lack of a consensus for a single accepted definition of adventure therapy. In surveying adventure therapy professionals, this study seeks to funnel theoretical orientation beliefs toward a majority definition for the field of adventure therapy, therefore, defining adventure therapy through the value system of the practitioners. A limitation to this survey methodology may result in a response bias due to the influence of training in other orientations.

Significance

Understanding adventure therapy through the shared orientation beliefs of its practitioners may advance the consensus for shared values of adventure therapy practitioners. Clarification of shared values of adventure therapy practitioners is essential in comparing research within the body of knowledge for this field. Without shared values, adventure therapy studies may or may not actually focus on the same field of

research and therefore may not be comparable or within the same body of knowledge. Therefore, shared values found through shared beliefs in this therapeutic modality may have positive social change implications for an entire field of research. These positive social change implications have been defined by Gass (1993) as addressing six specific areas: “1) treatment effectiveness, 2) issues of training and competence of practitioners in adventure therapy, 3) integration of adventure therapy with other therapeutic approaches, 4) treatment issues, 5) clearer definitions of programs, and 6) funding issues” (p. 305).

Summary

The literature on theoretical orientation beliefs supports the need to explore the commonly held beliefs among practitioners within a specific modality. Coleman (2007) developed the TEST instrument to be used to identify seven mainstream theoretical orientations based on separate beliefs held by practitioners of these orientations. Adventure therapy practitioners may hold similar beliefs to mainstream theoretical orientations, such as psychodynamic, biological, family, ecosystems, cognitive, pragmatic, and humanistic. The variables of licensure and area of study may be considered in defining who is and is not an adventure therapy practitioner. Shared orientation beliefs that do not correlate to these commonly held definitions of professionalism would help eliminate outliers. By gathering input from self-identified practitioners of adventure therapy on their established theoretical orientation beliefs, an increased understanding of adventure therapy practitioners would be established.

The purpose of this chapter was to introduce the topic of theoretical orientation beliefs of adventure therapy practitioners and provide a review of the research method.

Chapter 2 provides an in-depth review of the literature related to the definitions, practice of adventure therapy, and origin of adventure therapy. In Chapter 2, I also compare adventure therapy to existing related fields.

Chapter 2: Literature Review

Introduction

In today's evidence-based professional climate (Markin, 2014), with the recent trend of evidence-based treatments in psychotherapy, theoretical orientation has become a valuable metric. Practitioners seek to provide scientifically justified therapeutic treatments for people with mental illness. Despite being more than 50 years old (Itin, 2001), adventure therapy is a relatively new therapeutic modality that has a limited body of research scientifically proving the modality's merits (Bowen & Neill, 2013). To advance the field, adventure therapy professionals can align modalities with similar beliefs and values (see Norcross & Prochaska, 1983). As such, this study's results may provide scientific evidence to guide adventure therapy practitioners toward potentially allied orientation-based beliefs and values (see Coleman, 2007) that professionals within the field of adventure therapy exhibit.

Research on theoretical orientations has historically been identified as one of the most important criteria in allying and dividing psychology professionals (Garfield & Kurtz, 1974; Larsson et al., 2010; Norcross & Prochaska, 1983; Steiner, 1978). In establishing related theoretical orientation beliefs between psychological professions, a shared identity would be developed fostering a less polarized climate and a more coherent language for treating people with mental illness (Markin, 2014). Norton et al. (2014) discussed the need for professionalization in adventure therapy as well as training and professional development for adventure therapy practitioners. One of the issues

discussed was the lack of commonly accepted definitions in the adventure therapy field. Gillis et al. (2012) attempted to propose a unifying definition for adventure therapy.

Recent developments in the field of psychotherapy have shifted funding for research (Goldfried, 2016). The limitations of studies relying on descriptive data have altered priorities for research toward studies focused on the etiological nature of mental health disorders. Goldfried (2016) predicted this radical paradigm shift would have consequences in the training of psychology professionals. Goldfried (2016) proposed that evidence-based research become less dependent on randomized clinical trials and be focused on research domain criteria that emphasize the gathering of biological data that can be associated with observable and identified psychological phenomena related to diagnosis.

Evidence-based research in psychotherapy has become one of the most important standards therapeutic orientations and treatment protocols are judged by. Past psychotherapy research has identified therapeutic factors that influence outcomes such as the therapeutic alliance, client engagement, and therapist–client characteristics (Dobud, 2017). These factors have been identified primarily through randomized clinical trials that demonstrated evidence-based therapeutic orientation practices (Dobud, 2017).

In this chapter, I review the literature related to adventure therapy and theoretical orientation beliefs. Adventure therapy is defined, described, and compared to pre-existing therapeutic orientations and their modalities. Further, I explore the barriers to adventure therapy as well as the compatibility of the modality to be used with various theoretical

orientation beliefs. Theoretical orientation beliefs are defined, described, and the therapeutic outcomes of the beliefs are examined.

Literature Search Strategy

Research was conducted using Walden University library databases, Google Scholar, Academic Search Complete, Medline, Science Direct, Mental Measurements Yearbook with Tests in Print, and the World Wide Web. Information from textbooks, conferences, selected association and organization websites, and dissertations was used to support the research inquiry due to scarcities of related peer-reviewed scholarly journals. A Boolean search of key-word phrases for *theoretical orientation beliefs* and *clinical orientation beliefs* yielded 2,050,000 results, of which, 77,700 results were published post-2015. The terms *clinical* and *theoretical* were both included, as they appear to be used interchangeably throughout the research on orientation beliefs (see Coleman, 2007; Markan, 2014; Norcross, 1983). In addition, Boolean searches for *adventure therapy*, *wilderness therapy*, *play therapy*, *sport psychology*, *exercise psychology*, and *health Psychology* yielded 12,084,300 results, of which, 1,356,500 were published post-2015. Due to the inclusion of Coleman's (2007) instrument on theoretical orientation beliefs, the key phrase Boolean search of *social work* and the theoretical orientation subdomains of *psychodynamic*, *psychoanalytical*, *biological*, *family systems*, *ecosystems*, *cognitive*, *pragmatic*, and *humanistic* were included, resulting in 11,494,000 results.

The basis of these search strategies was to support inductive reasoning. Despite the focus of this research on theoretical orientation beliefs, I needed to include additional terms in the literature search strategy to be able to articulate analogous fields of inquiry.

Additional queries for *adventure therapy, wilderness therapy, play therapy, sport psychology, exercise psychology,* and *health psychology* were included to articulate the analogous parallel development of adventure therapy within similar fields of study. Vital relevant research extended back to 1915, but the majority of cited research was published within the past 5 years.

The search for related articles began in fall 2010 and continued through fall 2021. Sources included peer-reviewed articles, academic books, conference notes, dissertations, and webpages as they pertained to the subject matter and relevance in developing the research inquiry. The field of adventure therapy holds only a fraction of the research of more established fields in the discipline of psychology. In addition to peer-reviewed articles, academic books, dissertations, symposium and conference notes, and webpages were used in lending additional weight to the need for this study to survey the theoretical orientation beliefs of adventure therapy practitioners. Because little is known about adventure therapy practitioners as a group, symposiums and conference proceedings, dissertations, and interviews with key profession members were collected for this study.

Theoretical Foundation

Adventure therapy aligns with principles from four psychological orientations: humanistic, psychodynamic, behavioral, and systemic (Gillis & Ringer, 1999). Other researchers have claimed that adventure therapy principles can include psychoanalytic or psychodynamic, behavioral or cognitive behavioral, humanistic, and biological theories (Lynch, 2005). Adventure therapy closely aligns with the general theory of humanism through the philosophical principle of challenge-by-choice, where a client is allowed

autonomy to participate in the challenge activities promoting client dignity (Miles & Priest, 1990). Similarly, the I-Thou relationship is valued in both humanistic theory and adventure therapy (Blenkinsop & Beeman, 2012). Another suggested aligned theory is cognitive–behavioral therapy, that shares the goals to challenge distorted thinking and make use of natural consequences (Friedberg & Gorman, 2007; Gass et al., 2020). Ecosystems theory and adventure therapy share the promotion of the client as an interrelated part of their environment, enforced through group dynamics that often use outdoor or wilderness environments (Gas et al., 2020).

Adventure Therapy

Adventure therapy is poorly defined in the literature. The definitions are often contrary and overly restrictive. Of the definitions used for adventure therapy, Gass et al.'s (2012) is the most relevant and current definition: "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral level" (p. 1). This definition helps differentiate the concept of adventure therapy from similar concepts, such as adventure education, using intent as part of the definition for the concept of therapeutic adventure. Adventure experiences were defined by Priest and Gass (2018) as meeting the criteria of being voluntarily participated in, intrinsically motivated, and dependent on an individual's state of mind with an uncertain outcome. Mental health professionals would qualify as those licensed in their respective mental health fields, such as a licensed social worker, licensed mental health counselor, licensed psychotherapist, licensed psychiatrist, and licensed marriage and family therapist.

Adventure therapy requiring natural settings is of some debate because challenge courses, ropes courses, or high adventure courses are often used in the practice of adventure therapy to foster a therapeutic or educational experience. However, these can be located both in natural settings and in structured indoor settings, such as indoor rock-climbing courses. The inclusion of natural settings in the definition of adventure therapy is based on research supporting the "notion that nature is restorative and promotes healthy physical, psychological, and emotional development" (Gass et al., 2012, p. 107).

Bloom's taxonomy of educational objectives (1956) is the standard for defining kinesthetic or psychomotor outcomes. Kinesthetic or psychomotor learning relates to the physical movement of participants facilitated by a curriculum that includes reflex movements, basic fundamental movements, perceptual abilities, physical abilities, skilled movements, and nondiscursive communication (Harrow, 1972). These therapeutic experiences engage participants cognitively through the acts of group discussions, individual therapy, journal writing, and feedback. Participants are affectively engaged through the acts of debriefing, framing, teachable moments, group engagement, individual counseling, and journal writing. Participant behaviors are addressed through learning objectives, therapeutic techniques, and risk management practices (Gass et al., 2012; Miles & Priest, 1999; Priest & Gass, 2018).

Although adventure therapy practitioners typically operate within the modality of outdoor or wilderness programming, the use of natural consequences as an intervention is in no way limited to natural settings (Gass et al., 2020). Cognitive-based therapies also make use of natural consequences as interventions (Friedberg & Gorman, 2007). A

literature review of adventure therapy confirmed that adventure therapy has been used as a primary treatment regime or as an adjunctive modality with a traditional psychotherapy orientation to address maladaptive behaviors ranging from “the treatment of eating disorders, including anorexia nervosa and bulimia nervosa, substance abuse, developmental disabilities, marital discord, family dysfunction, schizophrenia, sexual abuse perpetrators, and other incarcerated convicts” (Lynch, 2005, p. 16).

According to Seligman (2001), there are more than 400 different types of psychotherapy currently in use, that can be reduced to four or five general theoretical orientations (Lynch, 2005). Adventure therapy programs apply principles from four psychological orientations: humanistic, psychodynamic, behavioral, and systemic (Gillis & Ringer, 1999). According to Lynch (2005), other researchers suggest adventure therapy principles can be grouped to include psychoanalytic or psychodynamic theories, behavioral or cognitive-behavioral theories, humanistic, and biological theories.

According to this principled-based grouping of adventure therapy within the four or five established general theoretical orientations, one of the aligned general theoretical orientations suggested is cognitive–behavioral therapy (CBT). CBT is currently the most popular orientation among clinicians according to recent research of Canadian practitioners (Jaimes et al., 2015); furthermore, adventure therapy practitioners regularly challenge distorted thinking (Gass et al., 2020) as part of therapeutic interventions, that is identical to those interventions used in CBT (Beck, 1995). Vocational data were found to be a significant predictor of CBT and behaviorism (Rosen, 2017), yet no such data have been collected for adventure therapy practitioners to date.

According to Lynch (2005), systems is one of four or five general theoretical orientations under which adventure therapy falls. As such, ecosystems is a type of systems theory. Ecosystems is a theory originating from the field of social work in the 1970's (Mattaini, 2008). Adventure therapy shares a similar belief to ecosystems. Clients are part of an inter-related ecosystem, as most therapeutic interventions are performed as a group modality and make use of group dynamics (Gas et al., 2020). Adventure therapy's use of outdoor or wilderness environments (Gas et al., 2020) also aligns with techniques used in ecosystems or eco-therapy (Beringer & Martin, 2003). Research by Pryor et al. (2005) found that ecosystems theory and adventure therapy are highly complementary.

Lynch (2005) further suggested that adventure therapy be closely aligned with the general theory of humanism. This began in 1979 with Project Adventure staff hosting training workshops instructing on adventure-based counseling as a treatment modality that influenced the development of adventure therapy (Lynch, 2005). Adventure therapy practitioners use philosophical principles to guide their work, such as the challenge-by-choice principle (Miles & Priest, 1990), where the client's dignity and autonomy are respected similar to those principles found in humanistic psychology (Seligman, 2006). The I-Thou relationship is often credited with being the most essential part of humanistic theory and shares a similarly high value within the field of adventure therapy (Blenkinsop & Beeman, 2012). Gestalt therapy is a humanistic theory that blends with adventure therapy among many parallels (Gilsdorf, 1998). Of the different theoretical orientations,

humanistic theory shares many similar values with adventure therapy according to a review of the literature (Miles & Priest, 1995; Seligman, 2006).

Theoretical Orientation Beliefs

The definition of theoretical orientation beliefs is key to understanding therapeutic practices in the field of mental health. Therapeutic orientation is the philosophy or set of principles that guide the therapeutic techniques to which a therapist adheres in their practice (Norcross & Prochaska, 1983). Coleman's (2007) research focused on therapeutic orientation beliefs as the underlying principles, values, and philosophies that define the therapeutic practice of mental health professionals. The concept of theoretical orientation has been used interchangeably with the concept of clinical orientation.

Due to the popularity of eclectic or integrative approaches to theoretical orientations (Prochaska & Norcross, 1994) being as high as 50% or more among practitioners; it stands to reason that a framework of negative pragmatism was necessary to explore the concept of adventure therapy. Literature review definitions, that contained sometimes contradictory and overly restrictive criteria has been restructured and eliminated by surveying adventure therapy practitioners to evaluate what practices, philosophies, values, and techniques they utilize. The established framework of theoretical orientation beliefs has been used to structure a survey of adventure therapy practitioners. Similar philosophies, values, and beliefs have been used to identify and define other established general theoretical orientations (Lynch, 2005). Adventure therapy has been evaluated within the framework of the humanistic, psychodynamic, biological, cognitive, family systems, pragmatic, and ecosystems domains (Coleman,

2007). Positive relationships between these seven theoretical domains have been used to indicate the true definition of adventure therapy, whereas negative relationships between these seven domains have demonstrated those concepts not within the theoretical orientation beliefs of adventure therapy practitioners. Research by Lynch (2005) suggested that adventure therapy should have the greatest affinity for the philosophies, values, beliefs, and techniques held by the humanistic, cognitive, and ecosystems domains (Group 1). Accordingly, the psychodynamic, pragmatic, family systems, and biological domains (Group 2) should accordingly have the least affinity (Lynch, 2005).

Literature Review

Defining Adventure Therapy

In 1976, Peterson authored an article asking if the field of psychology was a profession. The article details the criteria proposed by Flexner (1915) that evaluates a profession based on whether (a) the objectives are practical and clear; (b) there is a formal education available to learn the techniques to meet the objectives, (c) the techniques are primarily cognitive in nature and matched to the specific objective, (d) these techniques fall within a discipline and are inaccessible to laymen, (e) membership to the profession is organized with criteria for whom may join, (f) the organization has a code of ethics and aims are altruistic. The field of psychology met these criteria and is today considered a profession without question, (Peterson, 1976 & Itin, 2001). In 2001, Itin investigated the decades old field of adventure therapy pondering the same question. Itin (2001) concluded that adventure therapy was an interdisciplinary field thus in conflict with Flexner's (1915) criteria for (d) a discipline that it would fall under. In practice

adventure therapy has fallen within the field of experiential education (Association of Experiential Education, 2016). The current organization for the membership body of adventure therapy is the TAPG that is a subgroup of the Association of Experiential Education (AEE). Saso (2004) noted "that the lack of a proper definition of adventure therapy presents a stumbling block for the future development of the field" (p. 1).

For decades, the practice of adventure therapy has been isolated from mainstream psychology (Priest & Gass, 2018) despite evidence that adventure therapy programs have been found to be effective as treatment for psychological disorders, specifically in children and adolescents (Tucker et al., 2013, Davis-Berman & Berman, 1994 & 2013). Adventure therapy has shown efficacy in treating both anxiety and depression in adolescents (Norton, 2009), in the treatment of eating disorders (Kaye, 1999; Maguire & Priest, 1994), substance abuse (Bennett et al., 1998; Coons, 2004; Gass, 1991; Gass & Gass, 1993), developmental disabilities (Herbert, 1998), marital discord (Gillis & Gass, 1993), family dysfunction (Burg, 2000; Mulholland & Williams, 1998), schizophrenia (Stich & Senior, 1984), sexual abuse perpetrators (Kjol & Weber, 1990; Rayment, 1998), and other incarcerated convicts (Mossman, 1998). Adventure therapy has also shown promise at treating additional mental health challenges (Newes & Bandoroff, 2004). A definition provided by Gillis that addresses adventure therapy's relationship to mental health consists of "adventure therapy is an active approach to psychotherapy for people seeking behavioral change, either voluntarily or through some court-ordered coercion, that utilizes adventure activities, be they group games and initiatives, or wilderness

expeditions (with some form of real or perceived risk) as the primary therapeutic medium to bring about change" (Lynch, 2005, p. 39).

Adventure therapy programming continues to grow internationally (Bowen & Neill, 2013), and utilizes licensed psychologists, social workers, counselors, marriage and family therapists, and mental health professionals credentialed outside of the adventure therapy profession in those licensing fields. Currently, adventure therapy practitioners are not recognized by any division of the APA (2015). This lack of recognition results in treatments using adventure therapy techniques previously not being covered by major insurance carriers (Anthem, 2015) and continuing to struggle for reimbursement of costs. Comparisons of other fields of study that have struggled for recognition include sport and exercise psychology (Danish & Hale, 1981) and play therapy (Ray et al., 2001). In 1986, the APA formally recognized exercise and sport psychology by adding Division 47 (Becker, 2015). This meant that the field of exercise and sport psychology took 61 years, from its founding by Coleman Griffith in 1925 when he taught a course called "Psychology and Athletics," until its establishment as a division of APA (Green 2003, p. 268). In 1982, the Association for Play Therapy was founded that created professional standards and advanced the field of play therapy (Pehrsson & Aguilera, 2007). Play therapy is now included in Division 53 of the APA, Society for Clinical Child and Adolescent Psychology, that was founded in 1999 (Erickson, 2019).

Sport and exercise psychology describes itself as an interdisciplinary field that can be split into three distinct professions: education, clinical, and research (Weinberg & Gould, 2014). The field of sport and exercise psychology is similar to adventure therapy

in many ways. Both fields use kinesthetic-based interventions and programming that are described as interdisciplinary and are utilized in similar contexts such as camp programs and sport (Weinberg & Gould, 2014). Adventure therapy and exercise psychology are based on similar theories such as Flow Theory by Mihály Csikzentimihályi (Gass et al., 2012; Weinberg & Gould, 2014;) and make use of similar interventions like mindfulness as well as activity sequencing to optimize their efficacy (Russell et al., 2014, January; Weinber & Gould, 2014;). Flow theory is the ability and practice of being present both physically and emotionally in the current moment to appreciate the entire experience (Lopez & Snyder, 2009).

The fields of adventure therapy and health psychology are also similar. Health psychology is a rather new interdisciplinary field of study in psychology focused on the application of knowledge and interventions to prevent illness, improve and maintain health, and provide quality holistic health care (Marks et al., 2011). A significant topic in health psychology is the impact stress has on mental and physical health. Backpacking, hiking, canoeing, kayaking, and various other forms of exercise, interventions extensively used in the field of adventure therapy, have shown to improve an individual's ability to cope with stress and improve mental health functioning (Lippke et al., 2015). Health psychology and adventure therapy share many characteristics with the two fields' similar values of holistic care focusing on nutrition, exercise, social involvement, and personal well-being.

Interviewing researchers in the field of adventure therapy at the 2016 Association for Experimental Education conference in Minneapolis, Minnesota, revealed that the field

of social work may have significant influence on the practice of adventure therapy (Spaulding, 2016). The field of social work developed out of a need for additional mental health professionals and was recognized as a profession around the 1930's (Zastrow, 2013). The field of social work has limitations, with accredited doctoral programs currently being piloted. The field of social work culminates professionally with the conferring of a master's degree in social work (MSW). These MSW programs are accredited by the Council on Social Work Education (CSWE) that is the only organization accrediting MSW programs in the United States (Council on Social Work Education, 2016). There are Ph.D. programs for social work and these pilot programs are accredited by CSWE ("Doctorate of Social Work", 2021). This profession's membership is organized nationally by the National Association of Social Workers (NASW), that also oversees social work publications through NASW Press (National Association of Social Workers, 2016). There are currently no studies confirming whether adventure therapy practitioner membership is significantly influenced by the field of social work or what similarities adventure therapy has to the field of social work that may be attractive to practitioners.

Play therapy struggled for more than 60 years to establish itself as a valid intervention and provide research to prove evidence-based efficacy (Ray et al., 2001). Play therapy has roots in psychoanalytic theory and began in the early 1950's as a result of the need for mental health interventions for children (Homeyer & DeFrance, 2007). This practice involves the observation of children participating in the kinesthetic act of play (Kottman, 2014). Adventure therapy also involves the kinesthetic act of participation

in adventure programming with therapeutic intent and may involve participant groups beyond those focused on the treatment of children (Gass et al., 2012). Through multiple meta-analyses on the efficacy of play therapy, research has finally paved the way to the practice's acceptance into mainstream psychology (Ray et al., 2001). Play therapists now work in hospitals, schools, and court settings providing insight into a child's mental well-being through interpreting their acts of play (Kottman, 2014). Adventure therapy has been following a similar developmental trajectory as the field struggles to prove itself to be a valid intervention and provide enough studies for meta-analysis on adventure therapy's efficacy.

The current definition of adventure therapy is: "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral level" (Gass et al., 2012, p. 1). The current definition clearly positions the field of adventure therapy within the larger discipline of Mental Health, but the field of Mental Health is divided into several fields such as: psychology, psychiatry, social work, counseling, marriage and family therapy, etc.; so where does adventure therapy belong? A literature review of adventure therapy indicates that it is both a specific "type of psychotherapeutic intervention" and "a specialized kind of treatment modality" (Lynch, 2005, p. 33), that is often used in conjunction with other therapeutic interventions. Adventure therapy certainly no longer belongs under the discipline of Experiential Education based on this current definition. At first glance, the therapeutic milieu most notably void of adventure therapy values would be traditional psychoanalysis. Although, psychoanalysis can be

utilized as a therapeutic method during an adventure therapy program (Newes & Bandoroff, 2004). For instance, a hammock and camping-type chair can be placed outside to simulate the structure of the psychoanalyst's office and therapeutic techniques lending to that form applied. In fact, almost any form of therapy can be adapted for utilization in an adventure therapy context. One such adventure therapy program, the Homeward Bound program; utilized behaviorism, reality therapy, and cognitive behavioral therapy during segments of its programming (Massachusetts Department of Youth Services, 2005).

Adventure therapy seems to integrate aspects of several therapeutic orientations into an effective treatment (Clark et al., 2004). The very physical nature of adventure therapy has therapeutic benefits. One of these benefits includes improved physical fitness that allows the body to break down harmful byproducts resulting from hormones released during stress, such as adrenaline, catecholamine, and cortisol (Weber, 2010). The physical activity inherent in adventure therapy is also an effective coping mechanism for feelings of restlessness and anxiety that increases the desire for movement. Eye movement desensitization and reprocessing (EMDR) is based upon a walk where Francine Shapiro became aware of a decrease in her agitation that she credited to eye movements invoked by the physical activity, (Seligman, 2006). EMDR utilizes techniques that involve sound and light to affect client eye movements in conjunction with recalling and processing therapeutic content. Adventure therapy typically involves travel over terrain that invokes the same eye movements emulated by EMDR. Additionally, adventure therapy shares characteristics of other therapeutic orientations

such as cognitive, behavioral, psychodynamic, and humanistic theories (Newes & Bandoroff, 2004).

Within the context of psychodynamic psychology, adventure therapy utilizes object relations theory to understand the past development of client relationships (Kyriakopoulos, 2010). Adventure therapy draws upon techniques including journal writing, reflection, modeling, self-disclosure, and group and metaphoric processing to reframe past relationships and invoke positive change within clients (Newes & Bandoroff, 2004). The attachments that clients develop within the group context and through modeling foster good enough relationships by transforming past dysfunctional relationships (Kyriakopoulos, 2010). Furthermore, attachment theory is often used to explain the positive growth experienced by clients in adventure therapy programs (Eckstein & Rüth, 2015). These good enough and positive attachments are strengthened by the extended exposure to instructor role models throughout the typical length of adventure therapy experiences (Newes & Bandoroff, 2004).

Behavioral-based therapeutic approaches such as Glasser's choice theory, are heavily drawn upon in adventure therapy (Newes & Bandoroff, 2004). Choice theory postulates that a client's choices of actions, thoughts, and feelings are the determinants of their well-being (Seligman, 2006). Adventure therapy fulfills the five basic needs of belonging, achievement, enjoyment, freedom, and survival (Seligman, 2006). Attachments formed between group members and therapists/instructors foster feelings of belonging and connectedness. Challenges within adventure therapy programming, such as rock climbing, promote feelings of accomplishment, confidence, success, internal

locus-of-control, and increased self-esteem (Newes & Bandoroff, 2004). Clients often report experiencing fun and enjoyment within adventure therapy programming as they tend to journal about appreciating other group members, jokes shared, and moments of play (Russell, 2001). The freedom experienced by participants in an adventure therapy program emanates from the philosophy of *challenge by choice*; where clients are allowed to choose the level of challenge that they feel able to participate in (Newes & Bandoroff, 2004). Essentials of life are often reframed through adventure therapy programming, providing clients with food, shelter, and improved health in a natural environment (Russell, 2001).

Humanistic theories and adventure therapy have many shared ideologies. Humanistic theory has an overarching belief that the person's views, thoughts, experiences are the center of focus and that the human experience is meant to be the most critical to understand in therapy (Seligman, 2006). The ability to make decisions, have morals, and accomplish goals are the main focus of humanistic theory (Seligman, 2006).

Gestalt therapy is a humanistic theory that postulates change is a result of a disruption in the homeostasis of an individual causing one of two reactions, either return to their original balance or change (Gilsdorf, 1998). Gestalt therapy is continually assisting clients in experimenting with the boundaries of themselves to cause the disruption to their internal homeostasis (Gilsdorf, 1998). Adventure therapy, when utilized in coordination with Gestalt therapy, quite literally provides the challenge that promotes flux and growth (Gilsdorf, 1998 & Seligman, 2006). Gestalt therapy and adventure therapy, when utilized together, provide a real-world challenge, such as rock

climbing, that results in a vast emotional response in the client with the pivotal point for change being processing the internal response stimulated by the activity (Gilsdorf, 1998). This internal processing occurs in discussion with the therapist/instructor, group members, and in journal writing (Newes & Bandoroff, 2004). Gestalt therapists believe that their clients have *limited awareness* and are often too focused on internal thoughts, that are often negative, and result in inability to grow past this negative self-image (Seligman, 2006). Adventure therapy is a vessel providing a workable challenge that causes the client to be present in the moment, work past their negative thoughts, and upon completion of the experience, has shown to increase self-confidence (Gilsdorf, 1998).

Adventure therapy has a strong connection with existential psychotherapy (Glass, 2008). Existentialism addresses the feelings of meaninglessness, isolation, inevitability of death, freedom, and responsibility (Seligman, 2004). The practices of adventure therapy direct clients to look inward in understanding themselves and their separation from the environment and others, as well as using challenges within the environment to bring individuals together and build connections (Glass, 2008). Adventure therapy offers opportunities for clients to discover their meaning within the context of a group environment and as they encounter challenges of that environment (Glass, 2008). Risk is often cited as an essential part of adventure therapy and risks in adventure therapy, such as a fall from rock climbing, presents the concern of death (Glass, 2008). Clients are expected to confront these concerns and take responsibility for the dangers inherent in adventure therapy (Glass, 2008). A basic practice of adventure therapy is for groups to create a social contract at the beginning of courses identifying rules and responsibilities

that they would adhere to limiting freedom within the context of their group environment and assigning responsibilities to one another (Glass, 2008).

Cognitive therapy such as Beck's CBT utilize cognitive strategies similar to those in adventure therapy predicated on a strong therapeutic alliance (Seligman, 2006; Gass, Gillis, & Russell 2012). The cognitive strategies of self-talk, reframing, systematic decision making, problem solving, distancing, assessment of alternatives, and Ellis' ABCDEF Model share similarities with adventure therapy's Resiliency Model of Challenge, Commitment, and Control and Gass' Model of Debriefing (Seligman 2006; Priest & Gass, 2018). Additional strategies used in cognitive therapies such as distraction, thought stopping, journaling, flooding, visual imagery, role-playing, affirmations, and anchoring are all often utilized in adventure programming (Gass, Gillis, & Russell, 2012). Adventure therapy uses many of these strategies as educational tools and for the purpose of self-actualization differing from the reasons and goals of cognitive behavioral therapy (Gass, Gillis, & Russell, 2012).

The majority of adventure therapy programming takes place within the natural world or *wilderness environments* (Russell, 2001). Nature-assisted therapy or Nature-based therapy is similar in characteristics to adventure-based therapy due to sharing the same preferred environment (Annerstedt & Währborg, 2011). Nature-based therapy has the goal of utilizing the natural world to promote behaviors that influence a person's environment towards sustainability (Annerstedt & Währborg, 2011). Additionally, the theory of ecopsychology also shares similar environments and goals with both nature-assisted therapy and adventure therapy (Hafford, 2014). Ecopsychology differs slightly

from nature-assisted therapy and adventure therapy in that it presumes people have an inherent affinity for the natural world (Hafford, 2014). Adventure therapy, however, utilizes natural and wilderness environments mainly because it challenges the comfort zone of participants (Gass, Gillis, & Russell, 2012).

Adventure therapy utilizes many different activities in its implementation (Priest & Gass, 2018). Recreational therapy also utilizes activities as interventions to address psychological and physical needs to promote health and well-being of clients (Itin, 2001). The use of challenge courses or ropes courses by both therapeutic approaches is an intervention mutually shared by both theoretical orientations, but adventure therapy differs from recreational therapy in its goals towards self-actualization (Gass, Gillis, & Russell, 2012; Itin, 2001). Recreational therapies also include sport and other activities not necessarily restricted to the natural environment (Itin, 2001). According to Lynch (2005) the most significant obstacle in defining a formal and universally accepted definition of adventure therapy, is whether adventure therapy is a “distinctive type of therapy” (p.41). This definition shall indicate whether adventure therapy is, in fact, a specific therapeutic orientation or a modality of treatment (Lynch, 2005). As a modality of treatment, adventure therapy has the potential to be paired with other therapeutic orientations and their corresponding interventions; but as a therapeutic orientation, adventure therapy will have principles and interventions that cannot be reconciled with other treatment orientations (Lynch, 2005).

Adventure Therapy Is Environmentally Based

Adventure therapy is rooted in the idea of using the environment to treat patients. This began in the 1800's with Friends Hospital in Philadelphia, Pennsylvania where the natural environment was used to treat mentally ill patients (Davis-Berman & Berman, 1994). In 1901, Manhattan State Hospital East used what they termed *tent therapy* to isolate Tuberculosis patients but found exposure to the natural environment had beneficial results (Davis-Berman & Berman, 1994). Then in 1906, the San Francisco Psychiatric Hospital moved patients into tents following an earthquake and found mental and social improvements following exposure to the natural environment (Davis-Berman & Berman, 1994). Tent camping is a basic technique in adventure therapy (Newes & Bandoroff, 2004). Tent camping is an adventure therapy technique that is effective because it forms a community, breaks down barriers among individuals, and fosters a sense of cohesiveness amongst a group while creating a shared experience that bonds the group together (Newes & Bandoroff, 2004). The camping movement began with Camp Ahmek in 1929, that used a therapeutic approach to camping focused on socialization and behavior modification (Davis-Berman & Berman, 1994; & Russell & Hendee, 2000). In 1946, another camping program founded by Campbell Loughmiller and associated with the Salesmanship Club of Dallas focused on the therapeutic benefits associated with the natural environment (Davis-Berman & Berman, 1994). Davis-Berman and Berman (1994) briefly cited the camping program founded by Loughmiller as the beginning of the camping movement.

One of the most recognized techniques employed by adventure therapy is challenge courses, also known as high or low ropes courses; and incorporating *grass games*, ice breakers, initiatives, and many other forms of cooperative, competitive, and/or problem-solving activities (Newes & Bandoroff, 2004). Challenge courses have been applied in school settings, with in-patients, out-patients, and as part of initial or on-going groups. The issue with challenge courses or tent camping being utilized as therapeutic techniques is that these can also be for the simple purpose of having fun. This issue is addressed by intent. The Educational Model boasts the same experiences of using experiential education to promote positive change in individuals by increasing self-esteem, resiliency skills, and academic achievement. While academic achievement may be clearly within the confines of the field of education, concepts like self-esteem and resiliency skills are considered psychological constructs. Adventure therapy researchers recognize the field involves a blending of both psychological models and learning models.

The use of tent-camping and challenge courses was previously discussed as therapeutic techniques involved in adventure therapy. The following is a list of the techniques employed, and is in no way a complete list, as there has not yet been research detailing the techniques that are or are not adventure therapy. Although not an exhaustive list, techniques commonly applied in adventure therapy consist of tent-camping, challenge courses, travel activities (i.e., hiking, backpacking, canoeing, skiing, snowshoeing), outdoor cooking, campfire building, survival skills training, solo camping

experiences, non-travel activities (i.e., photography, fishing, and base-camp sports), and group experiences.

These techniques seem to operate on a continuum, on the one end, a few or even one technique may be employed in a therapeutic experience; on the other end there is the extreme form of adventure therapy that can be advocated or described to be what is known as wilderness therapy. Issues have been arising in this therapeutic industry in terms of pseudo-adventure and wilderness therapy programs that have been rightly accused of causing harm to clients (Stuffel, 2022). Boot camp style programs that utilize elements of adventure and wilderness therapy have resulted in numerous deaths of clients (Lilienfeld, 2007). Specifically: transportation to programs, the use of restraints, and seclusion have been identified as elements harmful to clients utilized by these pseudo-adventure and wilderness therapy programs (Stuffel, 2022). Efforts have been made to certify adventure and wilderness therapy programs through industry organizations such as, the Outdoor Behavioral Healthcare Council that began accrediting programs in 2013 in cooperation with the Association for Experiential Education (Outdoor Behavioral Healthcare Council, 2022) as an effort to reduce the potential for harm to clients and foster standards within this therapeutic approach. As wilderness and adventure-based programming inherently contains elements of risk; the duty of therapeutic and adventure-based programming is to minimize these risks in order to protect clients from potential harm (Priest & Gass, 1997).

Comparing Adventure Therapy to Experiential Education

John Dewey of Vermont, one of the founders of the progressive education movement, contributed the basis of what was to become the framework of adventure therapy programming in the form of Experiential Education (Association of Experiential Education, 2016). Experiential education is the idea that experience should be the basis of an education and the source of the curriculum. These experiences can be framed in many ways with several definitions of feedback mechanisms referred to as *generations of debriefing* (Priest & Gass, 1997). This idea of using experience as the source for education begets the Outward Bound school founded by Kurt Hahn in Aberdovey, Wales in 1941 (Association of Experiential Education, 2016). Kurt Hahn introduced the goals of using a journey, expedition, and challenges as teaching tools within the experience (Association of Experiential Education, 2016). The idea of using these Outward Bound School experiences to foster character and maturity, or character education became mainstream as Outward Bound programs spread across the world (Russell & Hendee, 2000). The first American Outward Bound program began in 1962 when John Miles introduced the concept in Colorado (Miles & Priest, 1999). In 1979, Project Adventure coined the term *adventure-based counseling* to describe the process of using adventure-based experiences for personal growth (Gillis, 2015). In 1980 the AEE started a sub-group named: Adventure Alternatives in Corrections, Mental Health, and Special Populations, that later became TAPG in 1992.

Barriers to Adventure Therapy

In 1998 at a symposium on child adolescent psychiatry, Dr. Rittersdorf addressed the use of "Unconventional therapy treatment settings in child and adolescent psychiatry" (Gillis, 2015, para. 35), namely adventure therapy. In 2004, the Mentor Research Institute began offering 24 continuing education credits on adventure therapy as it pertains to physical, mental, social, and spiritual health; as well as personal development and self-actualization for psychologists, counselors, and social workers with approval by the American Psychological Association (Gillis, 2015; Blackney, 2017). Since 2004, little progress has been made to bring adventure therapy further into the mainstream in the United States. In fact, progress has been hampered by several client deaths in adventure therapy programs (Gillis, 2015) and a societal trend toward funding reduction has caused the closing of many programs (Pan, 2013). Norcross and Wogan (Walker, 2013) found it necessary to survey multiple organizations in order to gain insight into the practices of generalized therapy because they found that many therapists belong to an organization different from the American Psychological Association (APA).

Funding

Mental health conditions have currently risen in priority, becoming the costliest health crisis in America at $201 billion (Roehrig, 2016). In the United States in 2014, suicides were more than double the number of homicides, topping out at 42,773 suicides, a 28.2% increase since 1999, (Lytle, Silenzio, & Caine, 2016) making it the 10th leading cause of death. Of the general population, this is the second leading cause of death for people between the ages of 10 and 34 years old, according to the Center for Disease

Control (CDC) (Lytle, Silenzio, & Caine, 2016). Yet, funding for mental health only amounts to 5.6% of the total expenditures for health in the United States (Weil, 2015). Additionally, this problem is compounded by a lack of trained mental health professionals to treat this epidemic (Weil, 2015). The populations that are the highest risk for psychopathologies are adolescents, veterans, and persons 65 years and older (Weil, 2015).

Adventure therapy has a proven niche for serving adolescent populations suffering from depression that contributes to suicide and the potential to address these needs (Berman & Davis-Berman, 2013 & Norton, 2009). In 2011, a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis was performed surveying practitioners of adventure therapy (Gass, Gillis, & Russell, 2012). This survey found that lack of funding was indeed an issue within the field of adventure therapy thereby limiting access to treatment, hampering program quality, and affecting research studies (Gass, Gillis, & Russell, 2012). As a result, adventure therapy programs have relied primarily upon the private pay industry and have focused mainly on adolescent youth in need of behavior modification (Gass, Gillis, & Russell, 2012). Another issue related to funding is access to land or program areas for adventure therapy to be located, as some adventure therapy programs use extensive areas of wilderness as mediums for their programming and additional funding is necessary to secure access to lands and/or program areas (Gass, Gillis, & Russell, 2012). Globally, adventure therapy has potential to address the issues mental health faces (Collins, Insel, Chockalingam, Daar, & Maddox, 2013). Adventure

therapy has the potential as an integrated discipline with experiential education to change the way mental health services are delivered.

Theoretical Orientation

The study of theoretical orientation beliefs appears to have begun with two articles written by Fiedler (1950a & 1950b). These articles examine divergent therapeutic orientations and seek to establish what influence theoretical orientation beliefs have on therapeutic outcomes (Fiedler, 1950a & 1950b). Norcross and Prochaska (1983) used the study of theoretical orientation beliefs to identify differences between APA divisions and identified theoretical orientation beliefs as the most significant variable in the understanding of therapists (Walker, 2013). Markin (2014) used theoretical orientation beliefs as criteria in a study to identify the core identity of relationally inclined clinicians across theoretical orientations. The study of theoretical orientation beliefs continues to be relevant today (Lacasse, Lewis, & Spaulding-Givens, 2010; Halbur & Halbur, 2015; Markin, 2014; Wolff & Auckenthaler, 2014; & Coleman, 2007), despite the objections of an opinion article written by Strupp (1978), that attempted to cast doubt on the significance of theoretical orientation beliefs in the field of psychology. Research is often labeled by the specific theoretical orientations with differing orientations receiving different funding. About 52,500 articles have been written containing references to theoretical orientation beliefs since 2015 according to Google Scholar. Instruments for delineating one's theoretical orientation beliefs have been continually developed and remain in use today. One such instrument by Halbur and Halbur (2015), the Selective

Theory Sorter-Revised (STS-R), has often been employed to guide graduate students to pursue a theoretical orientation that aligns with their beliefs.

Therapeutic orientation is the philosophy or set of principles that guide the therapeutic techniques to which a therapist adheres in their practice (Norcross & Prochaska, 1983). Types of therapeutic orientations include cognitive-behavioral, humanistic, behavioral, psychodynamic, family systems, ecopsychology, solution-focused, and eclectic (Coleman, 2007) to name a few. According to Norcross and Prochaska (1983), therapeutic orientation is the most important influential variable in therapeutic practice. Research by Mcaleavey, Castonguay, and Xiao (2014) concluded that therapeutic orientation remains an important variable in understanding the practice of therapy. Variables that were found to have significant effects on therapeutic orientation are: age, years of practice, graduate profession, continuing education, working hours (full/part time), licensure, and supervision (Liu, Cao, Shi, Jiang, Liu, Wei, Zhang, 2013). Coleman (2007) developed an instrument to study this construct as it applied to Social Workers. Steiner (1978) first found the importance of studying therapeutic orientation and its relationship to other variables for practicing therapists.

Lynch (2005) discussed theoretical orientations and adventure therapy from a philosophical basis. Lynch (2005) credited up to five general theoretical orientations of the more than 400 different types of psychotherapy, as supporting the basic beliefs inherent in adventure therapy. Observations by Gillis and Ringer (1999, p. 29-37) in the practice of adventure therapy with groups supports the use of four theoretical orientations: humanistic, psychodynamic, behavioral, and systematic. In his study of

adventure therapy, Lynch (2005) included 1. psychoanalytic and psychodynamic, 2. behavioral, 3. cognitive/behavioral, and 4. biological-based theoretical orientations. However, Lynch (2005) discounted those theoretical orientations associated with the medical model of intervention due to his view that these models philosophically counter the nature of humans that he views as supportive of adventure therapy. The popularity of the eclectic or integrative approach as a theoretical orientation has been credited by Lynch (2005) as resulting from the inadequacy of any one treatment model to prove more effective than any other model at treating disorders.

Research shows that no one theoretical orientation is superior to another regarding therapeutic outcome effectiveness, that is a concept called *relative efficacy* (Norcross & Prochaska, 1983). There is, however, a documented bias by clinicians to favor their own theoretical orientation over that of alternative theoretical orientations (Keinan, Almagor, & Ben-Porath, 1989). Furthermore, Larsson, Kaldo, and Broberg (2013) found that practitioners would stereotype alternative theoretical orientation practitioners, with those practicing an eclectic or integrative theoretical orientation the least likely to show bias toward stereo-typing alternative theoretical orientations. Norcross and Thomas stated that this competition and division between theoretical orientations has been an obstacle in the progress of psychotherapy (1988). Additionally, Dattilio and Norcross (2006) found that this division between theoretical orientations among psychotherapists could be driven by territorial presumptions. That is why documenting a relationship between adventure therapy practitioners and other theoretical orientations has been beneficial toward the field of adventure therapy.

This study on theoretical orientation beliefs has used an instrument developed by Coleman (2007) that has been specifically used to identify the basic theoretical orientation beliefs of social workers. Each of these studies establishes that practitioners of similar theoretical orientations have similar belief structures that are defined as their theoretical orientation beliefs. Adventure therapy practitioners have never had their theoretical orientation beliefs identified. Foundational research by Norcross and Prochaska (1983) identified theoretical orientation beliefs as the most significant variable between psychological practitioners (Walker, 2013). Therefore, theoretical orientation beliefs are being used to begin the current study of adventure therapy practitioners. Research questions for this inquiry relate to whether adventure therapy practitioners share theoretical orientation beliefs and whether these theoretical orientation beliefs are influenced by the degree type and/or state licensure of adventure therapy practitioners.

Summary and Conclusions

The purpose of this chapter was to review the existing literature for adventure therapy and Theoretical Orientation Beliefs. The working definition of adventure therapy as the "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral level" (Gass, Gillis & Russell, 2012, p. 1) fails to specifically cite any techniques or theoretical orientation beliefs specific to adventure therapy. Theoretical orientation beliefs have trended towards an increase in integrative and eclectic orientations (Norcross & Prochaska, 1983). Therefore, it is essential that this study identify those beliefs specific to adventure therapy practitioners and those beliefs

likely shared by other theoretical orientations to differentiate between adventure therapy and integrative or eclectic practices. It is likely that the popularity of integrative and eclectic practices has muddled past attempts at clearly defining what is and is not adventure therapy. Furthermore, trends in funding for psychotherapy have undergone several shifts towards evidence-based practices and random domain criteria that the practice of adventure therapy must adapt to. Part of this adaptation requires the clear definition of adventure therapy orientation beliefs of adventure therapy practitioners and practices. Chapter 3 will describe the research method for this study including research design, methodology, data collection, the research instrumentation, and plan for data analysis.

Chapter 3: Research Method

Introduction

The purpose of this study was to understand adventure therapy practitioners' theoretical orientation beliefs and how they may relate to degree and licensure. Practitioners of adventure therapy were surveyed using Coleman's (2007) TEST instrument. Participants were recruited from those practitioners belonging to the Association of Experiential Education's subgroup of TAPG along with other self-identifying adventure therapy practitioners from social media groups, professional conferences, and other adventure therapy practitioner groupings. Because limiting data to only TAPG members would have not met the power analysis, the general field of adventure therapy practitioners was surveyed. The findings from this study have the potential to better define the profession and potentially lead to recommendations for strategic positioning of the profession within mainstream human service organizations. Further knowledge of adventure therapy practitioners may also assist in defining and clarifying the practice. In this chapter, I review the research design for the study, methodology, procedures for data collection, description of survey instruments, the data analysis plan, research questions, hypotheses, validity, and ethical considerations.

Research Design and Rationale

The study was a quantitative survey design to research the observed values of self-identified adventure therapy practitioners. Variables included the outcome of their primary theoretical orientation beliefs, mediated by licensure status and area of terminal degree emphasis. This quantitative study was developed to address the central question of

whether adventure therapy practitioners have shared primary theoretical orientation beliefs and how these beliefs relate to other demographic data to understand adventure therapy practitioners as a group. Coleman (2007) indicated that licensure status and degree emphasis may influence the outcome of theoretical orientation beliefs. Adventure therapy practitioners' primary orientation beliefs have been predicted in the literature as humanistic, ecosystems, and cognitive orientations. Demographic information was collected; no study to date has identified demographic information from this population. This study occurred over the course of several months allowing for the quantitative survey design to fulfill the necessary power requirements.

Methodology

Population

The population was therapeutic adventure practitioners. Estimates indicate between 3,800 and 16,792 current practitioners of adventure therapy worldwide based on social media involvement in adventure therapy-based groups. Therapeutic adventure practitioners were defined for participation as those individuals who self-identify as adventure therapy practitioners, who have completed at least 1 year or more of practice in the field of adventure therapy, and who are active in the TAPG, APA, or other professional organizations, professional conferences, and/or social media groups with access to the survey through a computer or personal electronic device. TAPG was selected as the main sampling frame based on Itin's (2001) research that defined the International Adventure Therapy Conference and the TAPG within the Association of Experiential Education as the professional organization for adventure therapy

practitioners. However, TAPG was unable to distribute the survey to its membership; therefore, social media groups dedicated to adventure therapy became the main focus of recruitment for this study.

Despite the preliminary power analysis based on a paired t-test for the mean difference in data prediction for the total sample size would need to be equal to or greater 34 participants total with an effect size of 0.5 with a power of 0.8 (Walden University, 2020), the chi-square goodness-of-fit test power analysis showed a need for 133 participants. This preliminary power analysis would achieve significance at the 0.05 level with a 0.8 confidence interval (How can I calculate achieved power, 2020). In the case of too few respondents, the sample size would have been increased 20% to allow for missing and incomplete surveys. Therefore, I expected to have at least 147 participants to adequately meet the power requirements for this study. Due to too few respondents from TAPG membership, additional survey participants were sourced from social media adventure therapy groups, conferences, and other organizations dedicated to the practice of adventure therapy. Potential exclusion criteria included partially answered surveys and self-identifying adventure therapy practitioners with 0 years' experience. Additionally, to meet power analysis needs, additional groups related to the practice of adventure therapy were invited, such as therapists who use adventure therapy practices and techniques like challenge course elements and adventure-based activities. Duplicate data (multiple sets of data from the same email address) were discarded.

Initially, data collection was to focus on TAPG membership through a verbal agreement previously reached with their leadership in 2016. Approval for data collection

was not achieved until August 18, 2021, leadership in the TAPG and their commitment had changed. This required expanding the distribution of the survey to reach the power requirements for the study. The altered distribution plan was approved by Walden University IRB on January 31, 2022. Potential participants were recruited through phone and email contact to distribute the invitation letter, survey link, and flyer graphic to members of colleges, universities, professional organizations, and businesses, as well as social media groups, where adventure therapy is taught, represented, discussed, and/or practiced. None of these participants required their institution's IRB approval for their individual participation in the survey.

Sampling and Sampling Procedures

In this study, I used quota sampling on the population of adventure therapy practitioners. This survey is probabilistic for self-identified practitioners of adventure therapy. Demographic information collected from participants included age, race, gender, marital status, degree emphasis, employment status, licensure, licensing area, certifications, professional organization membership, and number of years in practice. Participants were recruited to the survey via a website link through phone and email contact, conferences, and social media groups related to adventure therapy.

Participants who opened the website link to the online survey were first directed to the informed consent page. The informed consent provided information about the research study, procedures, sample questions, data collection and storage, information to exit the study, potential risks and benefits, lack of payments or gifts for participation, privacy, and contact information for the myself and Walden University's Research

Participant Advocate. At the bottom of this webpage, the participants were able to submit their email address, that was used to avoid duplication of surveys, and they were prompted to continue to the survey, requiring a selection of *yes* to serve as informed consent to continue to the demographic questions. If the survey participant selected *no*, the webpage forwarded a thank-you message, and the survey discontinued.

Demographic questions were the next step for the participants who agreed to the informed consent and submitted their email address. The demographic information collected included age, race, gender, marital status, degree emphasis, employment, licensure, licensing area, certifications, professional organization membership, and number of years in practice. Demographic questions were displayed in the form of multiple-choice questions with the ability to either select one answer or select multiple answers in the cases of certifications and membership to professional organizations, for example. The option *prefer not to say* was available for race, gender, marital status, and employment demographic questions. To further protect privacy, age and potentially sensitive questions were listed as a range.

Procedures for Recruitment, Participation, and Data Collection

Data from the TEST survey and demographic information were secured on SPSS and Microsoft Excel spreadsheet software. Coleman (2007) granted permission for the use of the TEST instrument for this study. The TEST survey instrument was administered by computer server through an online website link. Following a participant's electronic signature of informed consent, participants were then given the survey. Additional demographic information on degree emphasis or education, location, age, practice,

licensure, gender, current memberships to professional organizations and their divisions, and race were used to further understand who adventure therapy practitioners are.

Participants had multiple avenues of exit throughout the course of the study. Participants could (a) choose not to participate, (b) choose not to consent, (c) choose not to complete the survey, or (d) withdraw participation or contribution to the survey by contacting me as the researcher. Of these options, the number who chose not to participate is unknown but may be estimated at the potential population minus 201 survey participants. There were 18 participants who chose not to consent to the survey and 28 participants chose to begin but did not complete the survey, resulting in a total of 46 participants who chose not to participate or complete the survey. Additionally, there were two participant submissions that were duplicate, with the earliest entry retained and the latest entry rejected.

Debriefing consisted of a thank-you message upon completion of the online survey. All surveys were administered in an online format as the IRB disallowed paper survey instruments. Survey participants who completed the survey and received the thank-you message also received a tabulation of their results. A select few participants voiced concerns about the TEST instrument questions as they felt the results did not accurately reflect what they felt they should be. Those participants who voiced these concerns were encouraged to email me their critiques in writing. I replied to such messages with a thank-you message and assurance the feedback would be incorporated into the published dissertation. This feedback is presented as part of the recommendations section of Chapter 5.

Instrumentation and Operationalization of Constructs

This study is a quantitative analysis using a survey instrument, the TEST developed by Coleman in 2007. This study utilized a quota sampling method because I ceased distribution of the survey once the power requirements for the study were met. The TEST survey was developed by Coleman (2007) utilizing social workers as his population sample. Coleman gave permission via email for the use of the TEST instrument on March 13, 2015 (Appendix D). The TEST instrument consisted of 30 questions scored on a 7-point Likert-type scale, 1 for "Strongly Agree" through 7 for "Strongly Disagree". A sample of the TEST instrument can be found at: (http://www.web.pdx.edu/~dcoleman/test.html). Subscales based on the results of an exploratory factor analysis (Coleman, 2007) are mathematically calculated for final scores in each of the categories: psychodynamic, biological, family systems, ecosystems, cognitive, pragmatic, and humanistic. The highest score identified the theoretical orientation beliefs of a subject according to the seven possible outcomes. The TEST instrument has been found to be reliable and valid based upon its implementation on a population of social work students (Coleman, 2007).

The TEST was originally utilized to determine the Theoretical Orientation Beliefs of graduate students in the field of social work (Coleman, 2007). The TEST was administered through convenience sampling (Coleman, 2007). Those with a social work background can be directly compared and contrasted with the prior studies of the survey instrument (Coleman, 2007). The average reliability for the seven scales on the TEST was measured by an average Cronbach's alpha resulting in 0.65 (range = 0.44-0.77)

(Coleman, 2007). Convergent validity was found (Coleman, 2007). Since the original TEST focuses on graduate students in the field of social work, it was also necessary to divide survey participants by area of study. The TEST instrument was developed to be used for mental health workers both with and without a social work background and research results may still be contrasted to prior studies of the survey instrument (Coleman, 2007).

The independent variables for RQ1 are the domains of the theoretical orientation beliefs. These independent variables are broken into two groups: humanistic, cognitive, ecosystems (Group 1) and psychodynamic, pragmatic, family systems, and biological (Group 2). These independent variables are derived through participant answers to the 30, 7-point Likert Scale questions on the TEST instrument. The dependent variable for RQ2 is the individual's scores on the orientation beliefs questions that are analyzed as means. The independent variable for RQ2 is degree emphasis of the individual participant. This information is acquired through the demographic question pertaining to individual's degree emphasis. This question required participants to select an answer from the choices: counseling, social work, psychology, other, and no degree. The dependent variable for RQ2 is the individual participant's scores on the 30, 7-point Likert Scale questions on the TEST Instrument. The independent variable for RQ3 is whether the individual participant has professional licensure acquired through the professional licensure question in the demographic information. Participants selected one of two options about whether they had professional licensure with their choices being "Yes" or "No." The dependent variable for RQ3 is the individual participant's scores on the 30, 7-

point Likert Scale questions on the TEST instrument. There were no mediating variables identified by this study.

Data Analysis Plan

The data was analyzed using the latest version of software available from IBM corporation's Statistic Pack for Social Services (SPSS), version 28. I have examined each survey upon completion to ensure the data is uncorrupted and complete. Each survey was reviewed to ensure questions were completed, all duplicate surveys were removed, and any surveys with 0 years of experience were also removed from the study results. No mediating variables were utilized during the course of this study. If adventure therapy practitioners belonging to the TAPG have higher scores on cognitive, ecosystem, and humanistic domains of the TEST than the domains of psychodynamic, family systems, biological, and pragmatic, then we would expect this to be reflected in the paired t-test analysis of the data.

There are two scores for every participant: the domains of cognitive, ecosystem, and humanistic (Group 1) that consists of one score and the domains of psychodynamic, family, biological, and pragmatic (Group 2) consists of the other score. Scores were reduced to their mean so as to be comparable since domain questions on the TEST are not of equal amounts. When a participant completed a survey with missing or corrupt data, pertaining to the TEST, then this survey was removed from the study. In the case of a participant completing the TEST but failing to provide complete demographic data, then this survey shall be used in the data analysis but population data for this specific participant shall be deemed inconclusive for this individual survey. A paired t-test's

results provided scores that may show one category as significantly different from the scores of the other categories. A priori analysis for the paired t-test shows an effect size of 0.5, power of 0.8, and a sample size of 34. A significant result would show that a group of theoretical orientation beliefs are more highly represented, and thus favored, by adventure therapy practitioners.

For the other two hypotheses, each participant's mean scores have been recorded and the highest mean score group was used for analysis. These scores have been analyzed using a chi-square goodness-of-fit test to answer the following two research questions. If there is a relationship between theoretical orientation beliefs and degree emphasis for adventure therapy practitioners and the hypothesis is accepted, then there is favored theoretical orientation beliefs and degree emphasis that relate to those beliefs. The hypothesis for RQ2 shall be accepted if the chi-square goodness of fit analysis revealed significance at the .05 level. An A Priori analysis showed that a chi-square goodness of fit test would have an effect size of 0.3, power of 0.8, and a sample size of 122. RQ3 relates to whether the theoretical orientation beliefs differ depending on licensure among adventure therapy practitioners. This is also evaluated by a chi-square goodness-of-fit on whether a participant does or does not have a professional license to practice related with significant theoretical orientation beliefs. A hypothesis for RQ3 shall also be accepted if the chi-square goodness of fit analysis revealed significance at the .05 level.

Research Questions and Hypotheses

RQ1: Do Adventure Therapy professionals belonging to the TAPG have higher scores on the Cognitive, Ecosystems, and Humanistic domains of the TEST than the domains of Psychodynamic, Family, Biological, and Pragmatic.

H01: Adventure Therapy professionals belonging to the TAPG do not have higher scores on the Cognitive, Ecosystems, and Humanistic domains of the TEST.

H11: Adventure Therapy professionals belonging to the TAPG have higher scores on the Cognitive, Ecosystems, and Humanistic domains of the TEST.

RQ2: Do the theoretical orientation beliefs differ depending on degree emphasis among Adventure Therapy Professionals?

H02: There is not a relationship between theoretical orientation beliefs and degree emphasis for Adventure Therapy Professionals.

H12: There is a relationship between theoretical orientation beliefs and degree emphasis for Adventure Therapy Professionals.

RQ3: Do the theoretical orientation beliefs differ depending on licensure among Adventure Therapy Professionals?

H03: There is not a relationship between theoretical orientation beliefs and current professional licensure for Adventure Therapy Professionals.

H13: There is a relationship between theoretical orientation beliefs and current professional licensure for Adventure Therapy Professionals.

Threats to Validity

An obvious internal threat to validity would have been if this study failed to meet the power analysis in terms of survey participants that would cause there to be insufficient evidence to support either the hypothesis or null hypothesis. Additional internal threats to validity included failure of survey participants to complete the TEST instrument and over selection of subjects to meet the power analysis requirement that could jeopardize the purpose of this experiment. Threats to external validity included the possibility that additional surveys or experiments may expose participants to treatment interference or other interaction effects.

Ethical Procedures

As with all studies involving human beings there are always ethical considerations. These ethical issues have been identified in the participant consent form for this study. Anonymity of a participant's responses was achieved through mechanical assignment of alphanumerical identification. All completed surveys and data have been catalogued on a back-up drive without direct web access to prevent electronic theft of personal information. Any hard copies of data are secured within a locked filing cabinet for storage. Participants have been informed within the consent form of all uses of this data and the security precautions taken. At any point participants were given the choice to opt out of this study. Participants completing the study were issued their TEST scores, upon completion of the survey.

Summary

Through utilizing survey methodology this study employed a nonexperimental design. The participants were limited to those who self-identified as adventure therapy practitioners with at least 1 year of experience as an adventure therapy practitioner. Participants completed the TEST instrument as well as the demographic form. The survey was administered utilizing an emailed link or a QR Code that linked to the Qualtrics survey site. The purpose of this chapter was to review the research method being performed for this study, including research design, methodology, procedures for recruitment, participation, and data collection, instrumentation, the data analysis plan, research questions, threats to validity, and ethical considerations. Chapter 4 will explore the results of the research study.

Chapter 4: Results

Introduction

This research study documenting the theoretical orientation beliefs of adventure therapy professionals is the first of its kind. Adventure therapy professionals include mental health professionals, lay practitioners, and support staff. For this reason, research questions were created to address licensure and area of study as additional outcomes affected by theoretical orientation beliefs. Because the original TEST focused on graduate students in the field of social work, I divided survey participants by area of study, as those with similar social work backgrounds can be directly compared to prior uses of the TEST instrument. Those without a social work background can be contrasted with prior studies of the survey instrument (Coleman, 2007).

The following research questions and hypotheses specifically address adventure therapy professionals' membership in TAPG, degree emphasis, and licensure and their effect on theoretical orientation belief outcomes. For this research study, the seven potential theoretical orientation beliefs outcomes of the TEST survey instrument (Coleman, 2007) were grouped into two potential outcomes based on prior research (Lynch, 2005). One potential outcome set was the cognitive, ecosystem, and humanistic domains; the comparison group of domains consisted of psychodynamic, family, biological, and pragmatic.

RQ1: Do adventure therapy professionals belonging to TAPG have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST than the domains of psychodynamic, family, biological, and pragmatic?

$H_0$1: Adventure therapy professionals belonging to TAPG do not have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST.

$H_1$1: Adventure therapy professionals belonging to TAPG do have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST.

RQ2: Do the theoretical orientation beliefs differ depending on degree emphasis among adventure therapy professionals?

$H_0$2: There is not a relationship between theoretical orientation beliefs and degree emphasis for adventure therapy professionals.

$H_1$2: There is a relationship between theoretical orientation beliefs and degree emphasis for adventure therapy professionals.

RQ3: Do theoretical orientation beliefs differ depending on licensure among adventure therapy professionals?

$H_0$3: There is not a relationship between theoretical orientation beliefs and current professional licensure for adventure therapy professionals.

$H_1$3: There is a relationship between theoretical orientation beliefs and current professional licensure for adventure therapy professionals.

In this chapter, I review the results of the research study. This information includes the data collection strategy, results, and answers to the research question hypotheses. The results include the answers provided to the demographic questions and the TEST instrument (Coleman, 2007). The demographic question results provide information pertaining to participants' age, race, gender, marital status, degree emphasis, employment, licensure, licensing area, certifications, professional organization

membership, and number of years in practice. The TEST instrument results include the average responses for participants compared to Coleman's (2007) sample and participants who are members of TAPG. This information is explored further through the application of data to the hypotheses, requiring a paired t-test for RQ1 and chi-square goodness-of-fit tests for RQ2 and RQ3.

Data Collection

The timeframe for data collection was December 2021 through May 2022. Data collection focused on recruitment through social media. The primary social media format used was Facebook groups focused on adventure therapy: International Adventure Therapy; South Australian Bush Adventure Therapy Community; Ecotherapy/Wilderness and Adventure Therapy; Adventure Therapy Europe; Adventure Therapists in Private Practice; Adventure and Nature Based Therapy – India; TAPG – Therapeutic Adventure Professional Group; Wilderness Therapy Symposium (Facebook group); Wilderness Therapists; Wilderness Therapy; Wilderness Therapy, Outdoor Recreation, Experiential Education; Wilderness Therapy Field Staff of Utah; and the Association of Ecotherapy and Nature-Based Therapy. Due to the lack of data available from Facebook Groups, I cannot provide the number of active members for each group. Membership of groups may include bots (computer programs pretending to be people), inactive members, closed accounts, and other social media phenomena. Therefore, response percentages are based on the entire group's membership. Table 4.1 reports estimated response rates for each social media group.

Table 1

Estimated Population for Adventure Therapy Practitioners

	n = Estimated group members	Engagement of individuals (n)	Estimated amount of responses
Adventure Therapy	1,500	39	2.6%
International Adventure Therapy	2,300	17	0.7%
South Australian Bush Adventure Therapy Community	181	3	1.7%
Ecotherapy/Wilderness and Adventure Therapy	624	4	0.6%
Adventure Therapy Europe	694	5	0.7%
Adventure Therapists in Private Practice	1,000	13	1.3%
Adventure and Nature Based Therapy – India	67	0	0%
TAPG – Therapeutic Adventure Professional Group	2,100	35	1.7%
Wilderness Therapy Symposium (Facebook Group)	781	3	0.4%
Wilderness Therapists	306	3	1.0%
Wilderness Therapy	166	0	0%
Wilderness Therapy, Outdoor Recreation, Experiential Education	2,800	2	0.07%
Wilderness Therapy Field Staff of Utah	473	1	0.2%
Association of Ecotherapy and Nature-Based Therapy	3,800	7	0.2%

Based on this sample, I estimated there are between 3,800 and 16,792 adventure therapy professionals, depending on the extent of concurrent individual membership the many social media groups adventure therapy professionals may belong to. No other representative samples of this population currently exist and the TAPG and other professional membership organizations have been unwilling or unable to share data

regarding membership numbers. This study represents the only demographic information available to the research community.

The complete sample of participants included 201 surveys. Of this sample, 48 were rejected due to incomplete survey participation, non-consent, or duplicate entry. Of the 153 remaining participants who had completed the survey and consented, three were rejected due to having 0 years of experience in the field of adventure therapy. Demographic results for the final sample of 150 participants are reported in Tables 2 through 12.

For a comparison of demographic information, no data have yet been compiled or published specifically about the adventure therapy industry. Therefore, comparisons have to be made with data from the U.S. Bureau of Labor Statistics (2022) and Zippia Careers (2022). Comparisons between adventure therapy statistical data and mental health labor statistical data are important to ascertain the viability of workers to continue these services and detect needs in the labor pipeline for the industry. The labor pipeline consists of training, that includes certification programs as well as college and university degree programs, internships, on-the-job training, performing, and retirement. As workers progress through an industry pipeline, it is vital for an industry to consider the importance of recruiting, training, and employing new workers.

Table 2

Age of Participants

Age range	Number of participants (n = 150)	% of participants
18–30	26	17.33
31–40	57	38.00
41–64	60	40.00
65+	7	4.67

Table 3

Race of Participants

Race	Number of participants (n = 150)	% of participants
Caucasian	133	88.67
African American	1	0.67
Latino-Hispanic	2	1.33
Asian	3	2.00
Native American	3	2.00
Native Hawaiian or Pacific Islander	1	0.67
Two or more	9	6.00
Other/unknown	4	2.67
Prefer not to say	3	2.00

Table 4

Gender of Participants

Gender	Number of participants (n = 150)	% of participants
Female	76	50.67
Male	71	47.33
Other	3	2.00
Prefer not to say	0	0.00

Table 5

Marital Status of Participants

Marital status	Number of participants (n = 150)	% of participants
Married	80	53.33
Single	50	33.33
Civil union	8	5.33
Prefer not to say	7	4.67
Divorced	5	3.33
Widowed	0	0.00
Separated	0	0.00

Table 6

Degree Emphasis Among Participants

Degree emphasis	Number of participants (n = 150)	% of participants
Counseling	40	26.67
Social work	36	24.00
Psychology	26	17.33
Other	43	43.00
No degree	5	3.33

Table 7

Employment Status of Participants

Employment status	Number of participants (n = 150)	% of participants
Full-time	118	78.67
Part-time	26	17.33
Unemployed	3	2.00
Prefer not to say	3	2.00

Table 8

Licensure Status of Participants

Licensure status	Number of participants (n = 150)	% of participants
Yes	96	64.00
No	54	36.00

Table 9

Licensing Area of Participants

Licensing area	Number of participants (n = 96)	% of licensed participants
Social work	34	35.42
Counseling	32	33.33
Psychology	12	12.50
Other:	18	18.75
Marriage & family therapy	6	6.25
Mental health	3	3.13
Dual (more than one type)	2	2.08
Non-mental health	7	7.29

Table 10

Certifications of Participants

Certification	Number of participants	% of participants
Cardiopulmonary resuscitation	104	69.33
Basic first aid	75	50.00
Wilderness first responder	55	36.67
Wilderness first aid	36	24.00
Mental health first aid	36	24.00
Other	32	21.33
Lifeguard	21	14.00
None	19	12.67
Emergency medical technician	10	6.67
Water safety instructor	8	5.33
American Mountain Guides Association rock climbing	10	4.00
Paramedic	4	2.67

Table 11

Professional Organization Memberships of Participants

Professional organization	Number of participants (n = 150)	% of participants
Association of Experiential Education	48	32.00
Therapeutic Adventure Professionals Group	43	28.67
None	42	28.00
Other	39	26.00
American Counseling Association	26	17.33
American Psychological Association	20	13.33
National Association of Social Workers	18	12.00
Outdoor Behavioral Healthcare Council	18	12.00

Table 12

Participants' Years in Practice

Years in practice	Number of participants (n = 153)	% of participants
None	3 (Eliminated from study)	1.96
Less than one	14	9.15
1–10	61	39.87
11–20	43	28.10
21–30	25	16.34
31–40	3	1.96
45+	4	2.61

In Table 13, the ranked mean of the domain or category is displayed for the TEST instrument. Displayed is the mean or average outcome for each category for the entire group of participants. Part of this table includes the comparison of means where the average mean for Group 1 (humanistic, cognitive, and ecosystems) is compared to the total mean for Group 2 (psychodynamic, pragmatic, family systems, and biological). Similarly, Table 14 displays the means for the adventure therapy professionals who participated in the study along with the ranked categories for the entire group of participants and the corresponding means for the 150 participants. This is then compared to the next column, which includes Coleman's (2007) study of 106 social workers. The next column shows the deviation in the mean of adventure therapy professionals versus Coleman's study. The final column displays the 43 TAPG members and their corresponding means. Again, below is the comparison of means for Group 1 and Group 2 for the 150 adventure therapy professional participants, Coleman's (2007) study of 106 social workers, the deviation of means for adventure therapy professionals versus

Coleman between Group 1 and 2, and the means for Group 1 and 2 for the 43 TAPG members.

Table 13

Ranking of Results

Rank of mean(n = 150)	Category	Mean
1	Ecosystems	6.05
2	Humanistic	5.57
3	Psychodynamic	5.03
4	Cognitive	4.98
5	Family	4.59
6	Pragmatic	4.14
7	Biological	4.12
Comparison of means		
Humanistic, cognitive, and ecosystems	Group 1	5.533152
psychodynamic, pragmatic, family systems, and biological	Group 2	4.472386

Table 14

Rank of Means Compared

Rank of mean for current study	Category	Mean (n = 150)	Coleman's (2007) study (n = 106)	Deviation in mean for current study (n = 150) vs. Coleman's study (n = 106)	TAPG members (n = 43)
1	Ecosystems	6.05	6.05	0	6.24
2	Humanistic	5.57	3.47	2.10	5.68
3	Psychodynamic	5.03	5.24	–0.21	4.92
4	Cognitive	4.98	5.00	–0.02	4.88
5	Family	4.59	4.55	0.04	4.72
6	Pragmatic	4.14	4.02	0.12	4.08
7	Biological	4.12	3.65	0.47	4.04
Comparison of means					
	Group 1	5.533152	4.84*	0.69	5.60
	Group 2	4.472386	4.37*	0.10	4.44

Note. *Extrapolated from Coleman (2007) study's data

Results

According to United States labor statistics, the average age of a mental healthcare worker is 44 years old (U.S. Bureau of Labor Statistics, 2022; Zippia: The Career Expert, 2022). The demographic information collected by the study indicates the mean age of approximately 42 years old. Potentially indicating the importance of certification, college, and university degree programs for training new workers for this industry as current workers will reach critical shortages within 18-24 years without viable replacements.

According to Statistics from the United States Bureau of Labor and Zippia, the most common ethnicity of mental healthcare workers is Caucasian, that constitutes 80.9% of the industry, Latino-Hispanic constituting 9.1%, and African Americans consisting of 6.7%. The study on Adventure Therapy professionals found that the majority were 88.67% Caucasian, followed by “two or more” ethnicities at 6%, with Other/Unknown, Prefer Not to Say, Native American, and Asian between 2-2.67%. The race and ethnicity statistics of this study are similar to the mental healthcare industry statistics in that Caucasians appear to be the vast majority of mental healthcare workers. Research on the adventure therapy industry has paid ample attention to the race and ethnicity of participants but almost none to the race and ethnicity of adventure therapy professionals (Norton &Hsieh, 2011; Harper, Fernee, & Gabrielsen, 2021).

Mental Healthcare worker statistics for gender indicate the industry is comprised of 65.1% female and 34.9% male (U.S. Bureau of Labor Statistics, 2022; Zippia: The Career Expert, 2022). The study indicates a fairly equal ratio of male to female (47.33:50.67) with 2% of participants identifying as “Other” gender. These statistics for the study indicate a significant difference from the mental healthcare labor force of the U.S. at large.

Labor statistics for marital status among mental healthcare workers was not indicated by the U.S. Bureau of Labor Statistics or Zippia, however, total labor statistics for the United States indicate that 62% of men and 56% of women were married (U.S. Bureau of Labor Statistics, 2022; Zippia: The Career Expert, 2022). In comparison, 53.3% of adventure therapy professional participants indicated that they are married,

33.3% indicated they are single, 5.33% indicated they were in a civil union, 4.67% indicated they "Prefer Not to Say," and 3.33% indicated they were divorced. While these statistics are not truly comparable by year or labor market, these statistics do indicate a slight significant difference between the U.S. labor force and adventure therapy professional participants.

Labor statistics for mental healthcare workers are divided into associates, bachelor's, master's, high school diploma, and other degrees (U.S. Bureau of Labor Statistics, 2022; Zippia: The Career Expert, 2022). No labor statistics appear to be available dividing mental healthcare worker degrees by emphasis: counseling, social work, psychology, marriage and family therapy, etc. The statistics for adventure therapy professionals reflects "Other" as comprising 43% of participants, followed by counseling (26.67%), social work (24%), psychology (17.33%), and no degree (3.33%).

The study indicates the majority 78.67% of adventure therapy professional participants are employed on a full-time basis with 17.33% employed part-time, followed by 2% unemployed and "Prefer Not to Say." Comparable statistics to the U.S. Mental Health labor market were unable to be located.

Licensure for mental healthcare workers indicates a master's degree education or higher within the U.S. 64% of participants indicated licensure compared to 36% that indicated no licensure. This statistic demonstrates that the majority of participants hold a master's degree or higher education.

The study showed that 35.42% of participants were licensed as social workers followed by 33.33% were licensed as counselors, and 12.50 % were licensed as

psychologist. While the other category indicated 18.75% of licensed participants, a breakdown found that this consisted of 7.29% licensed in a non-mental health licensure field, 6.25% licensed in marriage and family therapy, 3.13% were licensed as mental health, and 2.08% had dual licensure. No comparable statistics were able to be located for either mental healthcare workers or the U.S. labor force. This is likely due to licensing information being restricted to individual states and their licensing boards within the U.S.

The study indicated the most popular certification among adventure therapy professionals with 69.33% holding cardiopulmonary resuscitation (CPR) certification. This is followed by basic first aid certification (50%), wilderness first responder (36.67%), wilderness first aid (24%) and mental health first aid (24%), other (21.33%), Lifeguard (14%), none (12.67%), emergency medical technician (6.67%), water safety instructor (5.33%), American Mountain Guide Association rock climbing (4%), and paramedic (2.67%). An industry webpage on career development states that CPR, first aid, and wilderness first responder are the typical certifications required for employment within the adventure therapy industry (Adventure Therapist Job Description, 2022). The study's results confirm this industry standard as requiring the majority of adventure therapy positions to obtain CPR, first aid, and wilderness first responder certifications.

Mental healthcare professionals join professional organizations by their degree emphasis; therefore, social workers join the National Association of Social Workers (NASW), counselors join the American Counseling Association (ACA), psychologists join the American Psychological Association (APA), and marriage and family therapist join the American Association of Marriage and Family Therapists (AAMFT). Adventure

therapy professionals are represented by at least two national organizations and one subgroup. The Association of Experiential Education (AEE) serves as the parent organization of the TAPG and works in cooperation with the Outdoor Behavioral Healthcare Council (OBHC) so the study's data on professional organization membership can represent both the individual membership and affiliation with these organizations. The study indicated the majority of participants held membership with the AEE (32%), followed by 28.67% likely holding dual membership with the TAPG. The next most significant group, according to the data, represented participants with no organizational membership (28%) and 26% representing membership to "other" organizations not included in the study. It is important to note that few participants in the study held organizational membership to those professional organizations that nationally represent their degree of emphasis with data showing that only 17.33% are members in the ACA, 13.33% are members of the APA, 12% are members of the NASW, and 12% are members of the OBHC. Again, no comparable data for either mental healthcare worker or labor data for the U.S. is available for comparison.

Data for mental healthcare worker tenure indicates the majority, 35%, of workers between 1-2 years of experience followed by 21% with less than 1 year, 16% with 5-7 years, 15% with 3-4 years, 7% with 11+ years, and 5% with 8-10 years. The study's data indicates that 39.87% had 1-10 years of experience, followed by 28.1% with 11-20 years of experience, 16.34% had 21-30 years of experience, 9.15% had less than 1 year of experience, 2.61% had 45+ years of experience, and 1.96% had 31-40. 1.96% of participants had no years of experience in the field of adventure therapy and were

eliminated from the study. While these statistics are not directly comparable due to differing ranges in tenure, the data does indicate similarities in the tenure of mental healthcare workers with adventure therapy professionals.

This study required participants to self-select as adventure therapy professionals. Feedback from participants outside the field of adventure therapy reinforced the power of this assumption and its ability to accurately select for adventure therapy professional participants. Furthermore, adventure therapy professionals were required to complete demographic information that reported years of service to the field. Those few participants who reported less than 1 year of service in the field were removed from the sample. It is assumed that any participant with less than 1 year of experience likely is an inaccurate sample of the population in question. Another assumption was that licensed individuals also have obtained a master's or greater degree, specifically in the field of licensure (i.e., a licensed social worker likely has a MSW, or a licensed counselor likely has a degree in counseling), as these degrees are state licensure requirements within the U.S. It is additionally assumed that international requirements are likely similar to those of the U.S. for licensure. RQ1 was based on the assumption that adventure therapy professionals are likely to have an affinity for cognitive, humanistic, and ecosystem theoretical orientation beliefs (Lynch, 2005).

Research Question 1

RQ1 states "Do adventure therapy professionals belonging to TAPG have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST than the domains of psychodynamic, family, biological, and pragmatic?" In addressing RQ1, there

were two scores for each participant with Group 1 consisting of humanistic, cognitive, and ecosystems domains and Group 2 being comprised of psychodynamic, pragmatic, family systems, and biological domains. The scores for these two groups were reduced to a mean to enable comparisons since the items on the TEST are not equal. RQ1 required a paired t-test to determine if a group of theoretical orientation beliefs are more highly represented. A priori analysis for the paired t-test showed an effect size of 0.5, power of 0.8, and a sample size of 34.

A paired samples t-test was performed using SPSS to compare theoretical orientation beliefs for the members of the TAPG (n=43) in Group 1, that consisted of the humanistic, cognitive, and ecosystems domains, and in Group 2, that consisted of the psychodynamic, pragmatic, family systems, and biological domains. This statistical analysis found that there was a significant difference between Group 1 and Group 2. Group 1 (M = 5.603, SD = 0.522) and Group 2 (M = 4.442, SD = 0.584) domains; t (42) = 13.997, p = 0.001. This means that for the participants belonging to the TAPG, the study found that Group 1 (humanistic, cognitive, ecosystems) was significantly greater than the results for Group 2 (psychodynamic, pragmatic, family systems, and biological) supporting the hypothesis for RQ1 of the study.

The results indicate that Group 1 (humanistic, cognitive, and ecosystems) is significant higher at the .001 alpha level than Group 2 (psychodynamic, pragmatic, family system, and biological) for that TAPG subset group of the study. Therefore, we accept the hypothesis ($H_1 1$): Adventure therapy professionals belonging to TAPG do have higher scores on the cognitive, ecosystems, and humanistic domains of the TEST.

Research Question 2

RQ2 states “Do the theoretical orientation beliefs differ depending on degree emphasis among adventure therapy professionals?” For RQ2, each participant’s mean scores were recorded and the highest mean score group was utilized in the analysis. The chi-square goodness-of-fit test was performed to determine significance at the 0.05 level. A priori analysis showed the chi-square goodness-of-fit test would have an effect size of 0.3. The results indicate the acceptance of the null hypothesis (H02): There is not a relationship between theoretical orientation beliefs and degree emphasis for adventure therapy professionals. Since the asymptotic significance is greater than 0.05 alpha level the hypothesis is rejected.

A chi-square goodness-of-fit test was performed using SPSS to determine whether the chosen degree emphasis had a significant effect on the participant’s theoretical orientation beliefs. The results for this statistical analysis for the Pearson chi-square revealed a non-significant association between theoretical orientation beliefs and degree emphasis for adventure therapy professionals: $\chi 2$ (16, N = 16) = 20.000, p = 0.220. This showed there was no significant difference for RQ2.

Research Question 3

RQ3 states “Do theoretical orientation beliefs differ depending on licensure among adventure therapy professionals?” In RQ3, this study examined the licensure status of the participant and whether their licensure status or lack thereof resulted in different theoretical orientation beliefs. This data were analyzed through a chi-square

goodness-of-fit test about whether the participant has or does not have a professional license to practice relating to a significant difference of theoretical orientation beliefs. The chi-square goodness-of-fit analysis revealed significance at the 0.05 level. The results indicate the acceptance of the null hypothesis ($H_0$3): There is not a relationship between theoretical orientation beliefs and current professional licensure for adventure therapy professionals. Since the asymptotic significance is greater than 0.05 alpha level the hypothesis is rejected.

A chi-square goodness-of-fit test was performed using SPSS to determine whether licensure had a significant effect on the participant's theoretical orientation beliefs. The results for this statistical analysis for the Pearson chi-square revealed a non-significant association between theoretical orientation beliefs and licensure for adventure therapy professionals: $\chi 2$ (1, N = 16) = 2.000, p = 0.157. This showed there was no significant difference for RQ3.

Summary

In summary, the research findings of this study conclusively found that adventure therapy professionals are a unique group with an affinity for specific theoretical orientation beliefs and that these beliefs remain constant through multiple variables. The findings for RQ1 support the hypothesis that adventure therapy professionals (n=43) belonging to the TAPG do have higher scores on humanistic, cognitive, and ecosystems domains (Group 1) of the TEST (Coleman, 2007) than the domains of psychodynamic, pragmatic, family systems, and biological (Group 2) as suggested in research by Lynch (2005). The hypothesis of adventure therapy professionals belonging to the TAPG have

higher scores on the cognitive, ecosystems, and humanistic domains of the TEST survey was proven significant at the <0.001 alpha level. In RQ2, it was found that the theoretical orientation beliefs do not significantly differ depending on degree emphasis among adventure therapy professionals (n=150). Therefore, the null hypothesis was accepted. For RQ3, it was found that the theoretical orientation beliefs do not differ depending on type of licensure among adventure therapy professionals (n=96).

The findings of this study for adventure therapy professionals further informs the body of research providing previously unknown demographical data, as well as answering the postulated hypotheses regarding theoretical orientation beliefs of this population. The purpose of this chapter was to explore the results derived from the study, including the data collection process, demographic data, mean of the domains, results of the TEST, and analyses required for the research questions. Chapter 5 will discuss the interpretation of the findings, explore the implications and limitations of the study, and make recommendations for further study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this research was to ascertain the theoretical orientation beliefs of adventure therapy practitioners. By determining the theoretical orientation beliefs of adventure therapy practitioners, the nature and definition of adventure therapy as a theoretical orientation can be better understood. This has been achieved through the framework of negative pragmatism (see Stuhr, 2015), that has been used to define adventure therapy by both positive and negative relationships established by the research. In RQ1, I found a positive relationship with Group 1 (humanistic, cognitive, and ecosystems) more so than Group 2 (psychodynamic, pragmatic, family systems, and biological). However, in RQ2 and RQ3, I found no such relationship with differing degree emphases or types of licensure. Through these three findings and the corresponding demographic information, I uncovered several insights that could be used to inform adventure therapy as a field and its definition.

Interpretation of the Findings

The findings confirm and extend knowledge of adventure therapy practitioners as was found in the peer-reviewed literature. A previous theoretical orientation belief practice included the popularity of eclectic and integrative approaches, reported to be as high as 50% (Prochaska & Norcross, 1994). For this reason, the seven theoretical orientations—humanistic, cognitive, ecosystems, psychodynamic, pragmatic, family systems, and biological—were placed into two groups, that also served to reduce the power requirements (n = 147) of the study. The grouping of humanistic, cognitive, and

ecosystems theoretical orientations was influenced by research (Lynch, 2005) that has held that adventure therapy is more aligned with these three particular theoretical orientation beliefs. Nonetheless, when the seven orientations are reviewed individually, humanistic, ecosystems, and psychodynamic are most favored by adventure therapy practitioners in this study, although the cognitive theoretical orientation mean was 4.98, only 0.05 below that of the psychodynamic theoretical orientation whose mean was 5.03.

The results of RQ1 indicate support for the hypothesis that members of TAPG have higher scores for Group 1 (humanistic, cognitive, ecosystems) than for Group 2 (psychodynamic, pragmatic, family systems, biological) as Lynch (2005) suggested. Among the cohort of adventure therapy professionals, the TAPG scored a mean of 5.6 for Group 1 and a mean of 4.4 for Group 2, that was not significantly different from the overall cohort of participants (n = 150), which resulted in a mean for Group 1 of 5.53 and a mean of 4.47 for Group 2. A paired samples t-test using SPSS Version 28 found the data for RQ1 to be significant at the 0.001 alpha level, indicating that the TAPG held to the theoretical orientation beliefs of Group 1 (humanistic, cognitive, and ecosystems) more so than Group 2 (psychodynamic, pragmatic, family systems, and biological). These data demonstrates that membership to TAPG does not make a significant difference between the general data for adventure therapy professionals as both groups showed a significant affinity for theoretical orientation beliefs of Group 1.

According to Coleman (2007), the MSW students who took the TEST survey identified with ecosystems, cognitive, and psychodynamic as the theoretical orientation beliefs most. The validation work with MSW participants by Coleman (2007) that led to

the selection of the TEST for this study as I anticipated a significant portion of adventure therapy practitioners would be of MSW degree origins. This assumption was supported by social work licensure participants comprising 34 participants, the greatest ranked group among licensed participants.

Coleman's (2007) study of MSW participants yielded a significant difference in the score for humanistic theoretical orientation beliefs when compared to the results of adventure therapy professionals. The deviation of means was 2.10 with adventure therapy professionals having a significantly greater affinity for humanistic theoretical orientation beliefs. The results extrapolated from Coleman's (2007) original data for Group 1 (humanistic, cognitive, and ecosystems) demonstrated a slight significance in mean differences between Coleman's MSW participants and adventure therapy professionals. In contrast, the difference in data extrapolated for Group 2 (psychodynamic, pragmatic, family systems, and biological) showed no significant difference between means for the social work participants in Coleman's study and adventure therapy professionals.

Data for RQ2 showed that theoretical orientation beliefs do not differ depending on degree emphasis among adventure therapy professionals. Therefore, among adventure therapy professionals, there is no significant difference between social work, psychology, counseling, or marriage and family therapy academic training in forming their theoretical orientation beliefs. There was a significance among social work participants for Coleman's (2007) study—specifically with the humanistic domain—supported the idea that adventure therapy professionals do have differing theoretical orientation beliefs than other mental healthcare professionals.

For RQ3, I found that theoretical orientation beliefs do not differ depending on the type of licensure for adventure therapy professionals. These results again support the understanding that adventure therapy professionals have uniform beliefs apparently not altered throughout the course of training toward licensure. Type of licensure is of no significance in forming adventure therapy professionals' theoretical orientation beliefs. RQ1, RQ2, and RQ3 support the understanding that adventure therapy professionals have relatively homogenous theoretical orientation beliefs unaltered by professional organization membership, degree emphasis, or licensing type.

Limitations of the Study

The definition of *practitioner* consists of those participants having 1 year of experience or greater in the field of adventure therapy. Fortunately, only three participants surveyed had to be rejected due to having 0 years of experience in the field of adventure therapy. Despite 6 months of time dedicated to the study and recruitment through social media, email, organizational membership, and conference attendance, only 150 respondents qualified for the criteria, barely meeting the power requirements for the study. The greatest response rate was found to be through direct canvassing of potential respondents. The response rate for social media is estimated at 6% based on the limited data available. Due to the low response rate of the study and the difficulty in recruiting respondents, the study has limited power for its generalizable results. The study received feedback regarding the use of the TEST Instrument (Coleman, 2007) from participants who felt the limited spectrum of questions in the TEST failed to capture their full theoretical orientation beliefs, especially as their beliefs pertain to the humanistic

orientation which was limited to three questions throughout the TEST for its factorial dimension.

One of the implied limitations of the study was its restriction to surveying adventure therapy professionals. The survey results were evident that this limitation was enforced through the complexity of the demographic and TEST survey questionnaire out of the 200 respondents, only 150 completed the full survey, with incomplete surveys generally being upon reaching the end of the demographic questions and beginning to answer the TEST specific questions, which required some theoretical orientation knowledge. These respondents ceased in answering the survey.

The survey was limited to demographic questions and the TEST survey questionnaire and did not contain a malingering scale so of the 150 respondents it is unknown whether any were faking (good or bad) their results of their survey. In fact, only one respondent of the 200 surveys completed the survey twice but due to requiring email signatures, the study was able to remove the duplicate data from corrupting the results.

Recommendations

Further research that is grounded in the strengths and limitations of this study, theoretical orientation beliefs of adventure therapy professionals, is indicated and should be considered. Of these recommendations, a recommendation for further study includes detailing the humanistic, cognitive, ecosystem, and psychodynamic orientation techniques that are utilized in the practice of adventure therapy by professionals. This recommendation is based upon the popularity of eclectic practices that utilize techniques

from several different, and sometimes opposing, orientations in therapeutic practice, (Prochaska & Norcross, 1994).

Another recommendation implicated by the results is to ascertain the benefits versus costs of specific certifications. Specific certifications can impact liability insurance and risk management planning in the industry providing benefits for both the individual organization and the industry as a whole (Moss, 2015). Additionally, recommended are the implications for membership to specific industry organizations. An example of membership to a specific industry organization for consideration for licensed psychologists would be the APA Division 34: Society for Environmental, Population, and Conservation Psychology that includes the orientation of ecopsychology, of which adventure therapy could be considered a modality with shared therapeutic orientation beliefs. Similarly, the APA Division 32: Society for Humanistic Psychology, also shares theoretical orientation beliefs with the modality of adventure therapy.

Accordingly, adventure therapy could find benefit with its therapeutic orientation beliefs in any division or membership organization with similar established theoretical orientation beliefs, (Newes & Bandoroff, 2004). Other membership recommendations to specific industry organizations should include the OBHC, TAPG, as well as those orientation groups within the American Counseling Association, NASW, and the AAMFT that align with the results for RQ1. A fourth recommendation for future research is to determine which area of study: social work, psychology, counseling, or marriage and family; best prepares adventure therapy professionals for work in this industry despite data suggesting it does not affect the adherence to shared theoretical orientation beliefs.

An evaluation of college and university programs in preparing students for work in the adventure therapy industry has never been performed, despite the Wilderness Education Association's (WEA) urging for the professional development of outdoor leaders and educators since 1977 (Why Professional Outdoor Leadership Matters, 2022).

Although, feedback presented to the author by participants mainly consisted of concerns about the cultural differences in the use of the English language. The reception by the international community of adventure therapy practitioners proved to be beyond expectations with contributions from European, Australian, and other international based communities. The feedback presented concerns about the specific transferability of the TEST instrument (Coleman, 2007) between cultures despite a shared base language of English. The English language has colloquial differences between cultures and continents, for instance word meaning, usage, and even pronunciation can differ between countries with national language of English, such as the United Kingdom, India, Australia, Canada, and the United States (Kidd., Kemp, Kashima, & Quinn, 2016). Instruments, like the TEST that was used for this research, may be culturally specific similar to issues with intelligence testing (Ogbu, 1993). A future research recommendation would be for a study to compare the TEST validity between culturally separate groups of participants. These recommendations expand upon the research results, implications of the collected data, and the consistent industry-specific issues.

Implications

The implications for positive social change for the study on theoretical orientation beliefs of adventure therapy professionals include use of the first industry-specific

demographic information being collected, the implications for adventure therapy professional theoretical orientation beliefs, and the impact the professional's areas of study and licensure have on theoretical orientation beliefs. The potential impact for positive social change addressed by this study is limited to the adventure therapy industry and to those organizations serving these therapeutic professionals. Although, the results imply a potential industry ripple-effect to the theoretical orientations of humanistic, cognitive, ecosystems, and psychodynamic.

Since this study accepted the hypothesis for RQ1 and rejected the hypotheses for RQ2 and RQ3, there are theoretical implications that may be applied to higher education institution programs dedicated to training adventure therapy professionals. Essentially, the certification, college, and university programs with a focus on training adventure therapy professionals are not limited by prior training or degree emphasis in indoctrinating potential students into the shared theoretical orientation beliefs of adventure therapy professionals. These theoretical orientation beliefs are expected to continue beyond licensure and the training process, as indicated by the similar means for these domains of theoretical orientation beliefs.

The theoretical implications of this study may be used to direct future research studies focusing on the eclectic combination of adventure therapy humanistic, cognitive, ecosystems, and psychodynamic orientations as they pertain to the adventure therapy industry. As the focus of the adventure therapy is the practice of "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on a cognitive, affective and behavioral

level" (Gass, Gillis & Russell, 2012, p. 1), a greater understanding of these theoretical orientation beliefs will inform this practice and serve to streamline resources, support, training, and recruitment of mental health staff for adventure therapy programming. Thereby, providing more efficient services to adventure therapy program participants struggling with mental health concerns.

Conclusion

After an extensive review of the literature of adventure therapy professionals and theoretical orientation beliefs, as well as the practice of adventure therapy, the following conclusion serves to inform the working definition of adventure therapy professionals and their theoretical orientation belief system. For RQ1, the TAPG membership (n=43) and the larger cohort of adventure therapy professionals (n=150) showed similar results, proving that the TAPG adequately represents the same theoretical orientation beliefs of adventure therapy professionals as a whole. Furthermore, these results show the prediction of research by Lynch (2005) that the cognitive, ecosystems, and humanistic domains would be identified with more than the psychodynamic, family systems, biological, and pragmatic domains was mostly true, apart from psychodynamic and cognitive domain identification being similar.

In RQ2, theoretical orientation beliefs were not found to differ among degree emphasis of adventure therapy professionals (n=150) and theoretical orientation beliefs did not differ among types of licensure for adventure therapy professionals (n=96). In the majority of the 400+ differing theoretical orientations (Seligman, 2001), the theoretical orientations have been defined by the progenitors of that orientation, for example Aaron

Beck is credited with being the progenitor of cognitive behavioral therapy, Carl Rogers is credited with being the progenitor of person-centered therapy, Fritz Pearls is often credited with being the progenitor of Gestalt therapy, and William Glassier is credited with being the progenitor of reality therapy (Seligman, 2005).

This approach to defining adventure therapy through the theoretical orientation beliefs of the practitioners serves as a revisionist mechanism similar to those efforts of Karen Horney, Anna Freud, Heinz Kohut, Harry Sullivan, and Helen Deutsch in the continued development of psychoanalytic theory. By surveying the practitioners of adventure therapy, this research has been able to inform the definition of adventure therapy through the practitioners shared theoretical orientation beliefs. In doing so found that the profession of adventure therapy is not exclusive to any specific academic degree emphasis nor to type of licensure and that the theoretical orientation beliefs of adventure therapy professionals do form a unique subgroup with beliefs separate from other previously surveyed groups.

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Appendix A: Survey Invitation

Theoretical Orientation Beliefs of Adventure Therapy Professionals

Link to Survey: [redacted]

My name is Edward Spaulding, I am a doctoral student attending Walden University's Health Psychology Program. I am currently doing a research study on Theoretical Orientation Beliefs of Adventure Therapy Professionals. With this letter, I would like to invite you to complete a 10-minute survey on the subject. Please find more information below on the study.

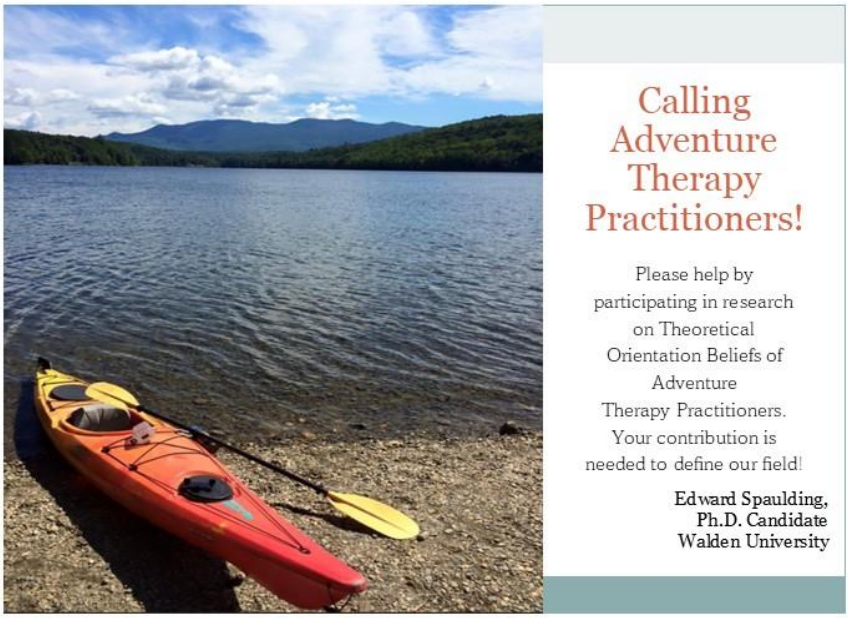
This research shall explore whether licensure, degree emphasis, and theoretical orientation beliefs have an impact on Adventure Therapy professionals. The Theoretical Evaluation Self-Test (T.E.S.T) developed and validated by Dr. Daniel Coleman of Fordham University and specific demographic information is to be completed by participants upon conformation of informed consent. It is expected that completing these tasks shall take 10 minutes, but participants are welcome to complete the tasks at their own pace and can take additional time if needed. The link above, supported by Qualtrics, shall navigate your browser to the informed consent form and continue to navigate the participant through the process. Upon completion, participants shall have their T.E.S.T. survey scored displaying their current theoretical orientation beliefs.

Due to the nature of online research, privacy and confidentiality cannot be guaranteed, although, the researcher shall strive to limit potential identifiers other than those essential to the research. Data collected shall be stored on the Qualtrics server for up to two years and analyzed using a non-networked hard drive and IBM's Statistical Package for Social Services (SPSS) software.

Any questions may be directed to the researcher, Edward Spaulding, via email: [redacted] or by phone: [redacted]. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at [redacted].

Sincerely,

Edward Spaulding, Ph.D. Candidate
Health Psychology Program, Walden University


Calling Adventure Therapy Practitioners!
Please help by participating in research on Theoretical Orientation Beliefs of Adventure Therapy Practitioners. Your contribution is needed to define our field!
Edward Spaulding, Ph.D. Candidate Walden University

Appendix B: Permission to Use T.E.S.T. Instrument

From: Daniel Coleman [redacted]
Sent: Monday, April 13, 2015 12:07:08 PM
To: Edward Spaulding [redacted]
Subject: Re: Disssertation Request

Hi Edward-
Permission granted.
Good luck with your study-- Dan

Daniel Coleman, MSW, Ph.D.
Associate Professor
Graduate School of Social Service
Fordham University (Lincoln Center)
[redacted]

On Sun, Apr 12, 2015 at 4:45 PM, Edward Spaulding [redacted]; wrote:

Hello Dr. Coleman,
I am interested in using your Theoretical Evaluation Self Test (TEST) for my dissertation to
assess the therapeutic orientations of the Therapeutic Adventure Professionals Group in the
Association of Experiential Education. I am a doctoral student at Walden University and am in
the early stages of my dissertation. Your TEST assessment would greatly assist me in completing my dissertation without the need to create my own psychometric assessment.
I look forward to hearing from you soon.
Sincerely,
-Edward Spaulding