Family Enrichment Adventure Therapy: A Mixed Methods Study Examining the Impact of Trauma-Informed Adventure Therapy on Children and Families Affected by Abuse

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Abstract Child abuse is epidemic in the United States and has dire long-term consequences. Innovative interventions are needed to address the negative cognitive, affective and behavioral effects of child abuse. This mixed-method study examined if adventure therapy is 1) an effective mental health intervention for child and adolescent survivors of abuse and neglect, and 2) an effective intervention for families affected by abuse and neglect. The effectiveness of the adventure therapy intervention was measured by a reduction in child trauma symptoms and improved family functioning, as reported via the Trauma Symptom Checklist for Children (TSCC), the Family Assessment Device (FAD), as well as qualitative data gathered via family focus groups. Findings

showed that trauma-informed adventure therapy with youth and families affected by abuse reduces trauma symptomology in youth and improves family functioning, particularly in the areas of communication, closeness and problem-solving skills.

Keywords Adventure therapy · Trauma-informed care · Child abuse · Multi-family groups

Introduction

According to the American Psychological Association (APA) (2013) trauma is an emotional response to a terrible event like an accident, rape or natural disaster that has initial and sometimes long-term reactions. The National Child Traumatic Stress Network (2013) expands this definition to include patterns of traumatic experiences that result in long-term or sustained stress responses. One of the most common sources of trauma is child abuse. Finkelhor et al. (2013) estimated that 1 in 4 U.S. children experience some form of child maltreatment in their lifetimes. According to the Department of Health and Human Services (2012), childhood sexual abuse is one of the most common forms of child abuse, with one in four girls and one in six boys reported as victims of sexual abuse. In the United States alone, “there are millions of maltreated children and youth in the educational, mental health, child protective, and juvenile justice systems,” many of whom go unnoticed and untreated (Perry 2009, p. 240).

Some children experience child abuse, along with other sustained traumatic experiences, such as poverty, community violence, domestic violence, war, and neglect. When people have endured multiple interpersonal traumatic events from a very young age and have been exposed to chronic and complex trauma—usually instigated by primary care-giving adult—there is a profound impact on a child’s long-term development.

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Complex trauma has profound effects on nearly every aspect of a child's development and functioning (NCTSN 2008). The Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5) (APA 2013) now includes a section called Trauma or Stress or Related Disorders. As awareness of the impact of trauma grows, organizations providing mental healthcare services have been called to become educated, aware, and adopt trauma-informed and sensitive practices.

The Department of Justice's Report of the Attorney General's National Task Force on Children Exposed to Violence (2012) called for the implementation of trauma-informed care and practices, with the need to incorporate evidence-based trauma-informed principles in all applicable federal agency grant requirements; to ensure that all children exposed to violence are identified, screened, and assessed for their trauma; and to develop and disseminate standards in professional societies and associations for conducting comprehensive specialized assessments of children exposed to violence; and to share information and implement coordinated and adaptive approaches to improve the quality of trauma-specific treatments and trauma-focused services and their delivery by organizations and professionals across settings (US Attorney General, 2012). In August 2013, three administering bodies all under the US Department of Health and Human Services called for improved trauma informed screening, assessment of functioning and evidence based practices into *all* services to children and families (OJJDP 2013).

Addressing trauma in children and youth is particularly important given the impact it can have on future functioning. The CDC's Adverse Child Experiences Study (Felitti et al. 1998) found a clear positive relationship between increased stress in childhood and increased risk for adult health problems including alcoholism and alcohol abuse, depression, and suicidal. Similarly, the Kilpatrick et al. (2003) examined correlations between childhood victimization, trauma-related mental health problems, substance abuse and delinquent behaviors, and found that teens who had experienced physical or sexual abuse/assault were three times more likely to report past or current substance abuse than those without a history of trauma (Kilpatrick et al. 2003; NCTSN 2008). In fact, research has shown that 70% of adolescents receiving treatment for substance abuse also had a history of trauma exposure (Deykin and Buka 1997; Funk et al. 2003). The field of neuroscience has found evidence that complex trauma seems to decrease an individual's ability to utilize executive functioning (Kleinberg & Stavrapalous, 2012). How trauma seems to affect development depends upon the age of such incident(s) and can be detrimental if not addressed (Hodas 2006; Child Welfare Information Gate 2009). As the research reflects these previously mentioned connections it becomes imperative that service providers adopt trauma informed practice so as to most effectively help those who are struggling towards real recovery.

Trauma Informed Care

The National Center for Trauma-Informed Care states; "Trauma-informed care (TIC) is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. It seeks to shift the paradigm from one that asks, "What is wrong with you?" to one that asks, "What has happened to you?" (SAMHSA 2013). TIC seeks to do no harm to clients through treatment practices that inadvertently re-traumatize, or through failure to address root (albeit dysfunctional) causes of behavior. TIC looks at presenting symptoms and behaviors with an understanding of trauma responses and developmental impacts, and seeks to address the fundamental needs of a person with respect to their trauma experience(s) towards real healing (Hodas 2006). Trauma informed care is different than trauma specific treatments, as they target specific stress symptoms and are associated with specific therapeutic techniques and interventions.

Trauma informed care is different in several ways than traditional treatment (Hodas 2006), including re-framing issues of power and control, authority and responsibility, goals, and use of language. In trauma informed care the focus of treatment is on empowerment of the consumer, and staff cede some control to clients. In line with this, authority and responsibility must be shared. This means psycho-education about trauma is essential including linking past abuse to current coping and reframing current symptoms as attempts to cope with past abuses. Goals are set that not only involve growth and change, but specifically promote long-term safety and a better overall quality of life, *not* just stabilization of symptoms (Hodas 2006). Support for the development of self-advocacy skills and the acceptance of intense affect and protest by a consumer, without regarding it as pathological, are essential parts of authority and responsibility. Finally, use of language should convey that staff view consumers as human beings, not as impaired cases, and speaks to a culture of recovery. Specific terms and phrases may need to be avoided (some of which may need to be identified by a specific consumer). This also entails the use of everyday language and the avoidance of clinical jargon. To be sure, non-verbal communication with consumers also needs to be respectful and welcoming (Hodas 2006).

A systematic approach to acknowledging the possibility of trauma must be adopted, regardless of the route that clients enter treatment settings (Rosenburg, 2011). As trauma informed practice guidelines emerge, a specific call is being made for engagement of the physical experiences of the consumer (Kleinberg & Stavrapalous, 2012). Adventure therapy is one setting that already acknowledges the value of the aforementioned trauma informed care values and incorporates physical awareness and engagement. It is perhaps poised to

be a leader in behavioral healthcare to adopt trauma-informed practices.

Applying Trauma-Informed Care in Adventure Therapy

Greenwald (2009) states that trauma-informed care takes trauma into account within a comprehensive treatment approach and milieu (i.e. adventure therapy) and can be applied to a wide range of presenting problems making it a trans-diagnostic approach. “Thus, whether for example, a given oppositional child’s problem behaviors are primarily due to trauma exposure, to inconsistent parenting, or some combination is immaterial, in that the treatment approach will be used systematically, regardless” (Greenwald 2009, p. 144). This is a compelling argument for why trauma-informed care is a lens that can be applied in adventure therapy settings. There are currently no published practice articles on trauma informed care within the field of adventure therapy. However, wilderness and community-based adventure therapy programs have begun to incorporate it into their interventions to various degrees, with others seeking to do so (Norton et al. 2014a). Given AT’s engagement of the affective, behavioral, or kinesthetic, and cognitive experience of a client, adventure therapy is a type of intervention in which a trans-diagnostic approach can be utilized.

Trauma-informed adventure therapy (AT) can be defined as “the prescriptive use of adventure experiences provided by a mental health professional, often in a natural setting that kinesthetically engage clients on cognitive, affective, and behavioral levels” (Gass et al. 2012, p. 1), and is sensitive to the client’s trauma symptoms and the impact that trauma has had on them. Though little has been written about trauma-informed adventure therapy specifically, there is a growing body of research documenting the positive impact of adventure therapy on overall youth functioning, positive youth development, and improvements in substance abuse refusal skills, motivation to change, depressive symptoms and psychosocial development (Norton et al. 2014b; Norton and Watt 2013; Bettmann et al. 2013; Norton 2009, 2010).

Adventure therapy experiences can vary across practice settings to be more or less tangential, adjunctive or primary as therapy (Gass et al. 2012). Adventure therapy as a primary intervention utilizes an experiential approach; while many therapies rely heavily upon talking alone, AT seeks to assess and kinesthetically engage the client affectively, cognitively, and behaviorally. The adventure-based activity is the unique, experiential tool to facilitate clinical change (Alvarez and Stauffer 2001). These adventure experiences are often viewed as “catalysts” for processing, creating concrete examples of new behaviors that can be utilized by all group members (Newes and Bendoroff 2004, p. 4). It is the job of staff and clinicians to manage the environment (physical, emotional, and cultural) in which these adventure activities are facilitated

and to properly choose, facilitate and process adventure experiences to address client’s clinical goals and support long-term clinical change (Alvarez and Stauffer 2001; Tucker 2009).

Adventure therapy activities can include problem solving activities and initiatives, hiking, primitive skills activities, orienteering/map and compass, canoeing/kayaking, and rock-climbing/indoor climbing wall, low ropes/challenge course activities, snowshoeing, cross country skiing, and overnight camping at campgrounds (Tucker and Norton 2013). All of these activities are used specifically as a therapeutic intervention, thus specific therapeutic considerations must be made to adopt trauma informed culture and practice across this broad range of activities. This is especially important as adventure therapy clients often present with a history of trauma (Smith, Tucker, & Gass, 2013; Zelov et al. 2013). In fact, in a recent case study of adolescents in residential treatment and wilderness therapy programs found 45.2% of all clients reported a *recent* trauma (Bettmann, Lundahl, Wright, Jaspersen, & McRoberts, 2011).

Trauma-Informed Adventure Therapy with Families

According to Pernicano (2010), there is a strong relationship between family functioning and reduced childhood trauma symptomology, so there is a need for innovative family-based interventions to trauma. The role of outdoor recreation in family enrichment has been established (Freeman and Zabriskie 2002), and many agree that the use of outdoor, adventure-based activities used specifically for therapeutic purposes, can play a useful role in engaging the family in the treatment process (Tucker et al. 2016; DeMille and Montgomery 2016). Current research on adventure therapy with families has also looked at the impact and role of family in treatment as well as impact of adventure therapy on attachment. Many wilderness therapy programs, a type of adventure therapy, have a requirement of family involvement in the treatment process (Harper, 2009) and research has shown mixed results on the impact of wilderness therapy on family functioning (Harper and Cooley 2007; Harper and Russell 2008). The evaluation of a one-day pretreatment and one-day post treatment multifamily program in addition to wilderness therapy showed significant impacts youth’s behaviors post discharge; however, limited impact on family functioning (Harper & Cooley, 2009). A mixed methods study looking at the involvement of family and impact of wilderness on family functioning found only one out four areas impacted in terms of functioning, yet qualitative interviews revealed families felt a stabilizing effect from wilderness therapy involvement (Harper et al. 2007). These findings point to the complexity of family relationships further highlighted by mixed impacts of wilderness treatment on attachment in youth participants. Bettmann (2005) explored the impact of wilderness treatment on youth and parent attachment and found

adolescents improved attachment relationships in terms of decreased anger and increased emotional connection; yet increases in problems of trust or communication with parents at discharge. In a similar study, Bettmann and Tucker (2011) found mixed results in terms of increases in connection, but decreases in trust and communication, as well as both positive and negative growth in attachment with peers. However, one study found that adventure therapy helps promote positive relationships between and among participants, including family and group members, especially in the area of communication (Liermann and Norton 2016).

These conflicting findings may be reflective of the fact that most of these programs involve out-of-home treatment for the adolescent and adjunctive work with the families, which makes family engagement difficult due to distance and expense; as well as the adolescent versus family focus of the treatment. On the contrary, this study focuses on trauma-informed adventure therapy with the whole family in a community-based setting. Situated in a traditional child advocacy center, this program uses adventure therapy as an adjunctive treatment to individual and family counseling. Similar to Swank and Daire (2010), the following program combines multi-family group work with adventure therapy, but specifically utilizes a trauma-informed approach for children and families affected by child abuse.

Program

Launched in 2009 with a grant awarded from the Texas Parks & Wildlife Department, ChildSafe's *Family Enrichment Adventure Therapy (FEAT)* program connects family members with one another while, as a unit, they connect with the outdoors and other families healing from the effects of child abuse and neglect. In conjunction with "talk therapy" in individual, group, and family settings, FEAT participants travel, hike, and camp outdoors, among other adventure-based activities. Based on protocol by the National Child Traumatic Stress Network (2008), adventure therapy personnel provide trauma-informed care in an adventure therapy context as they guide conversations and activities in ways that highlight a family's unique strengths and the family's preferred way of relating to and being with one another. They also connect with family members to recognize the family's need to be respected, informed, connected, and hopeful regarding their own recovery (SAMSHA 2013).

In order to recognize how ChildSafe's Family Enrichment Adventure Therapy (FEAT) program is trauma informed, it is important to first recognize this program is enveloped in an agency dedicated to being trauma informed and, when appropriate, providing trauma specific interventions. All ChildSafe staff members, from front line workers to the Chief Executive Officer, have received training in the effects of trauma on children and families. ChildSafe as an organization is

dedicated to honoring the unique experiences of clients as trauma survivors and, therefore, makes a concerted effort to consider routinely how clients' interactions with ChildSafe personnel, programs, and other clients may be affected by their traumatic experiences.

Referrals to the FEAT program come primarily in-house from two sources: 1) self-referrals from children and families receiving counseling or who have successfully completed counseling at ChildSafe and 2) the primary ChildSafe clinicians working with the children and families, who recognize participation in adventure therapy as a potential benefit to the families' clinical treatment. The FEAT program is a product of ChildSafe's Clinical Department. ChildSafe's mental health clinicians, including those serving in FEAT, receive training in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and, when appropriate, the Child and Family Traumatic Stress Interventions (CFTSI) model of treatment. Furthermore, assessments (i.e., Trauma Symptom Checklist for Children, Trauma History Questionnaire, Mood and Feelings Questionnaire, and the UCLA Post Traumatic Stress Disorder Reaction Index) used in the clinical department provide a snapshot of a client's trauma history and symptomatology. The results of these assessments, coupled with the trauma specific clinical models mentioned above, help primary clinicians guide treatment plans and formulate specific goals around the resolution of traumatic symptomatology.

With this framework, a family's primary clinician and clinicians of the FEAT program converse to target specific treatment goals during an adventure therapy event. Once a family is referred for adventure therapy, a FEAT clinician consults with the family's primary clinician to gather the following information:

- a. Family strengths, structure, and dynamics;
- b. Trauma History (e.g., type of abuse, relationship to AP, other traumas addressed during treatment; relevant findings in assessments, etc.);
- c. Identified treatment goals and current focus of treatment/interventions;
- d. Recommended focus of treatment during adventure therapy:

This information is not only used to formulate treatment goals in FEAT, but also invite a targeted cluster of families to experience an adventure together. FEAT families then participate in multi-family, trauma-informed adventure therapy activities such as kayaking, geocaching, archery, hiking, low and high ropes courses, rock climbing and camping. The FEAT program encourages and relies on the *collaboration* of children and adult caregivers to promote positive, healthy change in families. As such, FEAT clinicians are mindful of ways to

promote these elements with adults who may also be overcoming the effects of complex trauma alongside children in their care.

Method

Design

This research project utilized a mixed-methods approach in which quantitative data were collected and analyzed via a quasi-experimental non-equivalent groups design, and qualitative data were collected via focus groups.

Sample

Two purposive samples made up of ChildSafe clients were administered pretests-posttests assessing trauma symptoms and family functioning. Sample A included children and families who received counseling services at ChildSafe and participated in FEAT. Sample B included children and families who received counseling services at ChildSafe, but did *not* participate in FEAT. Sample B served as a comparison group to better isolate the treatment impact of the adventure therapy intervention. This study obtained informed consent from all individual participants included in the study. This study was approved by the appropriate institutional and/or national research ethics committee and was performed in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

At the time of this study, a total of 32 children and their families participated in the study with 18 youth in the study group and 14 youth in the comparison group ($N = 64$). Both sample groups were largely Hispanic or Caucasian, with the majority of youth having experienced sexual abuse. Overall more girls than boys participated, with youth as young as 8 and as old as 17 years old, and most youth in both groups had a primary diagnosis of Adjustment Disorder and lived with both parents. Chi square analyses found no significant differences between the groups in terms of gender, race, family income, primary diagnosis and number of parents in the home.

By demonstrating the efficacy of family-based adventure therapy interventions on trauma and family functioning, as well as the relationship between these two variables, this study sought to contribute clinically relevant and evidence-based information to mental health providers and consumers regarding the range of treatment options available to children and families affected by abuse and neglect, especially for those families living in underserved communities in the area of mental health. ChildSafe's demographics consist of mostly Hispanic, low-income families who often receive less care and poorer quality of care in the realm of mental health

treatment (NAMI 2013), and are also considered a medically underserved community.

Measures

Children in both sample groups who were referred to ChildSafe as primary victims of abuse completed the Trauma Symptom Checklist for Children (TSCC) before receiving any services and three-months post-admission. This assessment tool measured the impact of trauma as manifested both in symptoms of posttraumatic stress disorder and other psychological distress symptoms (Briere, 1996). One caregiver from each family that participated in this research study from both sample groups completed the Family Assessment Device (FAD) before receiving any services and three months' post-admission. The FAD is based on the McMaster Model of Family Functioning (Epstein et al. 1983) and assesses the structure and transactions of the family system. Quantitative data were analyzed via SPSS to determine both statistical significance and effect sizes of change pre-to-post intervention. Qualitative data were collected via focus groups and transcribed and coded for textual and thematic analysis. Focus groups were conducted with sub-sets of both Sample A and B. These data were used to give voice to participants' subjective experiences, as well as triangulate the quantitative findings. Sample focus group questions include: "What services did you and your family receive from ChildSafe? Which of those services were most helpful to you and your family? If applicable, why did your family choose to participate in FEAT? How did FEAT affect your relationships as a family? What, if anything, do you believe was accomplished during FEAT that may not have been accomplished in other counseling settings? How was it to spend time with other families who have experienced similar trauma?"

Per SAMHSA's best practices (SAMHSA 2013) to work in a collaborative and empowering way with trauma survivors, family and friends of the survivor, and other human services agencies, we involved consumers and family members in the design and implementation of this research project by engaging past FEAT family participants in 1) helping draft focus group questions for research study participants and 2) helping facilitate focus groups so that families felt more comfortable in discussing their concerns with other consumers.

Results

Table 1 show improvements in the TSCC subscales of anxiety, anger, PTSD, and depression symptoms for youth who participated with their families in FEAT compared to youth who did not participate in the FEAT program. Depression levels for FEAT youth significantly improved at the three-month mark, with mean differences in all four subscales associated with strong effect sizes greater than 1.0. Smaller to no

Table 1 Trauma symptom checklist youth self report at admission and three months post admission on selected subscales

	M _{Admission} (SD)	M _{3Months} (SD)	t	d	95% CI (lower – upper)
FEAT GROUP					
Trauma Symptom Checklist (<i>n</i> = 7)					
Anxiety t-score	50.9 (8.5)	44.3 (8.3)	2.22	1.20	-5.10 – 7.35
Depression t-score	54.4 (7.4)	42.4 (9.2)	2.55*	1.37	-4.12 – 8.18
Anger t-score	48.6 (8.2)	43.6 (10.3)	1.32	1.55	-4.53 – 9.18
PTSD t-score	54.6 (10.1)	46.7 (6.7)	1.92	1.07	-6.42 – 6.03
NON-FEAT GROUP					
Trauma Symptom Checklist (<i>n</i> = 9)					
Anxiety t-score	56.2 (9.6)	53.3 (9.6)	2.40	0.90	-5.37 – 7.17
Depression t-score	53.3 (9.6)	56.6 (14.1)	-0.85	-0.44	-6.71 – 8.77
Anger t-score	50.7 (7.3)	53.3 (13.4)	-1.01	-0.70	-5.47 – 8.06
PTSD t-score	56.3 (7.2)	55.1 (9.7)	0.36	0.17	-4.53 – 6.51

* $p < .05$

improvements were reported in the three subscales for dissociation symptoms or sexual issues for the FEAT youth, which are not shown here. For youth who did not participate in FEAT there were no statistically significant differences on any TSCC subscales. Despite no statistically significant initial differences between the comparison groups demographically, it does appear that the FEAT group was more acute in terms of family dysfunction than the non-FEAT group.

Though Table 2 does not show any statistically significant gains or losses for FEAT families pre-to-post intervention, data showed that FEAT families moved from clinical to sub-clinical scores in the areas of communication and general

functioning. In fact, for FEAT families, FAD scores decreased in all categories (the lower the scores, the less “stressed” the family), with moderate effect sizes in the area of communication. Families that didn’t participated in FEAT had no statistically significant improvements, and actually declined at a statistically significant rate in affective involvement. However, they did move from clinical to sub-clinical scores in the area of behavior control.

Qualitative data from focus groups was coded and analyzed thematically, and findings show that ChildSafe services improve family functioning both for FEAT and non-FEAT clients. FEAT families attributed this to adventure

Table 2 Admission and three months post admission FAD scores as reported by caregivers

	M _{Admission} (SD)	M _{3Months} (SD)	t	d	95% CI (lower – upper)
FEAT GROUP					
Family Assessment Device (<i>n</i> = 12)					
Affective Involvement	2.11 (0.44)	2.31 (0.57)	-1.25	0.52	0.20 -0.77
Affective Response	1.98 (0.45)	2.12 (0.49)	-1.11	0.46	0.18 – 0.71
Problem Solving	2.13 (0.35)	2.2 (0.44)	-0.74	0.28	0.03 – 0.48
Roles	2.27 (0.43)	2.4 (0.41)	-1.13	0.54	0.31 – 0.54
Behavior Control	1.65 (0.44)	1.74 (0.53)	-0.67	0.28	-0.02 - 0.53
Communication	2.19 (0.32)	2.17 (0.4)	0.23	0.10	-0.08 – 0.32
General Functioning	1.95 (0.43)	2.08 (0.42)	-1.03	0.44	0.21 – 0.69
NON-FEAT GROUP					
Family Assessment Device (<i>n</i> = 11)					
Affective Involvement	1.89 (0.63)	2.12 (0.77)	-2.35*	1.08	0.63 – 1.46
Affective Response	1.78 (0.45)	1.81 (0.55)	-0.30	0.12	-0.21 – 0.38
Problem Solving	1.82 (0.46)	1.87 (0.64)	-0.28	0.12	-0.25 – 0.40
Roles	2.01 (0.44)	2.07 (0.41)	-0.37	0.18	-0.06 – 0.44
Behavior Control	1.59 (0.5)	1.46 (0.5)	1.01	0.42	0.13 – 0.73
Communication	1.96 (0.5)	1.94 (0.41)	0.22	0.10	-0.20 – 0.34
General Functioning	1.71 (0.45)	1.71 (0.48)	0.01	0.01	-0.27 – 0.28

* $p < .05$, **Bold** Scores reflect scores at or above Clinical Cut-offs for FAD Subscales

therapy; non-FEAT families reported that traditional counseling was the most important service they received. However, FEAT families (who also received traditional counseling services) reported greater communication, trust/closeness and problem-solving skills gained through the adventure therapy intervention. One FEAT participant reported: “The overall working together as a family and the different activities really helped. You work together as a family and not only do you have fun but you have to, like we learned with kayaking, we have to work together and talk through things.” This was reaffirmed when by another FEAT participant who said, “Yeah, I actually agree...I think the rock climbing was probably the best for us because we had to trust on each other and I heard all my kids encouraging each other and there’s a lot of chaos on our house so it was nice to hear them all encourage each other and work together, to see them all fight through their fears.” Another FEAT participant said, “I think the rock climbing helped me trust my mom again and reminded me that she’s there to help me to make sure I don’t get hurt and stuff like that.”

FEAT participants also reported a faster return to normalcy, and a greater sense of empowerment and healing than non-FEAT families. One participant reported:

FEAT brought us very close. It’s brought us a whole lot closer than we were. We talk about things more, we talk problems out more instead of just me jumping straight to being angry and [my daughter] not wanting to be next to me and going into the other room. We still have disagreements but I think we, instead of going straight to tempers we kind of sit back and we have a little quiet time and we reflect on what, on why we’re both angry and we talk it out. A whole lot better. There used to be a lot of screaming and arguing. And now it’s, I don’t have to raise my voice very much. At all. I think she kind of sees a little bit from my point that it’s hard and not always easy and she, I appreciate all the help that she can give me. Just by doing the simple things that I ask her.

Another participant spoke about the tools she gained through her family’s participation in FEAT:

I know it gave us many tools to use on the programs and, um, many of the things you talk about and you say, it’s the chaos in the home, it’s kind of like it was a new, profound sense of peace and now we know how to talk about things that have led to anger and yelling, because that’s all we knew. It wasn’t until they gave us these other tools and we’re like what, we can use these at home? It really changed a lot of how we behave with each other and what we expect from one another.

Discussion

Quantitative findings from the TSCC showed that FEAT appeared to be an effective intervention for decreasing trauma symptoms in children and adolescents, particularly related to depression and anxiety. This is extremely important because depression and anxiety are two of the most common mental health disorders faced by youth (ADAA 2014). However, intervening early in response to the child’s trauma may prevent long term mental health problems from occurring (Arias 2004).

According to the FAD, FEAT families appeared more stressed at intake and did not show significant changes in family functioning; however, FEAT seems to help families move from “stressed” to “non-stressed” in the areas of communication and general family functioning. Considering the long term services provided for these families and their complex histories, three months may be too soon to see significant changes in the FAD, hence additional follow up is needed.

However, these findings are supported by the qualitative data, which show the FEAT intervention had a profound impact on communication, cohesion and problem-solving in participating families. Qualitative data also showed that FEAT enhanced family behavioral and skill building. Similar to Swank and Daire’s earlier research (2010), the qualitative findings also showed that the multifamily group setting in which FEAT occurred appeared powerful in helping families heal. This reaffirms prior research which showed that multifamily groups were effective in addressing the needs of families who had experienced trauma and were associated with positive parenting practices, parental self-efficacy, lower parental/families distress (Kiser et al. 2010) as well as higher rates of service use, reductions in child behavior problems and improvements in family functioning (Snell-Johns et al. 2004). Clearly more research is needed; however, this study begins to build a foundation for trauma-informed adventure therapy as an innovative and new intervention for children and families experiencing abuse.

Limitations

The limitations of this study mainly reflect the small sample size and quasi-experimental design. Though the small sample size allowed us to conduct this study in a relatively short time-frame, our statistical results may not be as robust as if we had a larger sample size. Furthermore, the quasi-experimental design did not include the random selection of participants, nor is there a true comparison group receiving no services, which may jeopardize internal validity. Further, there is no long-term data collected past three months. Future studies should examine the lasting impact of trauma-informed adventure therapy on families, rather than simply pre-to-post testing.

Implications for Practice

Though there are limitations to this study, the preliminary findings should motivate practitioners working with children and families who have experienced trauma to consider adventure therapy as a viable, trauma-informed intervention that can both reduce trauma symptomology and improve family functioning. FEAT provides an excellent example of how adventure therapy can incorporate the six core components of trauma intervention, per the National Child Traumatic Stress Network (2008) in order to achieve these positive outcomes. We have identified each of these core elements below with a brief description of how they are addressed in the FEAT program, which may serve as a blueprint for how they can also be adopted for creating trauma-informed adventure therapy programs elsewhere.

1. Safety- Creating a home, school, and community environment in which the child feels safe and cared for
 - a. Clients participate in the FEAT program with protective family members. Adult perpetrators never participate in services at ChildSafe. Children who are sexually reactive or siblings of primary clients who have sexually acted out on a primary client can only participate in FEAT activities with clearance from a mental health professional who acknowledges the children have successfully demonstrated and currently demonstrate respect for personal boundaries with one another.
 - b. FEAT clinicians are trained to safely lead activities and promote the safe use of adventure therapy equipment with clients. Prior to an adventure based activity, FEAT program staff members will scout the outdoor area to be used with clients to evaluate for safety and develop emergency plans. When appropriate, FEAT clinicians then share information with clients about how to appropriately help manage and access help should an emergency situation arise.
 - c. Often said at the beginning of a FEAT activity is, “The only rule out here is: Be Safe.” FEAT clinicians start with discussions about the physical and emotional safety of participants. FEAT clinicians make a concerted effort to discuss how a person’s sense of safety may be relative, which allows each participant to choose the level to which he or she participates or is challenged.
 - d. During multi-family adventure therapy groups especially, FEAT clinicians discuss the importance of participants respecting the healing process for all families involved and hold confidential conversations that occur during the FEAT event. This means recognizing some participants may be more comfortable than others discussing circumstances of the trauma the family has experienced which led to their involvement with ChildSafe.
- e. Throughout the course of an adventure based activity, FEAT clinicians encourage participants to help one another recognize environmental hazards such as low hanging tree limbs, insect dwellings, etc. Doing so promotes the physical safety of participants but also aims to build interpersonal responsibility, enhance positive regard for others, and increase familiarity among participants.
2. Self-regulation- Enhancing a child’s capacity to modulate arousal and restore equilibrium following dysregulation of affect, behavior, physiology, cognition, interpersonal relatedness and self-attribution
 - a. Consulting with a family’s primary clinician FEAT clinicians highlight client’s capacities to use self-talk, breathing, and other grounding techniques during moments of a client’s emotional and physiological arousal.
 - b. FEAT clinicians practice mindfulness strategies with clients to help enhance clients’ ability to attune by releasing the mind from struggle against what is, relaxing the body, and returning to the moment where all the needed resources are available.
 - c. FEAT clinicians help clients learn and practice technical skills in controlled ways that aim to slow down behaviors which may be anxiety producing to participants.
3. Self-reflective information processing- Helping the child construct self-narratives, reflect on past and present experience, and develop skills in planning and decision making.
 - a. FEAT clinicians consider the sequencing of adventure activities in order to foster healthy group interactions, but also recognize the importance of sequencing reflection exercises appropriately in order to create a safe environment for clients to construct self-narratives and reflect on experiences in a family or multi-family group setting.
 - b. FEAT clinicians use a variety of strategies to help clients reflect on their experiences, develop plans positive change, and construct personal and family narratives. These strategies include journaling, drawing, sculpting, and other expressive arts.
 - c. FEAT clinicians may reflect on participants’ behaviors during adventure activities to help clients interrupt unhelpful interactions and then develop helpful strategies for problem solving and conflict resolution which can be later implemented and honed at home.

4. Traumatic experiences integration- Enabling the child to transform or resolve traumatic reminders and memories using such therapeutic strategies as meaning-making, traumatic memory containment or processing, remembrance and mourning of the traumatic loss, symptom management and development of coping skills, and cultivation of present-oriented thinking and behavior.
 - a. At the onset of FEAT activities, clinicians acknowledge all ChildSafe clients, including FEAT participants have experienced trauma in their lives. Clinicians also recognize a family's participation in adventure therapy aims to provide opportunities for: 1) the family to practice ways to overcome the effects of trauma as a family unit and 2) individuals to use personal coping skills to reduce trauma symptomatology or potentially stressful situations.
 - b. Pre-session consultation with a family's primary counselor allows a FEAT clinician to identify which trauma resolution strategies a client may be working on in session that can be practiced during the adventure therapy experience.
5. Relational engagement- Teaching the child to form appropriate attachments and to apply this knowledge to current interpersonal relationships, including the therapeutic alliance, with emphasis on development of such critical interpersonal skills as assertiveness, cooperation, perspective-taking, boundaries and limit-setting, reciprocity, social empathy, and the capacity for physical and emotional intimacy.
 - a. FEAT clinicians and volunteers, when appropriate, participate in activities alongside clients to foster a stronger therapeutic alliance and provide opportunities for clients to experience healthy interpersonal relationships.
 - b. FEAT clinicians often present adventure based challenges to participants which typically require the utilization of healthy social skills in order for participants to be successful.
 - c. Multi-family FEAT events facilitate the creation of a sense community with people overcoming the effects of trauma. Families often report feeling a sense of comfort coming together in a supportive environment with other people who have experienced similar traumas.
6. Positive affect enhancement- Enhancing a child's sense of self-worth, esteem and positive self-appraisal through the cultivation of personal creativity, imagination, future orientation, achievement, competence, mastery-seeking,

community-building and the capacity to experience pleasure.

- a. FEAT creates opportunities to experience success on many different levels. Clients are routinely invited to recognize what success looks like.

Before the end of a FEAT event, clients are invited to celebrate aloud personal, familial, and large group successes. Participants may leave with tangible items (e.g., a rock, drawing, sculpture) symbolizing these accomplishments and are invited to spend time with these items periodically at home as a way of anchoring their experiences and reflecting on what they learned that they can use in their lives outside of therapy.

Conclusion

Working with children and families affected by abuse and who are negatively impacted in significant cognitive, affective, and behavioral ways requires a trauma-informed approach. Experiential opportunities for re-engaging in life are also critical. Clearly, the FEAT program provides a very intentional model of trauma-informed adventure therapy that aids in trauma recovery for children by reducing trauma symptoms and also improves family functioning. Findings also showed that trauma-informed adventure therapy that combines multi-family group work with adventure therapy has an even greater impact, as families share with one another to help normalize their experiences and move forward with less stigma and shame. By providing trauma-informed adventure therapy for survivors of child abuse and their family members, it is possible to rebuild the trust that was damaged, promote a sense of safety that was destroyed, and encourage positive feelings about the world once again. An exchange between two FEAT participants during one of the focus groups affirms this:

Participant A With me it was just it made me feel good to know that you don't have to think bad about other people. There's good and bad people. You like to think that humanity is still a lot of good, you know more than bad, so getting to know these other families made me feel good to know there's still hope out there and that not everyone is bad. You can't even turn on the news without hearing bad stuff. And at my job I hear about bad stuff all the time so it's pretty scary and then having a daughter, it's really tough and of course with unfortunate things already happening makes you want to clam up even more around her. But there is still good people out there and it gives me a lot of hope that that she'll be okay when she grows up to be a woman and off on her own. And I'm hoping that all these experiences show her that you don't have to lose faith in other people, that there's good out there still.

Participant B That's a good point. Because I think especially with going through traumas or a certain kind of situation I think it's hard to trust other people and I know for me personally, I'm just like, you know, I thought I knew this person and they turned out to be something else. It's hard to trust someone when you find out that someone you trusted so much is not the person you thought they were. And it's true, you meet these people and they're genuinely good people who have been through similar situations; it makes a difference. I know that my kids have gone through bullying a little bit for certain, because of our situation, and I think it's nice for them to know there are kids that really aren't like that. Like you said, there's still good people out there.

Compliance with Ethical Standards

Disclosure Statement This statement provides transparent information about who funded the study and any potential conflicts of interest related to the study.

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Conflict of Interest Authors D & E have worked for ChildSafe's FEAT program as providers of counseling and adventure therapy services.

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