ISSN 2206-3301

Volume 19, Number 1, April 2016

JOEE

Journal of Outdoor and Environmental Education

www.outdoorcouncil.asn.au

Exploring adventure therapy as an early intervention for struggling adolescents

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Abstract

This paper presents an account of a research project that explored the experiences of adolescents struggling with behavioural and emotional issues, who participated in a 14-day adventure therapy program in Australia referred to by the pseudonym, "Onward Adventures." All participants of this program over the age of 16 who completed within the last two years were asked to complete a survey. Additionally, the parents of these participants were invited to complete a similar survey. The qualitative surveys were designed to question participants' and parents' perceptions of the program (pre- and post-), the relationships (therapeutic alliance) built with program therapists, follow-up support, and outcomes of the program. Both participants and parents reported strong relationships with program leaders, stressed the importance of effective follow-up services, and perceived positive outcomes when it came to self-esteem and social skills, seeing comparable improvement in self-concept, overall behaviour, and coping skills.

Key words: adventure therapy, adolescence, family systems, interventions

Introduction

This study explored the experience of adolescents and families involved with Onward Adventures (this is a pseudonym used to protect the identity of participants and staff), an Australian adventure therapy (AT) program for at-risk adolescents. Led by a multidisciplinary team of social workers (including the author), psychologists, and outdoor education professionals, the program works with small groups of up to eight participants between the ages of 13 and 18 referred for varying life issues such as depression, anger management, family conflict, and patterns of self-defeating behaviour.

AT is a relatively new field and such research intends to help further investigate "the efficacy of AT as an effective treatment modality for improving psychological and/or behavioural functioning" (Bowen & Neill, 2013, p. 41). In addition, researchers such as McKenzie (2000) recommend increases of literature in the Australian context as most AT research explores US-based programs. This study offers a look into how AT programs can address the common factors that contribute to positive outcomes, such as comprehensive follow-up support, and the relationship, or therapeutic alliance, built between the practitioner and client (Hubble, Duncan, & Miller, 1999; Russell, 2001, 2005).

Defining adventure therapy

Due to its "historically eclectic and poorly-articulated" (Faddis & Bettmann, 2004, p. 57) beginnings in the US, adventure therapy (AT) programs are regularly linked with client deaths and "boot camp" style programs (Behrens, Santa, & Gass, 2010; Davis-Berman & Berman, 1994). This triggered the widespread search for an accepted definition to enable researchers to more clearly articulate the focus of their research in this area. For this study, the definition put forth by Gass, Gillis, and Russell (2012, p. 1) has been used, wherein AT is defined as the "prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective and behavioral levels."

This definition identifies a discrepancy between AT and other outdoor programs that provide outdoor experiences encouraging personal growth (Davis-Berman & Berman, 1994). Although outdoor programs may evoke therapeutic outcomes, practitioners "attempting to provide adventure therapy may be considered 'dangerous' if attempting to deal with the psychological needs of highly vulnerable clients to a depth beyond their own training" (A. Pryor, Carpenter, & Townsend, 2005, p. 7). This ethical dilemma has raised concern for service users interested in learning more about AT programs, but the impact can be softened with the understanding that AT must be delivered by practitioners adhering to their professional code of ethics and best practices, similar to those illustrated by the Australian Association of Social Workers (AASW, 2013) or the Australian Psychological Society (APS, 2007).

About the adventure therapy program

Onward Adventures engages small groups of adolescents in minimalist camping and hiking while teaching survival skills in the bush. The program generally runs eight times per year with follow-up support offered after each program. Adolescents are referred to the program by parents, school workers, allied health professionals, youth courts, and general

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practitioners (GPs) for various behavioural and emotional concerns. The majority of funding for the program is provided by the adolescent's family looking for alternatives to traditional mental health treatment, while education departments, schools, NGOs, Australia's National Disability Insurance Scheme and government agencies have also covered participant engagement.

Despite feeling coerced into attending the program, this program does not work as the motivator for getting the young person to attend. This feeling of coercion is common among adolescents as they are the least likely to engage in therapeutic support and the most likely to report feeling pressured or mandated to engage (Australian Institute of Health and Welfare, 2011; McGorry, Bates, & Birchwood, 2013; Rickwood, Van Dyke, & Telford, 2015).

With the referred adolescent being central to the program's focus, parents are also perceived as important members of the change process and are expected to help support the changes occurring on the program. Each family is given a workbook to discover parenting strengths and build insight into how they can use these strengths more often. While their child is on the expedition, parents also write two letters to their child that help to rebuild family relationships. The first letter, known as an "impact letter," (Russell & Hendee, 2000) discusses the struggles that have been occurring at home, while the second letter, occurring towards the end of the program, invites the adolescent to write about the changes they wish to see occurring both individually and as a family.

The 14-day expedition is divided into three distinct phases. The first nine days are spent trekking through the bush practicing self-sufficiency skills, such as making a fire without matches or lighters, building adequate shelters, and learning to navigate with a map and compass. During this time, the program leaders are focused on building a strong relationship with each participant and establishing a therapeutic focus. The second phase includes a two-day solo, where each participant creates their own camp for a night. During this time, participants receive their second letter from home and work with program leaders to consolidate the gains achieved on the program and formulate concrete goals for a successful return home. The final phase occurs at a house located at a pristine beach where the group spends time fishing, swimming, and relaxing after their time spent in the bush. Here, the focus shifts to preparing follow-up plans, relapse-prevention strategies, and concluding the program.

This program does not view AT as a miracle cure for psychological distress but instead sees the 14-day experience as a catalyst for continued therapeutic growth and progress. Upon returning home, program leaders provide parents with a comprehensive report detailing the young person's progress and ideas for creating a supportive environment at home. Families are then offered in-depth follow-up plans outlining the future involvement of the program leaders, other practitioners, and how the family can respond to lapses in progress.

Adventure therapy and at-risk youth

The numbers of youth in Australia struggling with mental health issues continues to climb with one in four adolescents reporting issues of psychological distress (Australian Bureau of Statistics, 2008; Australian Institute of Health and Welfare, 2011; Rickwood et al., 2015). In working with these young people, adventure therapy (AT) may be an effective alternative to traditional talk therapy or school-based interventions. Gass et al. (2012) note "two primary effects on AT participants: (1) the positive and significant development of self-concept from participation in an AT intervention, and (2) the development of adaptive and social skills due to the unique group-based treatment" (Gass et al., 2012, p. 291). Similarly, Bowen and Neill (2013) discovered, in their meta-analysis, larger effect sizes in clinical, self-concept, and social development measures.

Behrens et al. (2010, p. 110), in their review of experiential programs, found that adolescents tend to experience "significant decreases in suicidal ideation, anxiety, depression, substance abuse, social conflict, sleep disruption, violence as well as an overall reduction in externalising [behaviours] such as impulsivity, defiance and hostility." Using psychometric measures, AT has demonstrated "statistically significant improvement on immature defense and maladaptive behaviour scores, and on dysfunctional personality patterns, expressed concerns, and clinical syndromes scores" (Clark, Marmol, Cooley, & Gathercoal, 2004, p. 225). Although these findings support the case for AT's evidence base, the elements that occur during the AT experience may prove to be the best predictors of its effectiveness.

With a 21% increase in GP visits due to mental health concerns over the last 20 years, and adolescents still being the least likely to attend mental health services of any age group in Australia (Australian Institute of Health and Welfare, 2011), AT may provide a service that meets the needs of Australia's at-risk youth. By evaluating over 40 years of outcome research, Asay and Lambert (1999) found that regardless of a practitioner's theoretical orientation, client strengths (40%) and the relationship between the practitioner and client (30%) contribute more to positive outcomes than any other factor in mental health services. Olinsky, Grawa and Parks' (1994, p. 361) comprehensive review of this therapeutic relationship found that "the quality of the patient's participation in therapy stands out as the most important determinant of outcome." With

these factors in mind, the adventure setting may be an effective option as "adventure therapists often become more approachable and achieve greater interaction with clients when compared to traditional therapists" (Gass et al., 2012, p. 4).

Although adventure experiences can be challenging or push students out of their comfort zone, Brown (2008, p. 11) found that the greatest amount of growth and learning occurs when participants "feel safe, secure and accepted." This stresses the importance for practitioners "to create a therapeutic climate ripe for change, [by] having good listening skills, validating the client's thoughts and feelings, [displaying] of empathy, warmth, being genuine, conveying concern and caring behaviours" (Selekman, 2005, p. 27). These factors of therapeutic change may provide an explanation for why AT is "effective for unmotivated youth who otherwise may have not wanted to enter treatment" (Gass et al., 2012, p. 295).

Follow-up care is "a crucial component in facilitating the transition from an intensive wilderness experience to family, peer and school environments" (Russell, 2005, p. 205). Because progress is occurring away from the participant's normal living environment, ongoing support should be considered when "trying to return to home, school and/or peer environments that prior to treatment, may have perpetuated problem behaviours" (Russell, 2003, p. 374). In a comprehensive follow-up study, Draper, Bjorklund, Hess, and Preece (2013) interviewed 173 families to identify "unique patterns in long-term success" (Draper et al., 2013, p. 72) and the common obstacles affecting adolescents returning home from AT programs and therapeutic boarding schools. Continued substance abuse, negative peer relationships, and unchanged family environments were listed as the most common stumbling blocks. Adolescents also cited "positive incentives, encouragements and praise" (Draper et al., 2013, p. 84) as critical to their success, while parents found importance in setting consistent boundaries and expectations.

Other research also suggests increased value in "family-focused approaches … over working with the identified client alone" (Harper & Cooley, 2007, p. 393). By understanding the family context, practitioners can address how family members and external resources such as school counsellors, can support the participant's positive changes and goals for returning home (Draper et al., 2013; Gass et al., 2012; Harper, Russell, Cooley, & Cupples, 2007). Staying with this family context, the sustainability of outcomes in AT should be interconnected with parental involvement (Harper, 2007; Mulholland & Williams, 1998; Russell, 2005), a supportive family environment welcoming the child home (Draper et al., 2013), and hope and optimism exhibited by the parents (Hubble et al., 1999).

Onward Adventures assumes that change in AT occurs as a result of three factors, outlined by Gass et al. (2012). Firstly, a dynamic experience in a neutral environment exposing participants to challenges and problem-solving tasks gives practitioners the opportunity to work with clients in the present moment as events unfold. Secondly, the contained group setting provides ample time for practitioners to build a strong therapeutic relationship with each participant establishing a sense of safety and security that can facilitate "a diminishing of anxiety, an implicit hopefulness about the future, a perception of being in relationship with other human beings, a feeling of being loved or cared for, a sense of being worthy and often an expansion of awareness from self to others" (Ringer, 1999, p. 7). Finally, "natural consequences facilitate much of the learning" (Gass et al., 2012, p. 80) in AT. Although staff are present for support, participants are led to be "conscious in the moment of real or perceived danger … and [take] responsibility for it" (Mulholland & Williams, 1998, p. 22). Here, the model focuses on a "shift [of] motivation during a therapeutic process from an external source of motivation to an internal one" (Gass et al., 2012, p. 74).

The research process

The aim of this study was to explore participants' experiences through a semi-structured survey using both quantitative and qualitative questions. The objective was to inform various disciplines in mental health about the adventure therapy (AT) experience, follow-up possibilities, and family experiences. The study explored participant perceptions and considered the findings in relation to the study's review of the literature.

Ethics and method

Central to ethical conduct of the project was protecting the identity of the research participants. To ensure safety, data was collected from participants anonymously, which also improved the project's credibility as the "potential disclosure of confidential data might lead individuals not to reveal their true behaviour, consequently reducing the validity of the data" (Langhinrichsen-Rohling, Arata, O'Brien, DBowers, & Klibert, 2006, p. 426). Additionally, a pseudonym was used for the program name to further protect participants and those engaged with the organisation.

Participants were found using a sample of all adolescents over the age of 16 that had completed the AT program since January 2013. Parents were also invited

to complete the survey, although adolescents were first provided the opportunity to deny consent for their parent to be involved. Although most Australian states deem those 16 years and older mature and competent enough to provide their own consent, parents of those living where the age of consent is over 16 years of age were delivered consent forms prior to their child's, for further protection. As recommended by Corbin and Strauss (2008), this sampling method was chosen in relation to the purpose of this research investigating how these unique participants and parents involved in the change process perceived their AT experience.

The sample located 18 potential participants for the study and emailed them the link to the anonymous online survey as well as a copy of their consent form. The number of students returning the surveys was higher than that of the parents with 13 of the 18 adolescent surveys returned, while 10 of the 17 parent surveys were completed. Upon receiving completed [un-named] surveys, codes were given to label each response. Parent surveys were designated with a *P* while participants were given an *S*, for student. Next was the age of the participant, followed by their gender. Responses with identical codes were given a roman numeral to distinguish participants. For example, the second 17-year-old male survey received was labelled S17mII.

The survey provided tick boxes, numerical scales, and room for open-ended responses allowing participants to write freely. Questions were designed to explore areas of change common in AT literature such as family relationships, school performance, peer relationships, self-concept, coping skills, and overall behaviour (Davis-Berman & Berman, 1994; Gass et al., 2012; Neill, 2003; Norton, 2010a; Russell, 2000, 2001, 2003, 2005, 2008; Russell & Gillis, 2010; Russell & Hendee, 2000).

The survey first provided a tick box to gather the participant's age and gender. To clarify the survey's layout, in assessing the quality of the therapeutic relationship, the participants were provided with the prompt to, "Please rate your relationship with your program leaders" and given a scale of 1 to 5, with *1* being "no relationship at all" and *5* being "very strong relationship." Following the scale, they were asked to, "Describe the relationship you had with your trip leaders" and provided with a text box suitable for an open-ended response.

Because the author's involvement with the program as social worker was complicated by his role as researcher, it was necessary to address the dual relationship with participants, especially in terms of power relationships and responses to the surveys. To minimise this impact, anonymous surveys were utilised to allow participants to contribute without their particular responses being identifiable. The survey was accessible online with a link provided in the initial email contact. This study did not collect identifiable information and requested participants to omit all identifying information.

Presentation and discussion of findings

Although this study did not use pre-test and post-test methods, it did ask participants to recall how they felt about attending the AT program, prior to participation. The results found mixed feelings among participants in levels of anxiety and anger. Parents found their children felt angry and anxious, sometimes expressed in terms of parents trying "to get rid of" (P18fI) them. Some participants mentioned feeling nervous about spending an extended period in a bush setting, while others were blunt in stating that they did not want to go at all. Mentioned previously, this feeling of coercion, whether from family members or school workers, is common among young people.

Post-trip questions reflected a change of opinion. Many participants agreed in finding the outdoor environment challenging, mentioning that although the experience was definitely "better than I thought" (S16mII), it was still difficult adapting to the weather, food, and sleeping conditions. Despite these challenges, parents saw their children returning home with a new sense of optimism and positivity. One parent noted that her son "felt that he had done something important" (P18mI), while another perceived her daughter returning "enthusiastic about everything" (P18fII).

Using an 8-point Likert scale, participants were asked to provide a rating for how they felt prior to attending the program and upon its completion; *8* represented feeling "excited about attending," *1* meaning the participant "hated the idea of the program." Participants scored a pre-program rating of 3.69 and post- of 6.46. Parents also showed considerable change as a pre-score of 2.90 increased to 7. A sense of accomplishment was noted by both parents and participants, and may be responsible for the increase in scores. Participants were returning home mentioning, as one expressed it, that they had "achieved a lot" (S17fI).

The therapeutic relationship

Despite diverse preconceptions about attending the program, adolescents left feeling more positive about the experience with a strong connection to the program leaders. Measuring the therapeutic alliance was important for this study as this relationship is critical to success and also a common factor contributing to positive outcomes (Hubble et al., 1999).

Additionally, Garcia and Weisz (2002) have found that those who drop out of psychotherapy report issues with the therapeutic relationship and program fees more often than any other factor.

When asked to rate the relationships created during the program, parents reported an average score of 4.80 while participant scores averaged 4.46, both out of a possible 5. With many factors contributing to a strong alliance, the therapeutic climate created for the group was important for establishing a nurturing environment for the program to take place. Participants mentioned that program leaders were approachable and that they could "easily talk to them" (S16fI). A sense of authenticity emerged, illustrated by one participant who felt she could "be [herself] around both of the leaders and was comfortable sharing [her] thoughts and feelings with them" (S17fII). Parents also noted these connections, as one parent's son felt "trusted and understood" (P17mIV). Because of the importance of a welcoming therapeutic environment, having an experience where adolescents can build these genuine relationships is an enormous advantage for AT.

This was not a first-time therapy experience for many of the families engaged with Onward Adventures. Many of the participants had been engaged with psychologists, counsellors, and school professionals back at home. Parents also reported their adolescents never having had a relationship with other helping professionals and that the program leaders were welcoming and relatable. These findings accentuate AT as an attractive option for adolescents at risk of disengagement, as these participants found the experience to be effective in connecting with those that may have past negative treatment experiences (Behrens et al., 2010; Norton, 2010b).

Issues of trust and understanding were also important to the participants. Participants valued being able to "basically say whatever we wanted" (S17mII) and that the program leaders "had my back when it got hard" (S16mII). The engaging nature of AT is considered an encouraging building block for change. These reports reflect the therapeutic environment built during the program but have yet to illustrate how the relationship can lead to engagement and change. The following section will look at the reported outcomes as witnessed by the participants of the program and their parents.

Reported outcomes

In addition to an open-ended text box where participants could write freely about what outcomes or skills they had taken away from the program, participants and parents were both asked to report changes, rated on a 5-point Likert scale, in the areas of family relationships, school work, relationships with friends, feelings towards themselves, coping with conflict, and overall behaviour. Participants reported the highest scores in the areas of coping with conflict and overall behavioural, while parents also reported high scores in family relationships and their child's behaviour.

In the area of family relationships, both parents and participants noted that despite arguments or struggles at home, the family felt more equipped and prepared to handle the conflict. Participants noted that using positive coping skills helped to reduce the conflict. Parents and participants noted that their disputes were not as explosive as before and that both parties were able to remain calm and in control.

Being able to handle conflict, whether internal or external, is often a reason for referral for adolescents. Many adolescents who find themselves in therapeutic care struggle with anger management, school behaviour problems, anxiety, or depression (Rickwood et al., 2015; Selekman, 2005). When faced with challenges upon returning home, participants were

Table 1. Reported Outcomes

Title	**Student response**		**Parent response**	
Family relationships	Mean = 4.09	SD = 0.70	Mean = 4.70	SD = 0.48
School work	Mean = 4.00	SD = 0.77	Mean = 4.00	SD = 0.86
Peer relationships	Mean = 4.33	SD = 0.77	Mean = 4.00	SD = 0.94
Self-concept	Mean = 4.25	SD = 0.96	Mean = 4.40	SD = 0.96
Coping with conflict	Mean = 4.41	SD = 0.66	Mean = 4.33	SD = 0.70
Overall behaviour	Mean = 4.50	SD = 0.67	Mean = 4.44	SD = 0.52

able to reflect on their actions "instead of just reacting and shooting [themselves] in the foot" (P17mI). One adolescent female mentioned that even though she may have arguments with her mother, she can "stay a lot calmer and control [herself] rather than lashing out" (S17fIII).

These changes may be due to program leaders who efficiently present "challenges that are developmentally appropriate, in that they are concrete, attainable, and increase in difficulty and challenge as the intervention progresses" (Gass et al., 2012, p. 292). This study's outcomes support previous findings of AT's capacity to foster "improved physical, mental, social, community and environmental health and wellbeing" (A. Pryor, Carpenter, & Townsend, 2005, p. 4).

The final thread emerging from the data was that of happiness and optimism. Parents found that their children seemed "happier and no longer depressed" (P16mI), and "empowered, motivated, happy [and] capable" (P17mII). These confident feelings help with relapse prevention and follow-up plans and are also useful in working through lapses in progress or difficulty. Most importantly, the participants who may not have wished to engage in a therapeutic service left feeling as if the program had a significant impact on their lives. When asked if they would take part in the AT expedition again the results were significant with all but two participants reporting that they would engage in AT services again.

Follow-up support

Despite reports of positive change and strong therapeutic relationships, finding sustainable and long-term outcomes has been difficult for AT programs (Draper et al., 2013; Harper & Cooley, 2007; Russell, 2005). Gathering feedback about follow-up support was important, as Onward Adventures' in-house follow-up care is not common among youth programs. Of those participating in this study, all but one student and two parents had engaged in follow-up support since returning home. Upon returning home, all families worked with program leaders to prepare tailored follow-up plans. These were individualised and varied based on variables such as external practitioners, family values, and location. When asked on a Likert scale of 1 to 5 how effective participants observed follow-up support to be, both the parents (average 4.40) and students (average 3.84) reported finding additional support to be beneficial.

Parallel to Draper et al.'s (2013) and Russell's (2005) studies exploring obstacles in life experienced post-treatment, participants noted that although conflicts may still occur, they were better equipped to cope with stress in a positive way. Participants in this study valued follow-up services provided by their program leaders as they reported feeling able to talk openly about events that were taking place at home.

Parents reported that the follow-up support assisted them in helping their child return home. One parent felt that the program leaders were "always there to talk … and resolve issues" (P18fI) and three parents valued having practitioners or other professionals who could talk with schools to ensure that everyone was on the same page in helping. Parental support and coaching were also appreciated because they helped parents to "feel very supported" (P17mIII) and "stay in perspective" (P17mII).

Limitations

Due to the small sample size, there is no intention to claim generalisability, although this study still provides an important exploration of how participants and families perceived this AT experience. Future evaluations, if conducted, would provide larger sample sizes that could be used to generalise in various ways. A further limitation of this study involves the author's embeddedness in the program, which while positive in relation to knowledge of the program goals and procedures, may limit the objective distance achievable in connection with analysis.

A challenging aspect of researching AT or any therapeutic intervention is in the "black box effect" (Gass et al., 2012) where participants enter a certain environment for a matter of time and leave with certain outcomes, without literature gaining further insight in what phenomenon is truly occurring. The obstacle for researchers is to avoid describing "the treatment as if it is isolated from the most powerful factors that contribute to change — the client's resources, perceptions, and participation" (Duncan, Miller, & Sparks, 2004). Because there is limited understanding of the AT experience, researchers need to "address the question of what specific factors are most therapeutic and what is the long term benefit of participation" (Hill, 2007, p. 348).

Implications for practice

Stressing the importance of the relationship built between practitioners and participants — the therapeutic alliance — should assist similar programs and the helping professionals involved to engage difficult adolescents. Being skilled in providing developmentally appropriate interventions that are tailor-fit to each unique participant should help practitioners connect with their client and meet them as they are. Because adolescents can fall through the cracks of traditional treatments, AT programs could

be recognised as an intervention capable of connecting disengaged adolescents struggling with behavioural and emotional challenges. To connect with these clients, practitioners will benefit from working with the elements most commonly found in sustainable change, that is, a strong connection or therapeutic alliance, effective follow-up support, a safe and nurturing therapeutic environment, and an experience valued by the client (Behrens et al., 2010; Draper et al., 2013; Miller, Duncan, & Hubble, 2004).

This project showed that AT could be used to assess and reveal client struggles in a compassionate manner with clinicians practicing in a client-directed framework. In the contained setting, program leaders were able to work with challenges as they arose moment to moment. This experiential paradigm allowed program leaders "to discover the most effective road for connecting with [each] client" (Krill, 2014, p. 124). They were also able to remain patient and "stress what is working for the client and attempt to increase those feelings, actions and thoughts instead of focusing on eliminating thoughts, feelings and actions" (Gass & Gillis, 1995, p. 63). In this framework, AT practitioners can better focus on individualised interventions to meet the unique needs of each client.

Helping professionals practicing with young people may also take advantage of incorporating "experiential or adventure activities to evidence based treatments to make them more fun and interesting and to increase [participants'] willingness to participate in therapy" (Russell & Gillis, 2010, p. 83). Because 40–60% of young people involved in therapeutic treatment disengage despite professional advice (Duncan, Miller, & Sparks, 2007), the engaging elements of AT and a focus of the therapeutic relationship could be used to deliver more positive outcomes.

Conclusion

This study, although limited in size and scope, has shown this AT experience — Onward Adventures — to be an option valued by adolescents who may have been "reluctant to engage in treatment due to the barriers and stigma associated with traditional treatment alternatives" (Gass et al., 2012, p. 298). Despite predominantly positive outcomes reported, further evaluations with larger sample sizes and different methodological perspectives should help to "isolate and identify what it is about AT that creates changes in individual behaviour, cognition or emotional states" (Gass et al., 2012, p. 298). Even with the positive outcomes reported, viewing AT as a "band-aid" or miracle treatment for adolescents should "be avoided by structuring programs to foster more intensive long-term therapeutic change" (Autry, 2001, p. 301). This may be accomplished by having follow-up services delivered by "program leaders [that] have a deep understanding of what actually goes on during and after experiential activities" (Autry, 2001, p. 301).

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About the author

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