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The Efficacy of Adventure Programming in the Development of Cooperation and Trust with Adolescents in Treatment

Jeffrey P. Witman

This article presents the findings of a controlled study of the impact of “adventure” and “social recreation” programs on adolescents involved in psychiatric treatment. Scores on a Cooperation and Trust Scale, as well as observations of behavior were analyzed. Both suggest that “adventure” programs can create enhanced attitudes and actions regarding cooperation and trust and are superior to traditional “social recreation” programs in this regard.

KEY WORDS: Adolescents, Psychiatric Treatment, Adventure Programs, Cooperation, Trust

Adventure programs have increasingly become a component of therapeutic recreation/activities services for individuals with disabilities. Adolescents involved in psychiatric treatment are one of several populations for which the utilization of such programs has been advocated. Evans (1984) concluded that mental health professionals, parents of adolescents manifesting emotional disorders, and such adolescents themselves, viewed adventure programs as potentially an important component of adolescent treatment programs. Many treatment programs have become involved with building ropes courses and initiating adventure programs. The proliferation of adventure programs has not, however, been matched with expanded efforts at determining the value of such programs.

Rationales for inclusion of adventure programs in treatment typically focus upon potentials in the areas of self-esteem and group cooperation and trust (Havens, 1984). In regard to self-esteem, it is hypothesized that completion of adventure activities deemed as challenging will lead to greater confidence and sense of self-empowerment. Group cooperation and trust are seen as being enhanced through the sharing and helping required by the cooperative problem-solving and “spotting” for one another inherent in most adventure activities.

While the enhancement of self-esteem through adventure programming has received some attention from researchers (Hunter, 1984; Kimball, 1983; Stich, 1983) particularly in regard to Outward Bound type experiences, little attention has been paid to cooperation and trust. Group observation techniques utilized in several studies (Frant, Roland, & Schempp, 1982; Roland & Hoyt, 1983) have identified enhanced social skills in group cooperation as an adventure program benefit. Another study (Nold, 1982) has reported the acceptance of peers in relation to cultural and social integration as a significant benefit. Though not specific to adventure programs, several recent studies in social psychology are relevant to understanding the dynamics of involvement with adventure groups. Findings of these studies include:

- Commitment beyond self (transpersonal commitment) is developed and enhanced through positive experiences of high intensity involving giving, sharing and helping (Magen, 1983).
- Comforting behaviors (Burleson, 1984), sharing (Green & Schneider, 1974), and altruism (Lowe & Ritchey, 1973), increase with age throughout the adolescent years.

In considering the findings above, adventure programs appear to be a medium with potential for enhancing levels of cooperation and trust among individuals involved with psychiatric treatment. These individuals can, if perhaps only for hedonistic reasons, be altruistic. Both the cooperative goal structure and highly reinforcing nature of adventure programs can be valuable to encouraging cooperation with others and can perhaps expand upon this basic capacity to give to others. Manifestations of a cooperative attitude—sharing, comforting, giving—are, however, influenced by age and this variable needs to be considered in evaluating adventure program impacts.

The purpose of the current study was to determine if adventure programs really do enhance cooperation and trust. The study also compared adventure with traditional social recreation programming in regard to these variables.

Method

Subjects

All 17 patients in the adolescent program at a private psychiatric hospital in New England were the subjects of this study. Their ages ranged from 15-19, with primary diagnoses including conduct disorder, depression, adjustment disorder of adolescence, polysubstance abuse and borderline. They were randomly assigned to one of three treatment groups—control, social recreation, or adventure. The control
group had five subjects, while both the adventure and social recreation groups contained six subjects. Diagnoses appeared to be equally distributed.

Experimental Design

Prior to treatment each subject completed a Cooperation and Trust Scale (CATS) (Figure 1) and their personal counselors completed a Behavior Rating Scale. Treatments were conducted over a three day period. The “control” group participated in the regular schedule of adolescent programs. In addition to regular programs, the “social recreation” group participated in five hours of various cooperative sports and games. Included were a variety of warmups and tag games, t-ball, new games, cooperative relays, a tug of war and traditional cooperative games (e.g., 3-legged race, egg toss).

The “adventure” group also received five hours of programming in addition to their regular schedule. Their activities included several warmups, a variety of trust walks and falls, several group initiatives and participation on a low ropes course. The sequential program design of Roland and Havens (1981) was followed. This model emphasizes a progression from awareness activities through cooperative games through individual and group initiatives culminating in adventure activities. The premise of this approach is that the impact of adventure activities is heightened if participants have had the opportunity to first develop some group cohesion and rapport.

Leadership for the social recreation and adventure groups was the same—the hospital’s Adolescent Program Coordinator, and a Therapeutic Recreation Specialist and Certified Occupational Therapy Assistant from the hospital’s Activities Staff. All of the leaders were known to the subjects from previous contacts and the Adolescent Program Coordinator, in particular, had numerous contacts with them beyond the treatment groups of the study.

Introduction to and processing of both treatment groups were similar. The introduction for both consisted of detailing activities which would take place during the session and asking that participants monitor their comfort with and feelings toward the various activities. Processing consisted of discussion of participants’ responses to the questions, “How was the session for you?” “What did you most/least enjoy?” and “What were some of your feelings during the activities?” Two of the original 17 subjects were unable to attend treatment sessions (one was discharged, the other was sick), reducing the number of subjects to 15.

Following the final treatment sessions participants in all three groups again completed the CATS instrument and their personal counselors again completed the Behavior Rating Scale. These counselors were not aware of which treatment group their patients had participated in. Two counselors, who were absent from work, were not able to complete the Behavior Rating Scale for their patients, reducing the number of subjects involved in that component of the study to 13. Basic descriptive analysis of the data generated was carried out, as well as ANCOVA in analysis of treatment group differences on the CATS. This procedure allowed for control of differences attributable to pre-test scores and to age.

Instrumentation

The instruments utilized in the study were developed to discern subjects’ attitudes toward cooperation and trust, as well as their actual behavior in these two areas. The CATS Scale was designed by the investigator to measure attitudes. It consists of 15 statements which are rated for level of agreement. These statements were selected from a group of 25 statements of belief regarding cooperation and trust generated by participants (N = 96) in adventure programs who were asked their beliefs about cooperation and trust during initial program sessions. A group of adolescents (N = 26) involved in a summer adventure program offered by a school district rated these 25 statements. Those statements which were correlated most highly with overall ratings (+.75 or -.75 or greater) were selected for the CATS Scale. Content validity of the scale was established through review by a panel of individuals involved with social skill development programming.

Additionally, a small group of adolescents (N = 18) who completed the scale were also evaluated on the Behavior Rating Scale by their teacher. The Behavior Rating Scale, described below, is designed to record observers’ perceptions of individuals’ behavior regarding cooperation and trust. The correlation between these scores (r = .79) suggests a fair measure of criterion related validity. Finally, the scale’s reliability was tested with two groups of high school students (N’s = 92 and 20). Internal consistency estimates (Alpha) for the scale were .91 and .76, respectively.

The Behavior Rating Scale was designed to provide an estimate of subjects’ behavior regarding cooperation and trust. It consisted of 5 sets of adjective pairs: competitive-cooperative, selfish-altruistic, distrustful-trusting, individualistic-group oriented, and unfeeling-caring. These particular pairs were selected for their relevance to purported adventure program benefits (Robb

1. Trusting others is often a mistake.
2. Having a group’s support makes many things easier to do.
3. Cooperation is important to doing well in school.
4. Working as a team means taking orders.
5. Team sports and games are often frustrating because the mistakes of others can cause you to lose.
6. Employers think a cooperative attitude is important.
7. Cooperation is more enjoyable than competition in sports and games.
8. Helping others is enjoyable.
9. A group can often produce results greater than those of any individual in the group.
10. Cooperation is important to making and keeping friends.
11. Taking risks is an exciting part of life.
12. Showing compassion and caring for others is often not rewarding.
13. Working as a team means giving up your freedom.
14. Sharing is often enjoyable.
15. Success in the world is based more on your ability to cooperate than on your ability to compete.

NOTES:
1) Respondents express their level of agreement/disagreement with each item on a 5 point scale ranging from strongly agree—strongly disagree.
2) Items 1, 4, 5, 12, and 13 are reversed for purposes of scoring.
3) In addition to utilizing the scale to generate an overall measure of individual’s attitudes regarding cooperation and trust, it has also been used to stimulate discussion concerning these concepts. Specifically individuals are asked to review the items and select both a statement they most strongly agree with and one they most strongly disagree with. A further request, as they share their choices, is to provide examples from their life experience which support their choices.

FIGURE 1. COOPERATION AND TRUST SCALE ITEMS.
et al., 1983). Raters, based upon their observations of patients' interactions with others, were asked to rate each participant's behavior on each of these continua on a five point scale.

Findings

Adolescents involved in the study scored significantly (t = 2.70 and 3.21, p < .01) lower on the Cooperation and Trust Scale than two groups of non-disabled peers (Table 1). Differences were also evident among the three treatment groups. While the scores of the "control" and "social recreation" groups decreased, those of the "adventure" group increased (Table 2). ANCOVA, controlling for pre-treatment scores and age, indicated that these changes were significant (F = 13.8, df = 2,11, p < .001). Given the starting points of the groups (control and social recreation groups higher on the pre-test) regression toward the mean might explain some of this change. Also, individuals in the "adventure" group were perceived by their counselors as having more cooperative, altruistic, trusting, caring and group-oriented behavior following treatment. This was particularly true for the "group oriented" variable where all of the "adventure" group were perceived as having become more group oriented in their behavior following treatment (Table 3).

These findings suggest that, at least for a brief period of time following participation in adventure programs, the attitudes and actions of adolescents involved in psychiatric treatment tend to be more cooperative and trusting. Furthermore, adventure pro-

gramming was superior to social recreation programming in the enhancement of these attitudes and behaviors. While the scope of this study precludes any judgments regarding long term retention of program effects or transfer of attitudes and behavior beyond the hospital setting, it does suggest a window of opportunity for such occurrences.

Limitations

Small sample size and the developmental nature of the measurement instruments utilized in this study clearly limit its generalization. Despite a randomized study design, the small numbers in each treatment group raise the question of equality of certain variables (e.g., severity of illness, attitude toward treatment) among the various groups. While the measurement instruments utilized in the study were subjected to a variety of reliability/validity tests, results should be considered as tentative pending more rigorous review. Additionally, the study's results are subject to the inherent limitations of field research. Subjects in this study were involved in numerous other treatments and programs during the course of the study. The interaction of these experiences with the treatments of the study cannot be discerned.

Discussion

Several specific observations from the study warrant discussion. The inclusion of the Adolescent Program Coordinator as a group leader appeared to heighten the impact of treatment. He was able, across the variety of settings in which he worked with the subjects, to reinforce insights and experiences gained in treatment. Activities staff, as they are in many settings, were more limited in their contacts with subjects and thus had fewer opportunities to cite applications. The composition of adventure program group leadership, specifically inclusion of professionals from beyond the activities staff, might be an important variable in program success.

Also noted by the investigator and by treatment group leaders was the disparity between treatment groups in regard to observed indications of having fun such as smiles and laughter. The "social recreation" group displayed brighter affect than the "adventure" group. They appeared to have a better time. As the data from this study suggests, however, a good time did not translate to developing more positive attitudes toward cooperation and trust. This suggests that evaluation of adventure programs limited to perceptions of participant enjoyment can be misleading in regard to
Table 3.
Change from Pre to Post Treatment Rating of Subjects' Behavior Regarding Certain Characteristics

<table>
<thead>
<tr>
<th>Adjective Pair</th>
<th>Change</th>
<th>Control</th>
<th>Social Recreation</th>
<th>Adventure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooperative vs.</td>
<td>more cooperative</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>competitive</td>
<td>more competitive</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>no change</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Altruistic vs.</td>
<td>more altruistic</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>selfish</td>
<td>more selfish</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>no change</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Trusting vs.</td>
<td>more trusting</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>distrustful</td>
<td>more distrustful</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>no change</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Group-oriented vs.</td>
<td>more group-oriented</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>individualistic</td>
<td>more individualistic</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>no change</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Caring vs.</td>
<td>more caring</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>unfeeling</td>
<td>more unfeeling</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>no change</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

program impacts. Fun may not equal growth and development.

Finally, the time period in which this study took place was a fraction one for the hospital's adolescent community. As often happens at such facilities, the advent of a new set of limits (in this case policies curtailing freedom of movement) triggered much patient resistance, and some acting out. Members of the "adventure" treatment group appeared most flexible in accepting these changes. It may well be that the team-building which appeared to take place as a result of adventure sessions contributed to this adaptability.

Additional Research Needs

Several research questions for future study are suggested by the findings of this study:

- The impact of age upon attitudes toward cooperation and trust upon the impact of adventure programs. Burleson's (1984) recent demonstration of the positive relationship between age and comforting behavior and altruism could well be relevant to the helping inherent in Adventure Programming. Useful questions include "Do various activities work better with individuals of particular ages?" and "Is there an optimal age for program involvement?"

- The potential for long-term effects resultant from participation in adventure programs. Specifically, "How long are program impacts exhibited?" and "What factors enhance or inhibit retention of more positive attitudes and actions?"

- The differential impact of adventure programs upon individuals of varying disabilities. Plakun, Tucker, and Harris (Stich, 1983) have speculated that adventure programming is contraindicated for certain diagnoses. Useful questions include: "Are there significant differences among individuals with various diagnoses in their response to programming?" and "Are there differences in response to specific adventure program activities or processes attributable to diagnoses?"

- Additional considerations include discovering optimal program activities, duration and number of sessions, and leadership style. On the level of basic research, the fundamental questions of determining how groups of adolescents in treatment function remains worthy of study.

- Finally, though it defies full description, the adventure program observed in this study generated a set of responses frequently seen in such programs. Brief glimpses of synergy were evident as individuals put aside personal agendas and apparently became totally involved in the group challenge of the moment. Spontaneous support, caring, sharing, and helping were evident among young people whose normal interaction ranges from apathy to antipathy. The phenomenon of adventure programming, which this study has modestly attempted to decipher, remains largely an art rather than a science. The extent to which it remains so could well be the extent to which it remains on the periphery of treatment for adolescents.

References


