A FEMINIST ANALYSIS OF DEVELOPING AN ADVENTURE THERAPY INTERVENTION FOR THE TREATMENT OF EATING DISORDERS IN WOMEN

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ABSTRACT

The role of outdoor adventure programmes as a recognised approach for the effective treatment of psychological issues has, in recent years, reflected the growing interest in the development of adventure therapy. Although there has been an increased awareness of the possibilities of such a therapeutic approach there is limited practice, and thus very little instruction for how to implement such approaches, especially from a UK perspective. The aim of this study was to develop adventure therapy practice in the UK by specifically developing an intervention for women with eating disorders. Given that this specific approach for working with eating disorders didn't exist at the time of this study, this thesis is based on the principles of action research – a key aspect of the research process was the development of adventure therapy practice itself. Given the gender considerations of working in an outdoor adventure setting and the fact that eating disorders are largely a female phenomenon this study also took a feminist approach to ensure that disordered eating was in fact not reinforced by any adventure therapy approach developed.

The thesis itself describes in detail the processes of developing the adventure therapy intervention and the associated experience of the six women who were recruited and took part in the intervention. The dilemmas and decisions made with regard to a number of issues in implementing an adventure therapy approach are examined, for example, facilitating therapeutic processes in an outdoor setting, identifying issues related to eating disorders that might arise in an outdoor adventure context, and examining feminist principles in action (e.g. reflexivity). As well as the six women's experiences of the different aspects of the adventure therapy intervention, the overall impact of the intervention for each woman is also examined. Data collected from a range of tools completed by the women, including personal information sheets, the Eating Disorders Inventory (EDI), personal journals, individual interviews and a final focus group indicate changes in most, but

not all of the women. The results suggests that for the women with less chronic eating disorder symptoms positive change across a range of clinical symptoms were evident , including reduced troubled eating behaviors, improved body image, and motivation for change, albeit to different degrees for each woman. And for the one woman with the most chronic symptoms, although the intervention was a positive experience there was no evidence to suggest the intervention had any sustained impact.

Although, the results from this study are not representative of a large clinical population of women, there is an indication that the intervention did initiate therapeutic change for some of the women and thus suggests that adventure therapy has the potential to be an effective therapeutic treatment for eating disorders and is, therefore, worthy of further investigation. Inevitably, in continuing to develop work in this area many questions and issues are raised as result of the action research process and the thesis concludes with a consideration of some of the needs of developing future adventure therapy research and practice in the UK.

In memory of Nicholas Fox

Aged 34 years

'you left us too soon'

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*These photos are of the adventure therapy intervention developed in this thesis

Chapter One:

Introduction: Setting the scene

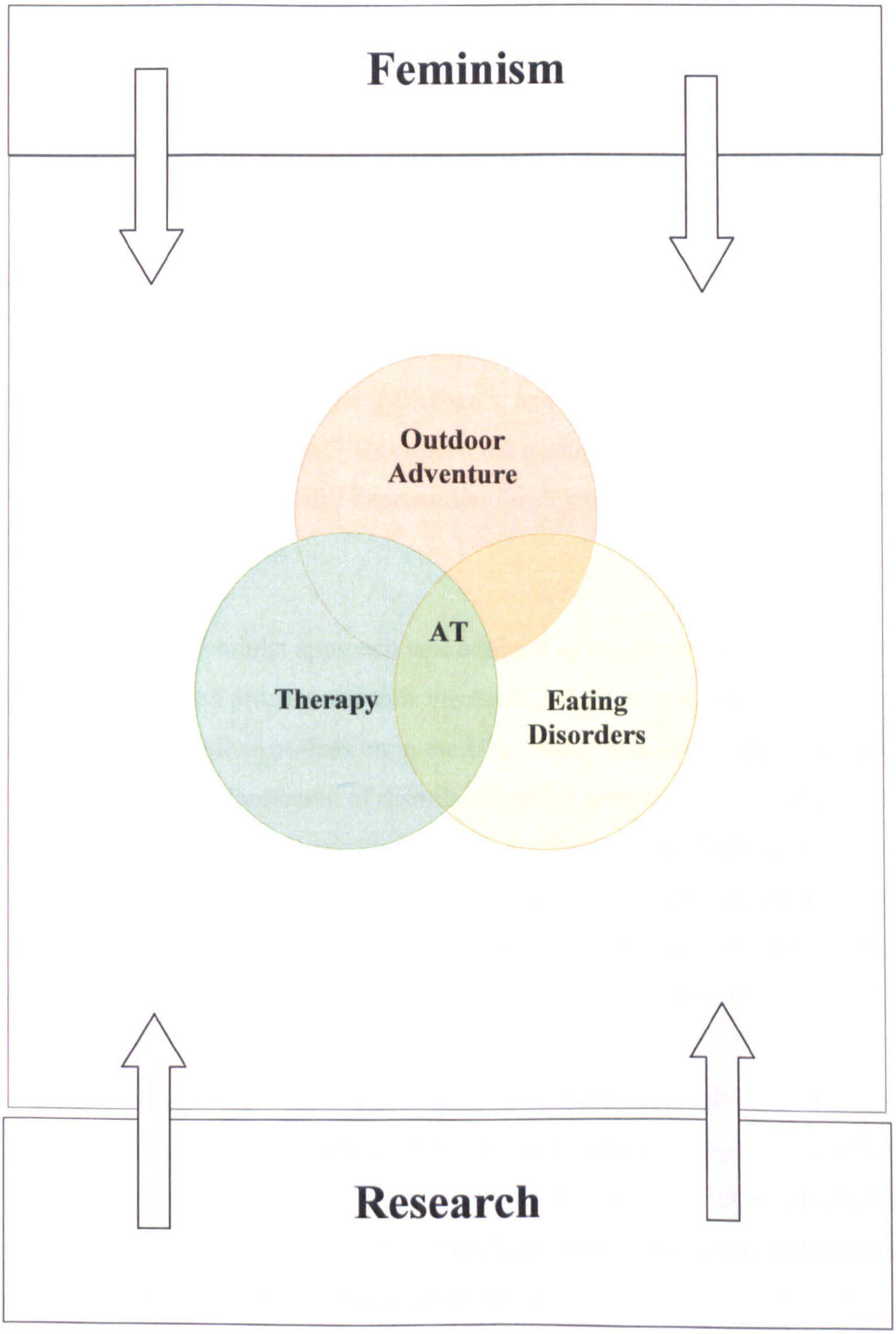
1.1 Setting the scene

This thesis describes the development of a research project that implemented an adventure therapy intervention for women with eating disorders. The research represents an interweaving of outdoor adventure, therapy and eating disorders, integrated with the guidance of feminist principles in order to develop the practice. This is best represented by Figure One –'HOPE' – 'helping overcome problem eating'. All of the areas identified in the model – outdoor adventure, therapy and eating disorders, along with feminism and research have not be brought together in this way in the UK before. This meant that in order to aspire to ethically safe adventure therapy practice, each aspect of the model required continual reflection, both from theoretical and practical perspectives. This was because each aspect of the model would play an influencing role in the impact that the whole intervention could have on a woman's recovery from an eating disorder.

As will be discussed throughout the thesis a key part of the study was to ensure that research procedures were consistent with good therapeutic practice, and therefore, this thesis views research and practice as inextricably linked. Given this, the research was not only aimed at uncovering and understanding the change processes taking place for those who took part in the intervention, it was also aimed at uncovering the processes of developing such practice. Consequently, an action research process, as understood from the theoretical perspectives of Reason and Rowan's (1981) 'dialectical research cycle', emerged during the development of the project and provides a basis from which the second part of the thesis is structured.

Figure 1:

The 'HOPE' Model: Helping overcome problem eating



Given the practice component of the thesis, a description of how the adventure therapy intervention was developed, along with the key decision making processes made throughout are discussed. Here, emerging knowledge as the intervention was put in place provides insight into how to approach work in this context. Furthermore, the women's direct experience of the different stages of the programmes, as related to practice dilemmas and decisions, are also discussed helping to identify aspects of practice that proved successful or otherwise.

Alongside the development and implementation of the adventure therapy intervention the research sought to examine whether it had any positive (or negative) impact for any of the participants, and if it did, what any associated psychological changes were? This posed the question as to whether adventure therapy could be a successful intervention for disordered eating and this question is considered in this thesis.

An overarching feminist approach was adopted as to offer a critical perspective to the action research process and thus the development of adventure therapy in the context of the outdoor profession in the UK. A key task of the feminist approach was to avoid a reinforcement of disordered eating symptoms as a direct result of the women taking part. As is examined in this thesis, outdoor adventure does present a number of inherent risk factors due to contextual issues, for example social and cultural influences. Given that a feminist stance was taken, a reflexive approach was also a central component of the research process throughout.

Taking into the account the participants' experiences of the adventure therapy intervention itself, and reflecting upon the lessons learnt in implementing the intervention, the thesis concludes by revisiting the 'HOPE' Model. Here each aspect of the model is reconsidered, offering evidence of a greater understanding as to how to approach similar practice in the future.

The thesis builds upon a previous small scale qualitative study that examined people's experiences of the outdoors and eating disorders (see Richards, 1998). The relevance of the findings from this previous study are briefly considered in Chapter Three, see pg. 35) and is in part why a critical perspective was adopted. This earlier study found some limited evidence to suggest that individuals had developed troubled eating behaviors as a way of coping with the gendered dimensions of outdoor education.

A number of sections of this thesis have already been published and thus aspects of the following publications are found across different chapters of the thesis:

Richards, K. (1999). Outdoor adventure and eating disorders: A personal perspective to research. *Horizons: The Journal of the Association of Outdoor Learning and The Association of Heads of Outdoor Education Centres*, 3, 23-26.

Richards, K., & Allin, L. (2000). Food for thought: Eating disorders and outdoor adventure. In B. Humberstone (Ed.), *Other Ways of Learning. Outdoor Adventure Education and Experiential Learning in Schools and Youth Work, Proceedings of the Fourth European Congress of the European Institute of Outdoor Adventure Education and Experiential Learning, Linkoping University, Rimsforsa, Sweden, September,2000 (pp. 83-90).* Marburg: Germany. EIOAEL.

Richards, K., Peel, J., Smith, B. & Owen, V. (2002). *Adventure therapy and eating disorders: A feminist approach to research and practice*: Ambleside: Brathay Hall.

Richards, K. (2003). Self-esteem and relational voices: Eating disorder interventions for young women in the outdoors. In K. Richards (Ed.) *Self-esteem and Youth Development* (pp. 103 –113). Ambleside: Brathay Hall Trust.

Richards, K. (2003). E*ating away the self: Relating eating disorders, women and self-esteem. Conference Report Research, Policy and Practice Forum on Young People: Self-Esteem.* The National Youth Agency, Joseph Rowntree Foundation and the Department for Education and Skills, 6 February, 2003, Birmingham.

Richards, K. (2003). Critical feminist reflexive action research in adventure therapy and 'eating disorders'. Exposing the Narrative(s) of an embodied, gendered and relational self. In. B. Humberstone, B, Heather, & K. Richards (Eds.), *Whose Journey's? Where and Why? The 'outdoors' and 'adventure' as social and cultural phenomena. Critical explorations of relations between individuals, 'others' and the environment* (pp.49-74). Cumbria: The Institute for Outdoor Learning.

Richards, K., & Peel, J.F.C (2005). *Outdoor cure: adventure and wilderness therapy. Therapy Today*, December, 16 (10): 4-9.

1.2 An Overview of Sections

1.2a Section One

Section One maps out the theoretical background to the development of the adventure therapy intervention and provides a critical analysis of the key literature related to the developing practice in this context. It examines key components of the 'HOPE' model including eating disorders, outdoor adventure, therapy, feminism and research. In order to understand the complexity of developing the 'HOPE' model, at times these components are examined separately. For example, an overview of the history and the etiology of eating disorders are provided (*see* Chapter Two) and the basic principles of outdoor therapeutic interventions are discussed (*see* Chapter Four). At other times, components of the 'HOPE' model are examined in relation to each other, thus ensuring that the ways in which different dimensions of the model interact with each other can be critically examined. For example, eating disorders and the outdoors (*see* Chapter Two) and feminist research approaches (*see* Chapter Five). All of these chapters develop a rationale for adopting a feminist approach to the study and the related issues for implementing feminist research and practice. This section concludes with a reflexive account of the researcher (*see* Chapter Six). The purpose of this chapter is to position the researcher and document aspects of the theoretical and practical development of the therapeutic intervention (the rationale for a reflexive process is discussed in Chapter Five). This final chapter of the section critically examines the central concepts that

are discussed in relation to feminist theory, eating disorders and the outdoors, thus positioning the researcher's subjectivity, and offering further insight into the complexity of the development of the study.

1.2b Section Two

Section Two examines the evolving process of the development of the adventure therapy intervention, identifying five phases of the research and related practice (*see* Chapter Seven). In doing so it provides detail of the emergent learning and knowledge development that emerged as the therapeutic team implemented the adventure therapy intervention. Data gathered as part of the study are related to each of the five phases, whereby the main aspects of the adventure therapy intervention are discussed, identifying related dilemmas and emerging issues as reflected from the women's direct experiences. The section then examines the womens' individual experiences of the intervention, identifying if any psychological change for them had taken place and, if so, what changes evident seemed to be a direct result of participation in the intervention (*see* Chapter Eight). The section then revisits the therapeutic team's experience of developing the intervention, whereby key issues related to the adventure therapy practice development are reviewed (*see* Chapter Nine). This section then concludes with a more detailed analysis of the 'HOPE' model, whereby components of each aspect of the model are re-examined (*see* Chapter Ten). In conclusion, the model of 'HOPE' is renamed the 'HOPE to HOPE' model – 'healing outdoors provides empowerment to help overcome problem eating' and some of the key issues in the ongoing development of adventure therapy in the UK are considered.

SECTION ONE:

Theoretical Background

Chapter Two:

Understanding eating disorders

2.1 Chapter overview

This chapter provides a context to key understandings that inform the treatment of eating disorders. This includes a brief overview of an historical perspective and the main theoretical models that guide therapeutic practice. As eating disorders are largely a female phenomenon, a gender perspective is considered and a feminist approach is introduced. Here the importance of considering a continuum of troubled eating, as opposed to only a diagnosis of an eating disorder, is discussed. Also, the developmental perspective of relational psychology is examined with reference to the onset of disordered eating. In conclusion, the relevance of relational psychology to the development of the adventure therapy intervention is examined, identifying wider considerations in the implementation of the 'HOPE' model.

2.2 Historical perspectives

The first medical account of an eating disorder was in 1689 when it became identified by Richard Morton as 'nervous consumption' (Silverman, 1997). It was not until approximately two hundred years later that the basis of what is now known as anorexia nervosa was recorded. Low body weight and self-starvation were recognised as the core physiological symptoms. These symptoms were addressed through the method of force-feeding and control over the sufferer, representing an understanding of eating disorders that was underpinned by a medical model of self-starvation. This focused on an asocial and highly individualised physical explanation, with limited recognition of the psychological and social dimensions in its aetiology.

It was not until the late 1960s, when the Diagnostic and Statistical Manual of Mental Disorders criteria emerged, that a growing awareness of the psychological formations in the development of eating disorders was achieved. In consequence, during the 1970s / 1980s the psychological aspects received greater attention. This included the emergence of psycho-analytical approaches (*see* Burch, 1978; Selvini Palazolli, 1974), alongside the suggestion by Crisp (1980) that anorexia nervosa was an attempt to, "cope with fears and conflicts associated with psychobiological maturity and phobic fear of adult weight" (in Silverman, 1997:8). Alongside this, bulimia nervosa, symptomatically characterised by cycles of binge-purge eating, became apparent and was defined in the early 1980s. It has been identified that of all psychiatric illnesses, eating disorder sufferers have the highest mortality rate, with between 10 - 20% of patients dying as a result (EDA, 1994). Such figures demonstrate why effective interventions, and more importantly effective preventative strategies, need to be more fully developed and made available to those at risk.

The classification of eating disorders generally distinguishes between anorexia nervosa, bulimia nervosa and binge eating (APA, 1994). Subtypes of these extend to anorexic restrictor type or anorexia binge / purger type and bulimic purging or bulimic non -purging type. The main classification of eating disorders has been distinguished between anorexia nervosa and bulimia nervosa. Russell (1970) proposed three criteria for diagnosis of anorexia nervosa:

1) Behaviour that is designed to produce marked weight loss.
2) A morbid fear of becoming fat which is the characteristic psychological disturbance.
3) Evidence of an endocrine disorder which in post - puberty girls causes the cessation of menstruation.

In 1979, Russell's criteria for bulimia nervosa consisted of:

1) A powerful and intractable urge to overeat, resulting in episodes of over eating.
2) Avoidance of fattening effects of food by inducing vomiting or abusing purgatives or both.
3) A morbid fear of becoming fat.

More recently the DSM - IV criteria (APA, 1994) breaks down further the different aspects of eating disorders, including an anorexic restrictor type and anorexia binge / purger type (*see* Appendix 1).

2.3 The aetiology of eating disorders

The issue of eating disorders continues to receive growing attention as the incidence among young women and girls continues to rise. Accompanying a greater preoccupation with body image and weight there has been a steady increased rise in eating-disordered behaviour over recent years. In the early 1990s The Royal College of Physicians suggested that between 60,000 and 200,000 people in the UK were suffering from either anorexia nervosa or bulimia nervosa (EDA, 1994). The incidence of anorexia nervosa is usually quoted at around one per cent of the population of women aged 15-30 years and another two per cent suffer from bulimia nervosa (Mind, 2004). Yet, the numbers of girls who may not show all the signs and symptoms that make up the diagnosis of anorexia nervosa and /or bulimia nervosa is much higher. Button & Whitehouse (1982) nearly 20 years again maintained that around 5 % of all teenage girls at that time develop sub-clinical anorexia nervosa after reaching puberty. So it is not surprising that more recently, and taking into consideration of the unreported cases, reports suggest that there could be as many as 1.15 million suffers of eating disorders in the UK (Eating Disorders Association, 2000).

The development of eating disorders has traditionally been linked to dysfunctional patterns in the family, early developmental factors, personality characteristics, social and cultural pressure, and age (Hsu, 1989). A multi-dimensional model is often used to take into account the range of factors that are seen to contribute in the onset of an eating disorder (*see* Figure 2). Generally, the developmental explanation for eating disorders is that they develop as an "individual fit of external events and inner psychological processes" (Elston & Thomas, 1985: 336). The sufferers use food as a way of control for what feel like uncontrolled aspects of their lives. It becomes a strategy for personal survival and is linked to a low self-esteem, perfectionist tendencies and struggles in developing a healthy identity (Button, 1993). So an eating disorder sufferer develops an intense and destructive relationship with food, body image and self-esteem. Impaired functioning in relation to the self emerges from feeling ineffective and powerless in the world, having a limited repertoire to responding to emotions and needs, personal struggles with personal identity, little awareness of self to value and looking to weight for a sign of self worth (Bruch, 1973). Low body weight and food control become a search and addiction for perfectionism of, "an external body configuration, rather than an internal state" (Brumberg, 1988). As suggested by Button (1993: 4), "the pursuit of the goal [of low body weight] becomes more important than the goal itself".

As identified in Figure 2, the interaction of the physical, psychological and social conditions of eating disorders illustrates the complexities of both understanding and addressing the phenomenon of disordered eating. Due to this complexity, a diverse array of theoretical perspectives can be examined in the context of interventions, for example family models (Eisler, 1995), psycho-dynamic models (Herzog, 1995), self-starvation models (Fitcher & Pirke, 1995) and social perspectives (Hepworth, 1999). Feminist models of eating disorders provide an important perspective, as approximately 90% of sufferers of anorexia and bulimia nervosa are women (Brown & Jasper, 1993). More recently both the medical and the psychological models have

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been challenged with a greater recognition of the ways in which eating disorders may be representative of conflicts in achieving the female contemporary role (Brown, 1993).

Figure 2

2.4 The body, eating disorders and gender: A common ground

Dieting is a risk factor for eating disorders, yet by the age of eighteen 80% of women have experienced problems and issues concerned with eating and losing

weight (Brown, 1993). Smolack and LeVine (1996) report that up to 40% of elementary schoolgirls report trying to lose weight. This practice of dieting is occurring young and younger, with girls as young as seven or eight years old controlling their food intake in order to lose weight and feel better about themselves (Bryant-Waugh and Lask, 1995).

From a feminist perspective the 'body' has been on the agenda for many years, although it is only recently that the subject of the body has become a central feature of wider disciplines, for example in sociology and psychology (Hepworth, 1999). When the theme of the body is considered it is important to recognise the complex gender constructions and relationships we have with our bodies and how they can form the basis of our gender identity. A feminist perspective of the body holds, as a basic premise, that patriarchal society has claimed and continues to hold claim to control over women's bodies. Thus, the body does not exist in a social or political vacuum. Instead, as Hall, A. M. (1996: 52) points out there is a need, "to conceptualise the female body as playing a major role in women's oppression".

One aspect of the role of the body in women's oppression is evident in the way women are socialised into being unable to accept their bodies. At the time of developing this intervention this was strikingly evident in an advertisement for women's deodorant that sported the slogan, "they hate their boobs, their bums, their knees and their noses. They love their armpits" (Guardian Weekend, 2000:48). Such advertising suggests that women disliking their bodies is both a common and acceptable phenomenon. Thus, for many women the way in which they view their bodies is an important factor in determining their self-identity. This relationship with their bodies often tends to become critical and negative, and leads them to determine their self-esteem with reference to the shape and looks of their bodies. Many women find themselves developing a preoccupation with their body and weight, "where the body becomes an object to criticise, torture, starve and perfect" (Hutchinson, 1994: 165). For example, as noted previously by the age of eighteen,

80% of women have dieted to lose weight (Brown, 1993: 53). Unfortunately, such a preoccupation encourages women to direct attention away from empowering themselves, a consequence that is one aspect of the processes that serve to maintain a patriarchal society. Women's bodies, therefore, provide a site of power where they become "sexualised, controlled and oppressed" (Hall, A. M., 1996: 64), illustrating that cultural practices exert constant pressure on women and their bodies (Bordo, 1993). This is evident in the celebration of the 'thin beauty' ideal for women in our western culture.

Components of the development of an eating disorder emerge predominantly throughout early teenage life, a crucial time for struggles of identity. Both gender and the developmental demands of growing up female add to the difficult transition from adolescence to adulthood, where the changing body is an outward sign of maturation. In western culture, the gender socialisation process typically means that girls are brought up with a limited awareness of the potential of their bodies (Young, 1990). Messages from key individuals and social institutions also contribute to women's sense of dissatisfaction with the realities of their body shape and size (Orbach, 1986). Moreover, the physiological realities of adolescence means that as they mature, girls move away from the societal 'ideal' thin female body type to a more curvy and rounded figure. Boys, in contrast, move closer to the ideal male body type (Smolack and LeVine, 1996). Further, the influences of the cultural values of dieting, consuming less or no fat / carbohydrate as health eating and excessive exercise means that those at risk are more likely to develop an eating disorder (Hartley, 1998).

The public acknowledgement of the way in which messages about the 'ideal body' contribute to the prevalence of eating disorders was exemplified in a UK Government Body Image Summit, held in June 2000 (Guardian, 2000). This summit aimed to address the way in which the media, particularly the fashion industry, convey an ideal of 'thin is best'. It was reflective of a preventive strategy,

in collaboration with the media, in reducing eating disorders by trying to reverse the current portrayal of extremely thin women. Whilst a commendable step forward in raising awareness of the social and cultural pressures on young women, the results of the summit provide girls with more contradictory messages. It remains unacceptable to be fat, but it is now also unacceptable to be thin. These societal conditions add to the already confusing expectations and uncertainties that exist in modern society in relation to women's roles and identities.

The problematic relationship between food and body that many women experience can, therefore, be seen as a result of the conflict involved in fulfilling prescribed notions of being female, where "women actually transform their bodies in an attempt to deal with the contradictory requirements of the contemporary female role" (Ettore, 1994: 89). It is important to recognise, therefore, that our bodies are not merely biologically determined, but that they have wider social and psychological meanings for us. As identified by Malson (1998: 12), "it is not our female (or male) bodies that make us feminine (or masculine) but the way in which we interpret our bodies".

2.5 Conceptualizing eating disorders: A continuum of troubled eating

An important step towards addressing the relationship between gender, human development and eating disorders is to locate eating disorders on a continuum of 'troubled eating', ranging between normal eating behaviour to extreme troubled eating behaviour (as described by the term eating disorder). This recognises that many people can have troubled eating behaviours (e.g. dieting), but do not necessarily fall within the medical criteria for an eating disorder. This is important because the experience of women suffering from disordered eating is not necessarily separate from most women's relationships with food, body and self-esteem (Brown & Jasper, 1993: 34). Consequently, a continuum of troubled eating allows preventive models to be developed and implemented as it does not rely

solely on the mental disorder diagnostic classification system (APA, 1994) to address the developmental symptoms of troubled eating (e.g. for anorexia nervosa, body weight being 15% lower than expected). Moving away from a medical model allows greater recognition of how wider social and cultural influences such as class, age and race can all contribute to women's search for control in situations that create feelings of powerlessness. For example, from an economic perspective, the bulimic episode of an unemployed single mother can, in part, be understood as a response to her feelings of financial powerlessness (Hepworth, 1999).

Being cautious of a medical model is an important component of a feminist approach to intervention, as such a model can imply that women's mental health rests within a woman's physiology or personality. As Worrell and Remer (1992: 20) identify, "traditional models of treatment that label the women as disordered and that locate the problem within her biology, personality, or deficient skills, are insufficient to address the multiple factors that impact on her well being". As will be discussed later, the concept of a continuum of troubled eating compels outdoor adventure to examine more carefully the ways in which it risks colluding with women's oppression and reinforcing disordered eating, identifying how the coping strategies reflected by a women's relationship with troubled eating can in fact be reinforced. This issue is discussed in some detail in the following chapter (*see* Chapter Three).

2.6 A developmental perspective on eating disorders: The importance of relationships

Initially, the development of eating disorders may be perceived as a result of the media influence in reinforcing the thin female ideal. However, wide ranges of alternative theoretical perspectives are available, including psycho-dynamic (Aronson, 1993), family (Eisler, 1995) and cognitive-behavioural models (DeSilva, 1995). Whilst the importance of these approaches is clear, from a gender

perspective it is the developmental context from which eating disorders arise that must receive attention. Eating disorders are most common for young women during adolescence and, as noted earlier, evidence suggests that 5% of teenage girls develop sub-clinical anorexia nervosa (Button & Whitehouse, 1982). It is perhaps not surprising then that eating disorders are most prevalent during adolescence. Developmental psychologists, Brown and Gilligan (1992), argue that young women face an increased psychological risk during this phase of development and it is this increased psychological risk that acts as one of the catalysts for adolescent girls to turn to forms of troubled eating.

In considering young women's transition from adolescence to adulthood it has been noted that sound relationships form an important component in the developmental process for women, where the maintenance of an inner sense of connection with other people is central to the development of women's self structures *(see* Jordan *et al.*, 1991). However, in our present day society the dominant masculine culture directs us towards pursuing goals of individual endeavour and achievement. This in turn places a greater value upon autonomy and individualism, whilst devaluing interdependence. As a consequence relational processes become "misinterpreted as dependent behaviour" (Kaplan *et al.*, 1991, p.131). This damages women's ability to maintain a real sense of self and raises the question of how women can survive in a society that tends to deny a core component of their identity.

Adopting disordered eating allows women to maintain control of how they define their identity. From a relational perspective, their focused relationship with food and their bodies is, in part, substituted for the relational process that is devalued in society. This relationship with food grows to become the most appropriate relationship as it is a self-determining process, which eliminates the danger that external influences may take control. Choosing a relationship with food seems to have an initial second 'pay off', in reversing the self-esteem loss they have experienced. However, this is paradoxical as it only serves to reinforce a low self-

esteem. Eating-disordered behaviour emerges when women turn to body weight and the use of restricting food intake, purging and bingeing to maintain their self-esteem and address their relational needs.

Women then experience psychological and emotional turmoil as the disordered eating begins to become the very foundations of their identity. Ironically, these eating patterns are kept secret as they fear self-disclosure might lead them to not only lose their sense of self-control, but also to be perceived as 'weak women'. Controlled, restricted and binge eating, therefore, become mechanisms through which women maintain a sense of self-empowerment in a world that seeks to disempower them. Thus, the difficulties which young women face as they make the transition from adolescence to adulthood may contribute to the emergence of an eating disorder. As identified by Sesan and Katzman (1998: 81), dysfunctional eating behaviour is representative of the barriers to relational connection that young women experience during adolescence.

> *"Eating-disorder pathology develops as a response to the confusion and 'crisis of connection' that girls experience around the loss of their relational world as they come of age within a culture that does not value these types of connections with others."*

As Striegel-Moore & Steiner-Adair (1998: 15) identify, the success of eating disorder prevention interventions will thus depend "in part on the degree to which the relational needs of the participants are recognised and addressed, and in part on the relational skills of the person providing the intervention". In developing outdoor adventure based interventions aimed at addressing disordered eating this theoretical perspective informs practice, whereby the process of relational connection needs to be both fully valued and nurtured. However, outdoor-based programmes need to ensure that they do not continually 'buy' into the concept of autonomy and individualism that often underpin the goals for outdoor adventure experiences. Thus, the current ways in which self-esteem enhancement are

conceptualised within an outdoor adventure framework need to be critically examined. This critique is discussed in the following chapter (*see* Chapter Three) and is one of the issues underpinning the reflexive chapter (*see* Chapter Six).

As will be discussed in the following chapter (*see* Chapter Three) physical challenge, risk-taking, overcoming fears, and trust still tend to be located within a success model of participation in outdoor adventure. This encourages change processes to be based upon a model of human development that provides an over-emphasis on independent endeavour. It is clear that until a move away from achievement and task-orientated goals towards a more balanced relational focus is achieved, addressing the developmental needs of women will be limited. Without this shift a patriarchal approach to both human development and outdoor adventure will be maintained.

By understanding the specific psychological and sociological processes that underpin non-outdoor based interventions, the role of outdoor adventure in providing an appropriate ingredient in the treatment of eating disorders can be examined and realised more fully. For example, how can focusing on "healthy functioning and self-respect in developing positive body image and exploring a pathway to success unrelated to outward physical appearance", as examined by Stewart (1998), be enhanced by an outdoor adventure experience? Thus, as practice develops it is important to give detailed attention to the ways in which we seek to inform ourselves of the theory that surrounds the aetiology of eating disorders and how the practice of treatment is related to any outdoor adventure experience. The next chapter aims to start to examine such links and continues to build the rationale for a feminist approach to the research and practice in this study.

Chapter Three:

Eating disorders and the outdoors:

An examination of the links

3.1 Chapter Overview

This chapter gives attention to the relationship between eating disorders and the outdoors. A more critical analysis of the social construction of eating disorders, and the fact that it is a largely a women's phenomenon, points to the need to consider gendered dimensions of the outdoor adventure experience. In beginning to understand these dimensions this chapter examines the ways in which women's physicality and links with body image are impacted upon in an outdoor setting, identifying how these issues pose risk factors in the development of eating disorders in an outdoor setting. The chapter, therefore, alerts us to negative impacts that might arise when working with an eating disorder client group in the outdoors, highlighting the need to be mindful of who defines and controls the embodied self, both in society, and in an outdoor adventure setting. This allows the social and cultural context of eating disorders to be addressed more fully, avoiding the medicalising and pathologising of developmental risk factors. It also continues to build the rationale of the role of a feminist perspective in developing adventure therapy in the treatment of eating disorders and the points in the research project which need to be critical of theory, research and practice in outdoor adventure.

3.2 Eating disorders and the outdoor experience

During the past decade the value of outdoor experiential learning in the treatment of eating disorders has received growing interest. Newton (1996) identified the importance of the outdoor leader being able to identify disordered or unhealthy eating. She suggests that, "early recognition and intervention can make a difference

in the eventual success of treatment" (ibid:.4). Arnold (1994) and Hayes (1997) refer to the value of addressing the specific dynamics of eating disorders, for example negative body image and low self-esteem, through outdoor adventure.

Maguire & Priest (1995) have made a link between the treatment of bulimia nervosa and the therapeutic aims of outdoor adventure. They suggest, that "adventure therapy is an adjunctive way to help live normal and productive lives, by providing effective coping mechanisms." (ibid: 48). They argue that adventure therapy programmes enables bulimic sufferers to, "build confidence or self-esteem and gain a new appreciation for their bodies" (Maguire & Priest, 1995:48). Copland Arnold (1994:51) also makes the suggestion that for eating disorder sufferers the value of outdoor programmes could be a valuable contribution on their recovery:

> *"They support the development of a "greater awareness of our body's capabilities ... leading to a greater appreciation of our bodies. This suggests that developing a reconnection between the physical and psychological self has a role in supporting the recovery from an eating disorder."*

As noted in Chapter Two four basic themes in the developmental components of eating disorders can be identified. These are low self-esteem, a negative relationship with the body, feelings of powerlessness and gender identity. It is these four themes that allow us to begin to examine the interface between eating disorders and outdoor adventure more fully. As noted above, a traditional model of outdoor adventure suggests that such experiences could provide a valuable framework in addressing these developmental components. That is, participation in outdoor adventure education has typically been associated with a rise in self-esteem through achievement and risk taking (Kimball and Bacon, 1993), a greater appreciation of the physical body through physical activities (Mortlock, 1984), a greater sense of control and self-sufficiency (Ewert, 1989) and a challenge to traditional gender roles (Humberstone, 1990). However, even though authors propose that outdoor

adventure experience can offer a positive role in the treatment of eating disorders, the following discussion will highlight some of the ways in which these benefits are not necessarily a given for all women participating in the outdoors and that disordered eating risk factors are inherent. As will become evident these concerns are essential considerations in developing therapeutic interventions for women with eating disorders in the outdoors, as social structures of adventure risk perpetuating the very basis of the development of eating disorders.

The fact that approximately 90-95% of anorexic and bulimic sufferers are women (Bordo, 1993, p.40; Brown, 1993, p.53) suggests that eating disorders are predominately a female phenomenon and thus gender is a central concern. Women's needs and issues, however, seem to go un-recognised in the context of outdoor adventure. Humberstone (1998: 47) states that, "discussions around women and what they might bring to outdoor adventure education are largely omitted", whilst Roberts (1995: 31) suggests that, "we merely have skimmed the surface with respect to listening to the voices of women and benefits of wilderness therapy".

3.3 Women's perceptions of the body outdoors

The aim of the programme was to work therapeutically with women, supporting them in their recovery from an eating disorder (anorexia nervosa and/or bulimia nervosa). The therapeutic application of outdoor adventure is commonly referred to as 'adventure therapy' (*see* Chapter Four for an overview of adventure therapy). The term 'adventure', however, has to be used cautiously as, in its traditional sense, the word is surrounded by gender constructions. Mack (1996: 25) points out that, "many women are weary of the word 'adventure', which conjures up heroic quests and intense physical endurance". Further, in developing a feminist approach to therapy for women with eating disorders, Brown (1993: 120) recognises that "very little instruction exists" for those who wish to adopt such an approach. This is echoed in the context of adventure therapy programming. Thus, it was imperative

during the process of the research that the gender perspective was taken seriously. As will be demonstrated in this chapter, without such an approach, the outdoor experiences could actually serve to reinforce disordered eating.

There are ways in which those working outdoors can either eradicate, or collude in, the perpetuation of gender relations and the politics of the body. Gender oppression may be eradicated by providing an environment where women can experience an empowering relationship with their bodies, free of societal pressures to conform to the female myth. West-Smith (1997) examined how outdoor women identified whether they had experienced changes in their body image as a result of participation in outdoor adventure activities. In her study nearly half of the women had experienced changes in their body image resulting in, "increased positive feelings towards their bodies' appearance, its capabilities and/or their realistic expectations for physical performance" (ibid: 6). Her findings suggested that outdoor adventure settings have the potential to challenge the social construction of women's bodies. These settings can provide opportunities for women to "positively experience their bodies as both attractive and effective, based on definitions and perceptions of physical attractiveness that are personally meaningful rather than on culturally prescribed dictates" (ibid: 6). However, this should not lead us to assume that all outdoor settings challenge the social constructions of both women's bodies and roles. It is necessary to remember that, as long as women's weight in society tends to be judged more severely than men's (Szekerly & DeFazio, 1993), we run the risk of both overlooking and reinforcing this tendency when operating in an outdoor setting. This was illustrated by Warren (1996: 7) as she recalled her experience of facilitating an experiential activity, often used on adventure programmes, with a group of women.

"As we stood before the various size openings of the web, the women began to speak. I listened empathetically as one by one, the women started to tell their stories of how body image had been such a difficult issue for them throughout their lives. As the women in my class assessed the challenge before them they

did not see potentials for co-operation or community building, but instead self-doubt and questioning about their bodies."

The centrality of physicality and the body to women's experiences of outdoor adventure is discussed in several research papers (Allin, 2000; Carter, 2000; Woodward, 2000). These studies consider the sense of empowerment that women can gain through participation in outdoor adventure. However, they also begin to show the ways in which such participation can be a source of dis-empowerment and lead to a lowering of self-confidence. For example, Allin (2000) noted that the criteria for positive evaluation in the outdoors is often the demonstration of physical competence or, at least, a "get stuck in" approach. In Carter's (2000) study, women reported a lowering of self-esteem through having to "prove" their capabilities, gain credibility or cope with challenges to their ability levels. One explanation for this lowering of self-esteem and confidence lies in the way outdoor adventure education is constructed and the links between physical competence and masculinity (Connell, 1987). This can lead women who may already lack confidence in their abilities to make negative self-assessments or, alternatively, feel pressurised into putting on a façade of bravado, which in consequence models a denial of emotional needs. Thus, risk factors in the aetiology of eating disorders, for example a lowering of self-esteem and being unable to value and address emotional needs, have opportunities to emerge in an outdoor adventure setting.

Messages that reinforce physical myths, such as the above, could serve to encourage women to place a greater emphasis upon their body image and weight, and as argued by Bordo (1990: 85) reinforcement of an oppressive 'gender relations' is maintained with aesthetics and politics of the body as its tool. Women can and do experience subordination of their physicality in outdoor adventure. Richards (1997: 42), in her study of gender inequalities in outdoor education, identified the impact that such subordination can have upon women:

"The jestful comments implied by men severely affected women. In particular comments about body weight were identified as having a deep psychological effect, causing some of the women to become receptive to eating disorders. Many women referred to incidents where they were told by men that they "would not make the grade [in practical outdoor skills] because they are too fat".

Thus, in considering gender-based physical myths, attention needs to be given to examining how women's experiences of the processes of physical subordination can manifest themselves in the development of eating disorders. In a study that examined the direct relationship between eating disorders and outdoor adventure (Richards, 1988: 41), two women identified how an unnecessary emphasis placed upon their weight was one of the prevailing contributing factors which had led them into developing bulimia nervosa.

"I don't think weight should have been the issue it was. I feel very strongly about that because that was very demanding ... I eat to cope with the course [training in outdoor education] because by that stage my eating was my way of coping with how I was feeling."

"It was "well right if you don't get fit and lose weight, we are not taking you out [into the outdoors]". I was in a state after he told me that ... I mean the fact that if I didn't lose weight that was it... But if I hadn't been pushed to get fit and [they had] said "don't worry the weight will drop off" or something then I think that would have made a big difference"

3.4 Addressing body image and eating disorders outdoors

As these women's experiences demonstrate, it is important to incorporate issues of body and eating into the current debates surrounding the psychological and social risks present in any outdoor experience. A first step in addressing such issues is to

identify how present practice reinforces gender myths (*see* Humberstone, 2000a, 2000b), as this will play a pivotal role in how representations of the body and self-image are reinforced or redefined in an outdoor setting.

The ways in which society seeks to control women's bodies and the ways in which individuals perceive their own bodies will affect the way in which a person engages both socially and psychologically (Faunce Spencer, 1990). Body identity, therefore, becomes a core factor in the way in which people make meaning of outdoor-based experiences. At present the gendered space of outdoor adventure risks colluding with the processes that lead women to experience physical oppression, rather than creating the opportunity for empowerment (*see* Allin, 2000). However, the relationship between gender and the body provides a key element in outdoor programmes. As suggested by Bell (1997:47) "gender matters more in experiential education than in other forms of learning, because experiential pedagogy depends on the performance of bodies and physical achievement".

It is evident that women who participate in programmes may bring with them a complex constructed relationship between self-esteem and body image. In view of this, it is alarming to note the lack of debate surrounding the relationships between gender, self-esteem and body image in outdoor literature. Surely this is somewhat contradictory considering that the rationale for many outdoor provisions is the claim that they have a positive influence upon self-esteem. It is necessary to become more critical of some of the common assumptions in outdoor experiential learning, for example that self-esteem increase is achieved though the simple process of successfully completing outdoor activities. Wider societal inequalities evident between women and men suggests that addressing gender issues, as they are reflected in self-esteem, is a complex process that requires a more comprehensive analysis. Hepworth (1999: 101) points out that, "inequalities in the economic, social and cultural status between women and men reproduce the conditions for women to experience low self-esteem and control over individual circumstances". A more critical examination of self-esteem is also required in the context of eating

disorders, as low self-esteem is a core issue in disordered eating. One woman in the study by Richards (1998: 42) made a clear link between the reinforcement of low self-esteem and disordered eating in an outdoor setting:

> *"I learned a lot from counselling sessions. I didn't learn how to control my eating. I learned why it was a problem. It went back to my training in Outdoor Education. That it had damaged my confidence."*

The issues in addressing disordered eating in outdoor adventure is further highlighted when, as suggested by Conner (1999: 8), "potential students with bulimia or anorexia, with a history of violent, destructive or suicidal behaviours should not be admitted to a wilderness programme". Outdoor adventure positively encourages provisions for disaffected young people, yet when violent and suicidal behaviour is linked specifically to what is largely a woman's phenomenon women risk being denied the wilderness experience. It could be argued that excluding women with eating disorders from outdoor programmes stems more from ignorance, fear and a medical model of eating disorders, rather than a realistic appraisal and positive management of the potential outcome. Physical risks need to be taken seriously, for example an increase rise in electrolyte imbalance and cardiac arrest with an extremely low body weight (Treasure & Smukler, 1995). However, suggestions such as Conner's (1999), in excluding potential students with bulimia or anorexia, fails to understand how this colludes with a reinforcement of troubled eating for women. By locating the gender perspective more fully, which is easily recognised as 90 % of eating disorder sufferers are women (Bordo, 1990), it can be argued that exclusion of such sufferers from the outdoor adventure experience is a reinforcement of the wider phenomenon of maintaining womens oppression in society. This alerts us to the debate surrounding who defines and controls womens mental health (Usher, 1991), in conjunction with the management of outdoor adventure programming for women. These debates strengthen the rationale for why recovery and reinforcement processes of eating disorders in an outdoor setting need to considered from a feminist perspective.

If traditional goals of outdoor adventure, as presented earlier, are now reconsidered, the ways in which a reinforcement model of eating disorders may develop becomes clearer. First, self–esteem through physical achievement risks encouraging physical failure, which in consequence could enhance further an already negative body image. This is of particular concern given the social constraints upon womens physical performance in an outdoor adventure setting. Furthermore, as highlighted in the previous chapter, self –esteem enhancement for women from a feminist perspective is based on a different set of values and principles to those traditionally expressed in the literature. Second, challenging the self to take risks has an inherent value in controlling the mind over the body. This could maintain the mind / body dichotomy which is prevalent for an eating disorder sufferer, as they are in continual denial of bodily needs. Further, such a dichotomy needs to be located within wider issues prevalent in eating disorders, for example exercise addiction (Pruitt *et al*, 1991). Third, self-sufficiency proposes independence and self-control. Self-control is central to an eating disorder, any inappropriate influences upon this dynamic of self-control risks prescribing to unhealthy notions of self-control. Fourth, eating disorders emerge out of struggles to overcome unequal power relationships and it would be naive to assume that group relationships avoid power relationships and that all outdoor adventure spaces actively seek to demystify gender roles. And finally, the way in which trust is assumed and constructed in fact risks colluding with women being unable to trust their own empowered search for identity.

In developing adventure therapy interventions aimed at addressing disordered eating it is fundamental that this process of relational connection is both fully valued and nurtured. Outdoor-based programmes need to ensure that they do not continually 'buy' into the concept of autonomy and individualism. However, the current ways in which self-esteem enhancement are conceptualised within an outdoor adventure framework may do just that. Physical challenge, risk-taking, overcoming fears, and trust still tend to be located within a success model of participation in outdoor adventure. This encourages change processes to be based upon a model of human

development that provides an over-emphasis on independent endeavour. It is clear, therefore, that until a move away from achievement and task-orientated goals towards a more balanced relational focus is achieved, addressing the developmental needs of women will be limited. Without this shift a patriarchal approach to both human development and outdoor adventure therapy will be maintained.

Chapter Four:

Adventure therapy: theory and practice

4.1 Chapter Overview

This chapter will introduce some of the historical origins of adventure therapy and the wide ranging goals of outdoor adventure experiences. It will consider the types of outdoor interventions available and associated benefits of participating in outdoor adventure programmes. An overview of terms associated with adventure therapy interventions and related differences are considered. Applications of adventure therapy are then examined, highlighting some of the current debates in adventure therapy – for example definitions and theoretical perspectives. The key ingredients of the adventure therapy experiences are described, providing an overview of some of the psychological processes and associated benefits with clients taking part in interventions. Wider issues, such as the needs for addressing physical safety, as well as psychological safety, are considered, along with ongoing debates in the provision and practice of adventure therapy.

4.2 Adventure experiences and the historical origins of adventure therapy

Participation in outdoor adventure experiences, such as climbing a mountain, walking in a forest, or kayaking down a river, can be associated with a range of emotions. For example there can be feelings of exhilaration, fear, excitement, exhaustion, achievement, connection, frustration, awe or wonder, along with all the other experiences associated with physical activity. These collective responses to outdoor experiences can add up to a greater awareness of self, feelings of well-being and a sense of connection with others and the world. In adventure therapy these experiences are used as opportunities for facilitating significant growth. Therapists in this setting are, therefore, concerned with what happens when the outdoor experience and a counselling and psychotherapy process meet.

The use of the outdoors, adventure and wilderness for promoting personal and psychological development dates back to the earliest times of the formation of human family groups. Myths and legends abound of young people being sent, or embarking, on adventurous journeys in order to complete rites of passage into adulthood. Jesus went into the wilderness for forty days in preparation for taking up his ministry (Mark Ch3 Vs ff.), while the tale of Jason and the Argonauts is a vivid account of young men developing personal qualities forged through hardship, adversity and eventual triumph.

In Britain, the experiences of torpedoed merchant seamen shipwrecked by German U boats caused training and education establishments to examine the potential of outdoor adventure experiences to create positive psychological changes in people. It was observed that experience-hardened, older men survived shipwreck in greater numbers than younger members of the crew. Soon it became evident that outdoor adventure could develop, in young people in particular, qualities such as hardiness, resilience, problem solving and the ability to work as a member of a team. This led to the development of what became commonly termed as 'character development' in the outdoors and formed the basis of the Outdoor Education movement in the UK. These historical routes were also significant in outdoor adventure being a realm of physical activity whereby masculine values and traits oppressed female values and traits. As was pointed out previously (see Chapter Three) the term adventure "conjures up heroic quests and intense physical endurance" (Mack, 1996:25) and overlooks perspectives as to what adventure might mean for different people, especially women.

4.3 The goals of adventure experiences

The development of outdoor adventure from purely a recreational pursuit to a potential therapeutic technique has been influenced by the developments in outdoor adventure over the past fifty years. Initially, outdoor adventure programmes made

the assumption that psychological development could be facilitated through experiencing different forms of adventure pursuits. This was evident amongst early generic 'Outward Bound' courses, which began in 1941, where, "the aim unequivocally expressed was character training" (Hunt, 1991: 28). Over fifty years later, as pointed out by Hunt (1991: 36), "whatever the specific nature of outdoor experiences, all round personal development of the individual has become increasingly recognised as the fundamental purpose".

It is necessary to clarify the learning processes and wider outcomes of outdoor experiences in order to relate them to the possible outcomes. Today, many organisations provide a variety of outdoor adventure and outdoor development training courses claiming that individuals who participate in them experience a range of benefits. It is widely recognised that outdoor adventure programmes do result in positive change. Gibson (cited in Gass, 1993: 44) argues that changes can occur in relationship to self-concepts, individual behaviours and social functioning of programme participants. Research suggests that self-concept and self-esteem are key benefits of outdoor programmes (see Bertolami,1981; Martin, 1983; Washburn, 1983; Wright, 1982). Further recorded benefits include reducing problem behaviour (Pommier, 1994), reducing recidivism rates (McNutt, 1994) and increasing self - efficacy (Hughes, 1993) and it is commonplace to see outdoor programmes working with young offenders (Redropp, 1997), corporate managers (Donnison, 2000), through to adults with post-traumatic stress disorder (Ragsdale et al., 1996).

With a growing recognition that outdoor adventure programmes have positive outcomes they have progressively been establishing a reputation as an effective form of treatment for psychological issues. Ewert (1989) argues that outdoor activities can provide benefits to mental health, as an adjunct to clinical therapeutic techniques. This is evident in the treatment of addictions (Luckner & Nadler, 1997), post traumatic stress disorder (Ragsdale et al., 1996), substance abusers (Gass & McPhee, 1990), survivors of sexual abuse (Pfirman, 1988), young offenders (Reddropp, 1997), marital intimacy (Hickmon, 1993) and psychiatric

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patients (Gilliam, 1991; Blanchard 1993). Further applications include training in interpersonal - cognitive problem solving skills (Walton, 1985) and addressing the self-efficacy of chemical dependant males (Hughes, 1993). A range of goals and distinguishing features of the different ways in which people can experience adventure and the outdoors is shown in Table I. This overview is illustrative of how the psychotherapeutic goals are for example, different to those adventure experiences that have recreational goals.

Table I:

In considering the above goals for adventure experience it is important to recognise that the table provides a simplistic view of associated goals and doesn't fully represent the wide range of practice that exists. For example, a whole range of teaching and learning strategies can be used in facilitating outdoor experiences with a wide range of goals and from a psychotherapeutic perspective different modalities

are used to approach working psychotherapeutically (e.g. cognitive behavioural, humanistic, and or psychodynamic). The goals are helpful though in that they encourage providers to clearly distinguish between work in the outdoors that may be for recreational purposes to work that may have psychotherapeutic goals.

4.4 Terminology

4.4a An overview of terms

A number of different terms are used for therapy outdoors, including adventure therapy, wilderness therapy, nature therapy, and more recently eco-therapy. The approach taken in this study was a preliminary adventure therapy approach, although, nature therapy and eco-therapy will be briefly discussed so the range of approaches that can be used in an outdoor setting are fully recognised. Inevitably, the Outdoor Education movement, with its focus on personal development, has driven the development of these different approaches.

The two key terms often used are adventure therapy and wilderness therapy and have to a large degree, been developed together over the past two decades and the terms are often used interchangeably. Within these terms Crisp (1996) identifies the three main approaches currently available:

1) **Adventure therapy:** is recognised as the "use of contrived activities and experiential, risk taking and challenging nature in the treatment of an individual/ group."

2) **Wilderness Therapy:** refers to a more "isolated natural environment, with the use of a living community."

3) **Wilderness -Adventure Therapy:** is recognised as a day activity in a natural environment, not extending to an overnight stay.

(Crisp, 1996: 5-6)

As is evident from the above definitions there is a distinction between adventure therapy and wilderness therapy, and this distinction will be discussed in more detail below. A fourth term should be included here, that of nature/eco-therapy as these approaches take place in an outdoor setting and come under the umbrella of outdoor therapy and these approaches are discussed below.

4.4b Adventure therapy

Adventure therapy can stand separate from wilderness therapy in so much as it focuses on clients and the therapist engaging in adventurous activities, such as kayaking, rock climbing or the use of purpose built adventurous activity constructions (high or low ropes courses) as the medium for psychotherapeutic work. It tends to occur within a framework of change that provides experiential activities that include challenge, risk and group activities, traditionally with a focus on achieving success. The key element is that clients are facilitated into placing themselves outside their comfort zone by taking part in an activity where they may experience fear, exhilaration and perceived danger - high-perceived risk, in a setting of low actual risk (see discussion later in this chapter). The adventure activities are also used to focus upon specific therapeutic issues, thus refined framing techniques are frequently used to therapeutically enhance metaphors for the individual (see below).

4.4c Wilderness therapy

By contrast, wilderness therapy, as its name implies, deliberately makes use of the healing effect of natural, wilderness settings. Programmes operate in more remote settings, where the process of maintaining participation in a group wilderness challenge experience provides an opportunity for extended processes of psychological growth and change. Here, although adventurous activities such as kayaking or rock climbing may be presented, the main intention is to provide clients with opportunities to make contact with the meanings and consequences derived

from engaging with journeying in natural settings over a prolonged period of time (Stolz, 2003).

This usually involves taking groups of clients, on wilderness journeys lasting weeks or months. During this time they travel, live in tents and confront natural challenges presented by weather, fatigue or physical objects such as rivers and mountains. Clients see clearly the ways in which the existential givens of nature comment explicitly and unequivocally on the existential givens of life. The fact that nature can be unforgiving and punishing, as well as inspiring and rewarding, provides profound teaching - uncontaminated by interpretation or the judgement of another. As identified by Davis-Berman and Berman (1994: 10) the wilderness therapy experience, "separates participants from environments that foster and maintain dysfunctional behavior. It is action oriented, provides immediacy of feedback, and enhances taking responsibility for oneself".

4.4d Nature therapy and eco-therapy

Relationships with nature are a central aspect of the outdoor experience. This relationship has always been considered a key component of outdoor education and can be seen in environmental education provisions that are often a key aspect of outdoor education programmes (*see* Martin, 2007). A focus on the relationship with nature within therapeutic applications of the outdoor experience has meant that terms such as nature therapy and eco-therapy have been coined (*see* Clinebell 1996; Burns 1998; Beringer, 2003; Berger, 2006;). These terms are often underpinned by eco-psychology concepts and recognise how relationships with nature have healing possibilities and applications range from example, nature guided therapy (Burns, 1998) through to horticultural gardening (Simson & Straus, 1998). These applications have in some ways developed separately to the outdoor education movement, and thus the theoretical underpinnings to these approaches often assume that outdoor education practices, and thus adventure therapy, are not concerned with relationships with nature.

It would be naïve to assume that adventure and wilderness therapy do not to take into account relationships with nature, as they do very much draw on the healing qualities of nature across a range of provisions. Yet, as pointed out by Beringer (2003) some of the dominate literature seems to place the focus on participation in activity and the human elements of the therapeutic relationships, but the literature does recognise that this activity takes places in a natural setting and as noted above this setting is a key factor to consider. The challenge is for all approaches to develop integrated theory and practice, to ensure that all components of the experience have appropriate recognition. For example, walking in nature does have associated physical benefits (Pretty et al., 2003) and taking part in adventure activities does mean a relationship with nature is present. So it could be argued that a more inclusive term for work in this area would be outdoor therapy as this would enable all approaches to immediately be included. For the purposes of this thesis the common term adventure therapy is used, but within that it recognises that the term outdoor therapy is actually more suitable as this would be more inclusive to all aspects of the outdoor experience as noted above.

4.5 Applications of adventure/wilderness therapy

Where adventure or wilderness therapy is offered to clients it comes in two forms – one as a complete stand-alone therapeutic programme - 'uni-modal' programmes (Gillis et al., 1996), or arguably the more effective form, as a therapeutic input that acts as an adjunct to other therapeutic interventions – 'multi-modal' programmes. In this latter case, clients may be offered the opportunity to join an adventure or wilderness therapy programme while they are participating in ongoing psychotherapy. The adventure or wilderness programme would then comprise an introductory programme of meetings and briefings, the adventure or wilderness programme itself, concluding with ongoing follow up after the outdoor intervention.

In the development of adventure therapy programmes it is therefore necessary to identify clearly the basis of the approach, defining the "presence or absence of therapeutic procedures," and the context of any such approaches (Crisp, 1996: 6). This is because the word therapy can be used in many different ways. For example, it may imply therapeutic benefits (which may not include any psychotherapeutic interventions), or to refer to psychotherapeutic interventions being clearly used. This distinction is an important key ethical requirement, as clients may be misled into believing they are being offered psychotherapeutic interventions when in fact they are not, and instead the model of intervention that is being offered is more inline with a development training model (as explained in Figure 1, p. 43).

This research project is composed of a uni-modal psychotherapeutic provision. The programme evolved, however, to become a multi-modal approach, as some of the women engaged in other forms of psychotherapeutic intervention (*see* Chapter Seven). The programme design consisted of pre-course, residential and follow-on phases. The objectives included supporting women in developing a greater awareness and appreciation of their self and body, alongside a greater awareness of the underpinning dynamics of their troubled eating. It was recognised that group therapy would be the most effective approach to troubled eating, as Brown (1993: 134) points out "women are able to both share and learn from other women". Alongside this, it was decided to support therapeutic processing of the adventure experience and achieve greater psychological depth by providing individual therapy sessions during the residential phase - this included the use of Interpersonal-Process-Recall (*see* Chapter Five).

4.6 Key ingredients of adventure and wilderness therapy

4.6a An introduction

Adventure and wilderness therapy is clearly located within the tradition of experiential approaches. The emphasis is as much on using process reflection to

facilitate clients' awareness of what is happening and how they are responding, as it is on empathic reflections (Rennie, 1998). In addition the elements of novelty and challenge are key ingredients that differentiate adventure and wilderness therapy from more conventional experiential therapies.

4.6b Novelty experiences and relationships with nature

Adventure and wilderness therapies usually place clients in an unfamiliar environment doing unfamiliar activities. The dramatic nature of this unfamiliarity should not be underestimated. It includes all the basic elements of life – unfamiliar clothes, food, and accommodation. The settings in which the therapeutic work takes place – mountains, forests, lakes and moorland - are often impressive, awesome places. The significance of this novelty is that it provides clients not only with an opportunity to examine their pre-existing beliefs about themselves, but also to have experiences beyond the 'ego' that can be transformational in nature. These are often referred to as flow experiences and such experiences are often associated with outdoor adventure experiences (Csikszentmihalyi & Csikszentmihalyi, 1999).

Another premise here is that relationships with nature offer healing benefits. It is argued that detachment from the natural environment has consequence for our physical and psychological well being. As Burns (1998: 4) states, "we are part of our environment, and unless, we are living in a state constant with that environment, we cannot expect neither health nor happiness." The 'person-nature' connection is key to the outdoor experience and it has been shown that "simply looking through a window upon a natural scene has beneficial effect" (Ulrich, 1984). So the outdoor experience capitalises on the beneficial effects on being in nature, and the non-human environments - "the wilderness quality of the environment, the serenity, the solitude, the aesthetic and spiritual qualities of the wilderness environment" (Beringer, 2003: 200).

4.6c Challenging experiences

The effect of the novelty of many outdoor experiences is itself challenging, but in addition, many of the activities presented carry an element of real or perceived risk. A client's perception of the risk involved may be such that they have an additional emotional level of arousal to manage. The key concept here is of inviting clients to step outside their comfort zone and in so doing examine the experience they have of themselves in a new zone of disequilibrium (Gass, 1993).

Gass (ibid) describes this as 'edge work'. It is largely a process oriented approach based on a number of assumptions about the process of therapeutic change. It holds the view that clients may find it difficult to achieve change in the context of their normal everyday circumstances. In such settings, much in their lives and thinking will conspire to keep things the same. Thus, if clients stay within their comfort zones change is unlikely. However, if clients are facilitated to work at the edge, or even step over the edge of their comfort zone, then they are likely to experience at best, new aspects of themselves and new ways of coping, or at least, gain some insight into their habitual coping behaviour. For example, a counter dependent client who is undertaking treatment for addiction has identified for himself that, in order to help himself to become free of an addiction he needs to build trusting relationships with others. If that client were to take part in a rock climb, it is highly likely that at some stage in the climb he would be forced, by features in the rock, to put aside his resistance to asking for help. He would find that he had to rely on others in order to move forward. In such a situation, the experience of achieving success through co-operation with others may enable the client to reflect on its metaphorical meaning for other areas of his life.

4.6d Metaphors, isomorphs and transfer of effect

Therapeutic work outdoors can invite clients and therapists alike to make use of readily available metaphors and isomorphs to enhance the therapeutic effect of their work. Journeys through wilderness may metaphorically represent a client's journey

and struggle through life. Clients frequently see for themselves the metaphorical links between elements of the outdoors or aspects of an activity and issues that they are working on in themselves. Therapeutically, this offers immediate and tangible insights into client's habitual ways of thinking, behaving and construing the world.

In the outdoors the metaphorical elements available for clients and therapists are not merely broad-brush metaphorical parallels. Rather they can be fine-tuned individual elements – isomorphs, where one element of an activity represents a single strand in a person's life. Consequently, metaphors and isomorphs can be, and are, frequently selected by clients.

4.6e Memorable experiences

The experience of success of completing outdoors activities can also enable people to incorporate a new sense of themselves as achievers into their self- structure. From a therapeutic perspective, it could be likened to what Mearns and Cooper (2005) call 'touch stones'. The therapeutic power of these experiences of change is enhanced by the fact that they are highly distinctive and memorable. One may make a change in one's perception of oneself in a conversation with a therapist - and forget what was said as soon as one is out in the street. Clients rarely forget what it was like to reach the end of a series of rapids on a river, for the physiological effects of endorphin and adrenalin release enhance the impact of novelty, challenge and success.

The collective aspects of the outdoor experience, therefore, provides a context in which clients explore their constructs, behaviours and general approach to life in a direct way. In short, the psychological and physical demands are often so different and more intense than those experienced in everyday life, that they offer psychological, sociological and physiological benefits (McCormick, et al., 2003).

4.7 Theoretical modalities

At times, the way in which adventure and wilderness therapy has developed can create a fundamental confusion and conflict with respect to its theoretical basis and objectives. The problem arises because so many constructive outcomes can be achieved by working adventurously in the outdoors, allowing adventure providers to select from a range of aims.

As noted previously (*see* Table 1, p.43) four aims are commonly described. These may be recreational and personal enrichment, educational, personal development and training (as in confidence and team building), or psychotherapeutic. However practitioners, clients and commissioning bodies alike frequently can fail to fully differentiate between the four styles of engagement. To some degree this is understandable, for the adventure/ wilderness setting itself contributes to the confusion; the therapeutic power of work in the outdoors means that experiences that are designed to be say 'merely' educational or recreational may well provide participants with profoundly therapeutic experiences. Whatever the causes of the confusion, it is a problem, which the industry needs to be mindful of.

Given that serious tensions exist between competing approaches to therapeutic work in the outdoors (of which the character building, development work versus more process-oriented therapy are two diametrically opposed perspectives). Gestalt, client-centred (Gilsdorf, 2003), psychodynamic, and narrative (Stolz, 2003) orientations have all vied for influence. Maybe the lesson to be learnt here is that there is room for all kinds of approaches and a variety of theoretical modalities in adventure therapy. This would also align with key research findings in the counselling and psychotherapeutic literature that identify that relatively equal positive outcomes are associated across different modalities (Stiles et al., 2006).

4.8 Managing physical and psychological safety outdoors

Even though the outdoors can provide a rich milieu for therapeutic work, it also makes the client more vulnerable than they might be in a more controlled, indoor setting. The outdoors has extended psychological and physical risks, e.g. keeping a group physically safe climbing a mountain. Therefore, working as a therapist in the outdoors expands the role of the therapist to one who may have to manage physical as well as psychological safety.

As few would advocate a practitioner offering counselling and psychotherapy without having the right credentials, clearly this requirement needs to be recognised for the outdoors. As well as the right therapeutic credentials, there is also a need for therapists to have the right outdoor qualifications to lead groups ethically and safely outdoors. If this is not feasible, then it is essential that therapists work in partnership with qualified outdoor practitioners. Currently the greater danger is the other way round – that therapeutically unqualified outdoor practitioners conduct what they see as therapy without having had the necessary formal training in counselling and psychotherapy and dismissing the need to collaborate with a qualified counsellor/ psychotherapist.

In spite of the obvious importance of the issue of training and competence, no adventure/ wilderness therapy qualifying body exists in the UK at present - a vacuum that urgently needs to be filled. Although there are a few practitioners who are competent both in outdoor leadership skills and psychotherapy, currently most adventure and wilderness programmes work in a partnership approach, as was used in this intervention. In fact, in order to inform the development of the adventure therapy intervention in this research, phase one of the project actively worked with counsellors and psychotherapists in exploring ways of working therapeutically outdoors (see Chapter Seven for a description of this work).

4.9 Ongoing debates in adventure therapy

The current debate in adventure therapy generally is around its place and purpose (Ringer, 1995). The question still remains whether adventure therapy is a therapeutic approach, with a separate identity from other therapeutic modalities, an eclectic approach, or merely, "a specialist application of adventure activities? " (Ringer, 1995: 3). A consistent theoretical model and the limits of applications of outdoor adventure therapy still remain unclear (Loynes, 1997). Wider issues in the practice of adventure therapy also include ethical concerns (Crisp, 1996), assessment models (Gass & Gillis, 1995) and programme evaluation (Berman, Berman & Capone, 1994). It also still remains unclear how theoretical models of therapy correspond with the models of change in adventure therapy and wilderness therapy. As Gillis (1998: 19) identifies, "writings on models of therapy that fit with adventure are one of the weakest areas available to our field at the moment". Thus, although practices in adventure therapy and wilderness therapy have developed over recent years, there still remains some ambiguity as to how therapeutic change processes occur in these settings and how these correlate to specific client groups and these issues continued to be raised internationally (*see* Itin, 1998; Richards & Smith, 2003; Bandoroff and Newes, 2005).

4.10 Conclusions

It is an exciting time in the UK in this area as it is a time when the two worlds of the outdoors and counselling and psychotherapy have a possibility to meet and to share ideas, theories and practices in ways that will enrich practice both indoors and out. There is no doubt that adventure and wilderness therapy has many impelling ways to offer clients a new window into experiencing and understanding the self, where relational connections are ripe and the physical and psychological metaphors are intense. However, there is a clear developmental need for this approach to therapy to continue to develop an integrated body of theory as well as practice - how do we offer adventure and wilderness therapy to clients in an accessible, responsible, ethical and sustainable way? It is these key questions that the action research project aimed to address.

Chapter Five:

The research approach

5.1 Chapter Overview

This chapter will introduce the general research approach taken in the study. It will do so by first considering the emergence of feminist research in relation to the development of a constructivist paradigm. This will highlight how a feminist approach raised a more critical analysis of knowledge generating processes and practices. The emergence of a constructivist paradigm (in contrast to a positivist paradigm) will be briefly considered. This will illustrate the ways which quantitative and qualitative research methods are often associated with different paradigmatic positions. (i.e. positivist – quantitative; constructivist – qualitative). Given that a feminist approach was adopted in this study, the aims of feminist research are discussed in some detail, identifying key principles that guided decision making processes throughout the research process. The chapter then goes on to describe the research methods used and why an action research model emerged as the research evolved. The chapter concludes with examining some of the issues related to trustworthiness in data collection and analysis, including setting the scene to why a reflexive research agenda was a key aspect of the study.

5.2 Principles of Research Paradigms

In considering the philosophical basis of research approaches it is necessary to consider the basic ways in which paradigms of knowledge influence the research approach adopted. As identified Hoshmand (1994:81), "research paradigms are conceptual and methodological frameworks for guiding systematic inquiry". In examining such conceptual frameworks there is a need to explore the relationship between epistemology, methodology and method.

Harding (1996:31) highlights the need to distinguish between each one of these:

> *"The term method tends to be used as a catchall phrase, one should distinguish one's epistemological positions (assumptions about the basis of knowing) from one's research methodology (a theoretical analysis defining a research problem and how research should proceed) and in turn from any specific method (that is the strategy or technique that is actually adopted)."*

Any paradigm will have an underpinning epistemological, ontological, and axiological assumptions (Hoshmand and Martin, 1995). Epistemological assumptions are based upon the question of how can we know what we know? This then leads to defining both ontological assumptions (what the world is made up of), along with 'axiological assumptions' (what sort of knowledge is intrinsically valuable). In considering epistemological, ontological and axiological assumptions we can recognise that the paradigm debate moves beyond simply distinguishing between the 'quality and quantity' debate. This is necessary because although qualitative methods may be used it is naive to assume that all qualitative methods have the same epistemological, and hence ontological and axiological position. As Barbour (1998:353) argues "it is problematic to categorise all qualitative research as dependant on the same assumptions", when mixing qualitative methods these may "involve several potentially divergent qualitative paradigms". Madill et.al. (2000:2) also point out that there are a number of epistemological positions within which the qualitative researcher can work and many different methods of analysis. For example, a feminist researcher may adopt a relational ontological perspective, and thus, as discussed in Chapter Three, adopt a relational psychological understanding of women and thus follow a qualitative method of data collection that reflects such a position (*see* Mautner & Doucet, 1998).

It is evident then that discussing research simply in terms of qualitative and quantitative approaches merely serves to reinforce an "absolute methodological

dichotomy" (Jarantyne & Stewart, 1995: 224), giving insufficient attention to the different epistemological positions that are evident within qualitative and quantitative approaches. Thus, whether one uses quantitative or qualitative methods, research approaches will be located within different paradigmatic frameworks. Further, as highlighted by Hoshmand (1994), deriving one's philosophical position is not necessarily a simple process as, "one's temperament, native way of knowing and personal worldview is likely to contribute to the epistemic style in use". This issue was notably relevant in adopting a feminist research approach, and is expressed in the reflexive section of the thesis (*see* Chapter Six).

5.3 Research paradigms: The emergence of a feminist approach

The research paradigm debate has evolved as a result of the rejection of a positivist tradition of science. Traditional positivist / foundationist science based itself upon an epistemological assumption that regarded knowledge as objective, whereby "universal logic is based on a shared foundation of rationality." (Hoshmand and Martin, 1994: 7). The overarching goal of positivism is to '*predict and control*'. This directs the researcher to control the research situation, as it is viewed that there is an external objective truth that can be discovered. Such an assumption then leads to a quantitative emphasis upon data collection whereby, research becomes dominated by reductionistic hypothesis testing. This research approach is still emphasised in therapeutic psychology today (Hoshmand and Martin, 1995: 15).

During the 1950s a growing awareness of some of the limitations of a positivist paradigm emerged and thus a paradigm shift became evident. The extent to which knowledge based on these assumptions was truly representative/accurate started to be questioned. As pointed out by McCarl Neilsen (1990:7), this led to the, "post - empirical period - realisation that the scientific method is not the ultimate test of knowledge or basis for claims to truth that we once thought it was". However, this

progression away from positivism was still strongly influenced by the positivist assumptions – hence the term post-positivism. Although qualitative approaches became more acceptable these were still in many ways influenced by the need to search for an objective truth. This is perhaps evident as the approaches to data analysis are examined (for example using statistical analysis with qualitative data) and the lack of acknowledgement in the ways in which the researcher's subjectivity influences the research process and, thus, construction of knowledge.

As the trend towards questioning the epistemological basis of knowable truth became more accepted, the interpretive / constructivist / hermeneutical paradigm emerged. Its main epistemological basis was that there was no one fixed truth – it was socially embedded and time specific. As a result of such a shift research could no longer be separated from the social, cultural and historical perspectives - it was argued that "human knowledge is varied in rationale and socially embedded" (Hoshmand, 1994). Research, therefore, became "concerned with the importance of meaning in social interaction and argue that limiting research to observable human action misses the most important part of the story" (McCarl Nielsen, 1990: 7). As a result research approaches aimed to gain "*understanding*" and, thus, sought for accounts of subjective experiences in order to gain these understandings (*ibid*). This then required a hermeneutical process of gaining knowledge, whereby knowledge is, in part, generated through a process of dialogue. This led to the methodological approaches such as ethnography and phenomenology and today contemporary hermeneutics, emphasising narrative approaches, are evident.

Although the constructivist paradigm recognised the subjectivity of the researched and the social embeddedness of the world, it failed to fully acknowledge the potential biases to gender, social class and dominant worldviews. This was probably because theory was still dominated by white, male, heterosexual, experiences and hence constructions of the world. It was such criticisms that led to

the development of a more 'critical' approach, and hence what became termed "critical hermeneutics". This differs from the traditional hermeneutics in its purpose. As McCarl Neilsen (1990) suggests, a critical approach "strives to be a more positive act of detecting and unmasking, or exposing, existing forms of belief that restrict or limit human freedom." Research developments from this paradigm were strongly influenced by feminist epistemology, as it challenged male-centred perspectives to both knowledge and the processes of constructing knowledge. Its agenda is about '*equality and empowerment*':

> *"Feminist research is a challenge to the scientism that refuses to address the relations between knowledge (and knowledge generating practices) and power and corresponding attention to reflexive issues in the theorising and transforming of the process of academic production, including the position and responsibilities of the researcher."*

Also, as Bannister (1994: 124) identifies, taking a feminist perspective to research, challenges the more conventional approaches as it recognises that the researched and researcher both contribute to the construction of knowledge and that the 'personal' is very much the 'political'. Furthermore, Acker et al's (1991) criteria of adequacy of feminist objectivity to truth illustrates the ways in which the social context and history of the research is addressed. These criteria include the following questions:

1) What are the social relations that produce this research situation and the enterprise of research itself?
2) What makes it possible to raise this research problem at this time, in this place and in this society?
3) What are the processes that have resulted in the research and researchers coming together in a particular kind of social relationships?

5.4 A feminist approach to the research

There has been a general tendency to associate feminist research solely with qualitative research methods (Maynard, 1994). Such an assumption derives from the initial feminist critique of the traditional positivist paradigm where, in ensuring that the oppression of women was challenged, it was necessary to reject the positivist claims that research could be value free (Jarantyne & Stewart, 1995). Hence, the uses of qualitative research methods were seen as a way of beginning to access women's voices and uncover 'alternative' meanings. However, it is not the simple use of qualitative methods instead of quantitative methods that determines a feminist approach to research, or any research approach for that matter. Discussing research simply in terms of qualitative and quantitative approaches merely serves to reinforce an "absolute methodological dichotomy" *(ibid.*: 224), giving insufficient attention to the different epistemological positions that are evident within qualitative and quantitative approaches. Research can be seen, therefore, as a process of aligning philosophical position with practice, with the need to find, "a balanced reciprocal relationship between philosophy and methodology, between paradigms and practice" (Green & Caracelli, 1997: 12). However, this process is not a simple task: no single philosophical research position can represent a feminist approach, as feminist theory and research exist in many diverse forms. For example, the theoretical positions of feminism can vary between cultural, liberal, radical and socialist (Enns, 1997).

Recognition that the 'personal is political' and the need to address egalitarian relationships are key strategies in ensuring oppression in the research process is not recreated (Worrel & Remer, 1992). As Powell (1996) highlights feminist research addresses, "political and ethical considerations head on as all research is located within an ideological and structural context". Feminism also recognises the risks of methods and methodology supporting, "sexist, racist and elitist attitudes and practices that [negatively] affect peoples lives" (Jarantyne & Stewart, 1995: 219).

The overarching aim of feminist research is to place the social construction of gender central to its agenda and to ensure that patterns of discrimination are challenged throughout all stages of research. This requires bringing together, "subjective and objective ways of knowing in the world" (Jarantyne & Stewart, 1995: 228). It also requires the "discussion of power, subjectivity and political commitment" (Bannister, 1994: 114). The continual agenda is, therefore, how research practices can serve to eradicate conditions which maintain a patriarchal and oppressive society. A key way in which discussions of power, subjectivity and political commitment are made transparent in research is with the use of reflexivity. This approach to research has become a key technique in feminist research (this is discussed in more detail later in this chapter).

As noted above there is no single research design that can represent a feminist approach (Bannister, 1994: 114). A variety of methods may be used in the collection of data, with the aim of maintaining a feminist agenda (Holland and Blair, 1995). As pointed out by Harding (1987: 2) it is how we, "carry out these methods of evidence gathering which is often strikingly different". The empowerment of all women (irrespective of class, age, race or sexuality) should become a key agenda of the research process. This requires the researcher to remain critical of the consequences of research upon women's lives. For example, women may experience intra-psychic change as a result of their engagement in research, yet they risk experiencing many conflicts and difficulties when faced with maintaining these changes in a patriarchal society. This moves away from the objectification of both the research participants and the researcher. As highlighted by Maynard (1994:75) consciousness may be raised, "but there may be no opportunities for them to take action". Research needs to consider, therefore, how social change is facilitated alongside intra-psychic change. For example, any initial positive effects of participation in research will soon be replaced with a greater sense of disempowerment than previously experienced. For example, addressing the link between womens' relationships with their bodies and the conditions of their lives

(Brown, 1993: 66) and being alert to the fact that, although consciousness may be raised through participation in the research, opportunities for women to take corrective action may be limited, and socially and culturally impinged upon (Maynard, 1994).

Achieving and maintaining womens empowerment throughout research allows a greater recognition of the consequences of research strategies upon people's lives, requiring the researcher to maintain a continual focus on "power, subjectivity and political commitment" (Bannister, 1994: 114). Research needs, therefore, to include a political analysis of experiences and findings, an analysis of the implications of the results for womens lives, and active participation in the dissemination of the research results (Holland & Ramazanoglu, 1995). Thus, it is not so much the methods used but, more importantly, the ways in which such methods are employed that concerns feminist researchers. As suggested by Gill (1994: 415), the implementation of research methods should aim to achieve an egalitarian approach that is, "empowering, non-hierarchical and process orientated". This sets a methodological challenge to ensure that sound foundations of knowledge are developed in the service of developing practices that support empowerment and personal growth. Perhaps this is where the alignment of research with the core aims of adventure therapy, in terms of personal development, can be capitalized.

With this goal of achieving empowerment through out the research process in mind `the following six guiding principles can be followed to support the decision-making processes throughout the research:

- Fostering egalitarian relationships
- Achieving care, respect and honesty
- Valuing diversity
- Addressing both intra-psychic and social change
- Valuing a balance between healthy autonomy and relational competence
- Valuing feminist scholarship

(Adapted from Worrell & Remer, 1992: Brown & Brodsky, 1992)

Having proposed a framework through which research can provide an emancipation agenda for women, the more difficult task was to ensure that the agenda could start to be achieved during each stage of the research process. With this goal in mind, these six guiding principles noted above were followed to support the decision-making processes throughout the intervention. The ways in which these guiding principles influenced the decisions during the research and practice intervention can be seen in Table Two. This highlights how the decision making processes of both the research and practice were aligned – this is evident of how a relationship between research and practice was central in this action research process.

Green and Caracelli (1997) remind us that if any research process truly engages itself with philosophical debates then the research approach will become unfolding, especially if the researcher is new to such debates. Hoshmand & Martin (1995:21) also state that as, "a result of method being a process of trial and error, the process of research can be seen as an evolving process". This was notably evident in this piece of research, especially because the research process needed to be responsive to the development of appropriate and ethical, feminist, therapeutic practice. This meant that the research process was not only dealing with the immediate needs of a research process it also needed to deal with the immediate needs of a client group in a therapeutic setting. Thus, a process of trial and error became of particular significance as feminist principles were applied to both therapeutic and outdoor practice. It was with a growing awareness of both the implications of locating a feminist approach and the wider philosophical issues framing research approaches that impacted upon an evolving approach to the research for this thesis. For example, the research saw the emergence of specific reflexive strategies – e.g., embodied relations - as a feminist research approach was developed in action and the role of an action research approach became evident as the research developed (*see* Chapter Six)

Table Two:
Feminist principles in the research and practice

FEMINIST ETHIC	RESEARCH	PRACTICE
Fostering Egalitarian R'ships & Achieving Care, Respect & Honesty	• Offering variety of research methods, allowing women greater freedom of choice. • Clearly and openly discussing all aspects of the research process. • Researcher and researched seen as collaborators in the construction of knowledge. • Therapists and research team completing questionnaires alongside the women. • Addressing relations between knowledge and knowledge-generating practices. • Researcher self-disclosing, both in the interview process and by sharing her reflexive account to encourage issues of commonality. • Critically examining the ways in which research structures reinforce power relationships.	• Valuing and expressing emotions. • Sharing decision-making. • Recognising and addressing the risks of more prominent power relationships in outdoor settings. • Being mindful of power relationships outside outdoor settings, e.g. ethics committee requirement for doctors' permission to participate in programme. • No screening: trusting women to determine appropriateness of course based on pre-course information provided. • Self-disclosure of therapists and researcher. • Sharing of concerns and fears.
Valuing Diversity	• Examining individual change process, not assuming commonalties. • Recognising how womens individual backgrounds may affect their recovery from an eating disorder. • Recognising that the researcher's class, race, sexuality will affect what she finds in the research process. • Recognising different approaches to feminist theory. e.g. cultural, liberal, radical.	• Individual and group therapy. • Allowing women to determine their own pace and goals for therapy. • Avoiding DSM-IV-R criteria. • Anti-discriminatory recruitment practice. • Addressing prejudices emergent in the group. • Recognising diverse backgrounds of women (class, age, race and sexuality).
Achieving Both Intrapsychic Change & Social Change	• Implementing empowerment as a goal of research: 'catalytic validity'. • Examining barriers to social change upon having consciousness raised. • Considering a gender analysis of quantitative measures. • Completing a political analysis of findings. • Being mindful of how women are portrayed in research findings. • Completing appropriate dissemination of theresearch findings. • Providing appropriate personal and professional supervision for the researcher. • Addressing gender discrimination in research communities.	• Individual and group therapy. • Metaphors in outdoor activities with 'consciousness-raising' aim. • Team's critical reflection on their own issues of body image and weight. • Challenging the social construction ofbody image and eating disorders. • Addressing the social and cultural barriers in the transfer of healing to everyday life. • Developing coping skills to manage the self in everyday life. • Raising the profile of wider intervention and prevention work needed to be done in this area.

Healthy Autonomy & Relational Competence	Analysing relational component of change process. • Examining a relational model of nature. • Emphasising relational component in interviewing and data analysis. • Self-disclosing in the interview process.	Modelling vulnerability and strength. • Helping women identify and value their relational self by using activities with nature. • Individual and group therapy. • Self-disclosure of researcher and therapists.
Valuing Feminist Scholarship	Making women's lives the centre of analysis. • Maintaining a reflexive diary and making reflexive links to theory. • Keeping the social construction of gender central to data analysis. • Using a feminist perspective on eating disorders. • Ensuring women's voices contribute to the development of theoretical models of adventure therapy. • Using wider feminist theory and research to deconstruct theoretical models of outdoor adventure.	• Using an all-women delivery team. • Using women therapists to examine the practical link between adventure and therapy. • Examining and avoiding hierarchical models in practice. • De-emphasising food intake in therapy. • Critically reflecting upon theory in practice. • Addressing gender-projected thinking. • Using feminist principles in both therapy and adventure therapy.

5.5 Research Methods

5.5a An Overview

It is important to re-emphasise that it is the key aim of a feminist research approach to ensure that the power imbalances that serve to oppress women in society are not recreated in the research process. Therefore, ethical considerations are inseparable from methods, as will become apparent in the following discussion. It is also important to note that the research methods evolved during the course of the intervention, allowing the researcher to respond to individual and group process and to ensure ethical integrity. This methodological evolution highlights how research design and methods contain an "element of trial and error" (Hoshmond & Martin, 1995: 21). Initially, a decision was made to use both qualitative and quantitative methods.

The qualitative methods used included:

- Women's journal writing throughout the intervention (prior, during and after the intervention).
- Interpersonal Process Recall (discussed shortly)

- Individual interviews with the women at the end of the intervention (six months after the adventure therapy residential)
- Focus groups with the women participants at the end of the intervention (six months after the adventure therapy residential)
- Focus group with the therapists after completing the five phases of programme development.
- Researcher's reflexive diary.

The quantitative methods that were initially decided to be use were:

- Eating Disorders Inventory (Garner et al., 1983)
- Rosenberg Self-Esteem Inventory (Rosenberg, 1965).

The women also completed an initial personal history questionnaire to gain more detail about specific dynamics of their eating disorder prior to participating in the intervention.

The methods were chosen as they seemed to be the most appropriate ways of collecting the data required to examine the development of the intervention, along with how the women experienced the intervention and any consequential impact on related disordered eating symptoms. Accompanying the above methods, the group and individual therapy sessions during the residential were recorded, either by audio or videotape, allowing the researcher to revisit any of the processes in more detail. However, because of the time restraints of the project the recordings of all the sessions have not been individually analysed.

From the methods listed above, the participating women were asked to choose those that they felt would be most useful in illuminating the therapeutic process and identifying the outcomes of the intervention. Offering a choice of methods is an approach, consistent with the feminist aim of fostering egalitarian relationships. i.e. women were not coerced into completing any methods that they did not feel they

wanted to. It was also recognized that as the women completed the inventory questionnaires, the therapists, outdoor trainer and researcher could have also completed individual questionnaires alongside them. This would have not only allowed the researcher to identify changes that took place for the research team, but it could have also served to address power dynamics. This would have communicated to the women that the whole team might undergo change and that the intervention was a collective group experience and not one that singled them out as experimental subjects.

By using and comparing the results of a variety of research tools, the researcher was able to increase trustworthiness of the data as it was taken in a variety of ways at different times. Offering a choice of method avoided the risk of asking the women to take part in research techniques that made them uncomfortable. And of course all women were offered detailed explanations as to what completing each method entailed. As the researcher actively reminded the women of their choice not to complete any of the research methods she noted her own anxiety fearing that, by giving this option, she could limit the amount of data collected. This highlights the tension of maintaining the ethical integrity of a feminist approach when faced with the need to collect data in order to complete quality research.

Despite these attempts to maintain ethical integrity, ethical issues still arose. At one point it was recognised that the data provided by the women in their journals should have been responded to during the residential and the follow-on phase. When the researcher had sufficient time to begin to read the journals in greater depth, it became clear that one woman had been directly asking questions of the team via her journal, yet because the researcher had not fully read the journals she failed to respond to these questions. Had she responded, the researcher could have had a more significant impact upon the woman's healing as it appeared that the woman was having difficulties maintaining her participation. In the final individual interview the researcher explored with the woman how she felt about this incident

and how the lack of response had impacted upon her. The woman highlighted that even though she did not necessarily expect a response, she felt disappointed. Had the journals been read more diligently and had the researcher continued an open dialogue with the women about their journal entries, the therapeutic process might have been more easily maintained. This would have not only increased the quality of the intervention for the women, but it would have also provided a deeper understanding of the women's experiences and increased the quality of the research data. So a research lesson here is that the guidelines for the women needed to be clearer, i.e. state if the researcher will or won't respond to any requests made via journal entries. (*see* Appendix Three for research journal guidelines given to the women at the start of the intervention).

5.5b Interpersonal Process Recall

In trying to access and understand the therapeutic process of the intervention it was necessary to consider an analysis of moment-by-moment changes. Elliott's assumption *(as interpreted by* McLeod, 1994: 153) is that, "if researchers can supply participants in therapy with the means of describing close detail of what goes on before and after these change events, then powerful models can be generated that can be applied to make therapy more effective". In addition, there was the question of how to align good therapeutic practice with sound research methods. Both of these needs were addressed by using a process first developed by Kagan et al., (1963), known as "Interpersonal Process Recall" (IPR). IPR is a technique frequently used in therapy research as a way of supporting individuals in the recall and analysis of the therapeutic process *(see* Elliott, 1986; Elliott & Shapiro, 1992; Wiseman, 1992). The IPR process consists of video recording the therapeutic events, which are then played back to the client providing a cue for memory retrieval. The client watches the therapeutic events (in this case the ropes course activities) and then pauses the video at events that had meaning for her or him. Through dialogue the client is supported by the therapist to uncover the meaning of this event and, once the event has been processed, the client continues the same

procedure throughout the remainder of the video recording. Other researchers have observed a standard memory decay curve when this technique has been used (Elliott, 1986).

For this study the IPR sessions occurred within 24 hours of the outdoor sessions. The IPR sessions were tape-recorded and aimed to enable an analysis of the ways in which the ropes course activities had been used to achieve therapeutic goals and move toward change. Through the use of IPR, the aim was to both examine what was happening in the therapeutic process, and facilitate a deepening of that process. It provided fruitful insights for the women, leading them, with the support of the therapist, to identify individual therapeutic objectives on which to focus during the programme.

Video work, alongside the research objectives, was aimed to initiate a process of reconnection between the body and self. It could not be expected, however, that the women could easily let go of their negative body images. As Hutchinson, (1994:165) points out women, "have built their identities around their struggles between themselves and bodies and letting go of negative body attitudes threatens the very foundation of how the women see and construct themselves". The use of video was challenging for some of the women, providing a direct visual representation of their body and if they chose to use video they were supported in working through these issues. This highlights how research and practice were inextricably linked.

The use of this technique provided an innovative tool for the researcher to try to uncover the meaning and processes of adventure therapy. To date, no other research studies in adventure therapy have been identified that have used such a technique. Thus, applying this technique in an outdoor adventure setting may be a new way of approaching future research. It also illustrates a method of moving away from asking the question "does it work ?", and towards research that provides an understanding of the processes at work (*see* Hovenlynck, 2003). However, this

technique needs to be approached with caution. Highly refined therapeutic skills are required in order to manage the psychological safety of the client during this process. Unfortunately, in this study an unforeseen technical hitch with the tape recordings meant that the recordings were not fully audible and thus could not be used for full analysis. However, the women's journal entries do provide some insight into the ways in which the IPR proved valuable, along with moments of awareness that seemed to in part be initiated by this technique (*see* Chapter Six and Seven).

5.5c Quantitative methods

The quantitative methods of the Eating Disorders Inventory (EDI) (*see* Appendix Four for a copy of the Inventory) and the Rosenberg Self-Esteem Inventory was initially chosen as they have frequently been used in the evaluation of eating disorders intervention *(see* Button *et al.*, 1997; Kileen *et al.*, 1993; Wolf & Crowther, 1992). The EDI is a self-rating questionnaire that assesses a range of behavioural and psychological traits common in anorexia and bulimia nervosa. It consists of eight subscales: drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, introspective awareness, and maturity fears. It has 64 items in total, with a 6-point likert scale for responses. Responses for each item are given a weight of 0, 1, 2, or 3. Three of the six possible responses to each question are assigned a score of zero, then a score of 1 -3 is assigned to the other 3 responses farthest in the symptomatic direction respectively (APA, 2000). So any score over 0 indicates some symptoms related to that item are presented and obviously the higher the score the more significant the symptom (*see* Appendix Two for normative data of the EDI).

Using the EDI could help identify whether specific areas of the women's cognitive and behavioural functioning might have been influenced by the adventure therapy intervention. The aim was to apply these measures at five times during the programme: at the beginning of recruitment, prior to the residential, at the end of the residential, six weeks after the residential, and at the end of the post-residential

follow-on programme. However, the questionnaires collected at point two (at the beginning of the residential) were misplaced so scores are only available for the other four points.

As the research evolved, it was recognised that a traditional experimental design would not be used as this would be too complicated to implement (e.g. small sample size, the need for a control group etc). Furthermore, the overall goal of the research was to uncover a more in depth analysis of how the women experienced the intervention and what meaning it had for them. So the practical concern was coupled with the realisation that an experimental design was incongruent with the constructivist philosophical approach that was evolving. As a more detailed critical examination of perspectives of eating disorders and self-esteem was achieved, the usefulness of the Rosenberg Self-Esteem measure was also questioned. It was felt that it did not provide much insight into how self–esteem, reflected in the construction of eating disorders, could be directly correlated with the adventure therapy process and it was, therefore, abandoned as a tool. However, at this stage the researcher did acknowledge that, although using the questionnaires as part of an experimental design was not appropriate for this study, this type of research could in someway be useful for gender analysis. Such an analysis could include a large study that examines both women's and men's responses to the Eating Disorders Inventory. This would help to identify whether any specific cognitive and behavioural functions (as identified in the Eating Disorders Inventory) are more prevalent for women than for men. It was not within the scope of this study to complete this type of analysis, however the situation does highlight that, when taking a feminist perspective to research, quantitative methods can still be used in the service of examining the social construction of gender and eating disorders.

5.5d Mixed methods and the researcher

Using a combination of research methods was a way of gaining a more informed insight into the needs of, and possible changes for, each woman, as well as those

aspects of the intervention that did not work for this group of women. However, there is a cost to such a comprehensive approach. The demands of managing the research process and implementing the programme meant that the researcher was often concentrating on practical aspects of managing the programme and attention to developing relational capacity with the women was overlooked.. Not only is this incongruent with a feminist and relational therapy approach, but it may also have affected some of the research data. The researcher felt as if a relational distance had been created between her and the women and that, when interviewing the women, this created a resistance to working at psychological depth in the research interviews. This was an example of relational ontology emerging, whereby issues of relational intimacy and relational ethics came into action.

5.6 An action research approach

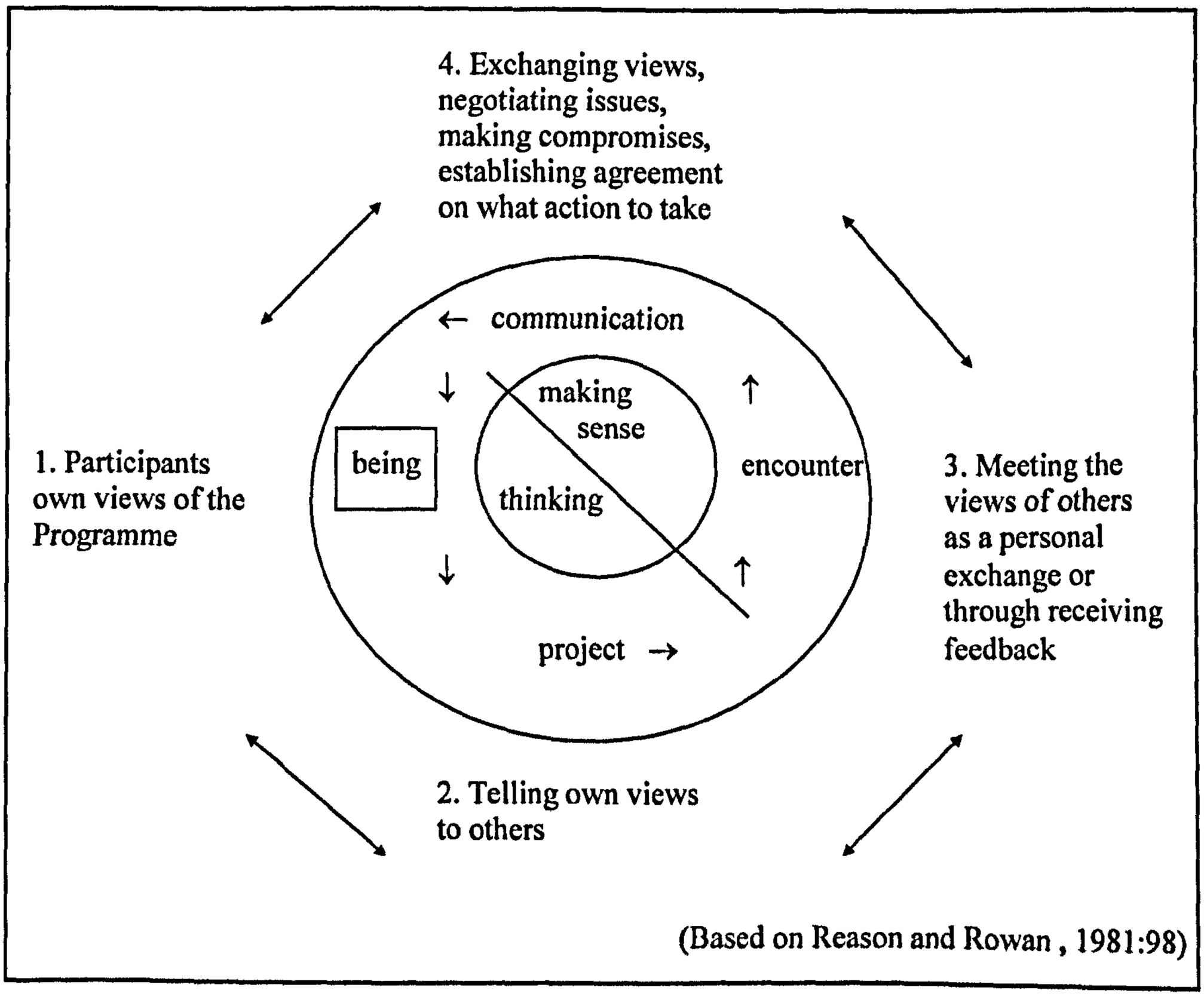
As the research developed it became clear that the research process was underpinned by an action research approach. For example, a process of ongoing review and reflection from each phase of programme development reflected the cyclic processes of action research as explained by Reason and Rowan (1981). Each phase of programme development can be viewed as an action research cycle, with a total of five key action research cycles (labelled as project phases) in this project. These included:

1) Exploring adventure therapy practice
2) Recruitment and pre-course design
3) Adventure therapy residential
4) Follow-on course and closure
5) Developing and reflecting upon adventure therapy

(*see* Chapter Six, for a detailed explanation of each phase).

The internal workings of each action research cycle are understood as a process of 'dialectical exchange'. During such a process views are exchanged, negotiated, analysed, fed back and critically reviewed, whereby learning and knowledge development takes place; hence the term 'action'. Figure 3 gives an insight into these processes, where at the core of the model are the processes of thinking and making sense of action.

Figure 3:
The Action Research Cycle: The process of dialectical exchange



Given that the action research approach emerged as the research developed, the decisions made about the development of the intervention, along with the impact these decisions had on the women's experience of the intervention, were part of the

data gathered as part of the fieldwork diary. Thus, description of the questions asked problems faced and how these were addressed in the practice setting, along with consideration of the ways in which this process links to the women's experiences and, thus, impacted on the adventure therapy intervention, need attention. As pointed out by Argyris & Schon (1991: 86):

> *"Action research takes it cues – its questions, puzzles and problems – from the perceptions of practitioners within particular, local practice contexts ... It builds descriptions and theories within the practice context itself and then tests them there ... through experiments that bear the double burden of testing hypotheses and effecting some ... desirable change in the situation."*

Facilitating 'desirable change' in the research setting is key in action research as the notion is that as a result of the process, awareness, knowledge and decisions will be influenced and goals will emerge. Thus the action required as relevant to the local context will be identified and acted upon.

In this study the desirable change was for the team moving from not knowing how to implement an adventure therapy intervention for women with eating disorders, to having the knowledge and skills to do this successfully. Also, desirable change for the women participating in the intervention was obviously essential to achieve this and was a key objective of undertaking the study. So what was needed was to find ways of developing ethical outdoor therapeutic practice, along with understanding ways of working with an eating disorder client group therapeutically in this setting. What is also interesting to note, as highlighted previously in Chapter Five, is that the goals of facilitating intrapsychic and social change are central to feminist research and thus the process of action research and feminist research ethics complimented each other in this way.

What is also useful about viewing the research from an action research perspective is that as Rowan (1981:105) argues:

> *"It gives a new way of seeing pilot work. Instead of wanting to get rid of the pilot work as soon as possible, and get into the real thing, we start to being very interested in different kinds of pilot work and how they can throw light on one another. We start to call them early cycles instead of 'pilot work' and to write them up properly, and learn from them as much as possible."*

Given Rowan's (ibid) view on the early cycles of action research it is acceptable to recognise that even though this research could be viewed as pilot work in ascertaining the general value of working with an eating disordered client group in an outdoor setting, it is in fact an important piece of work as it attempts to make transparent many of the decisions and issues at the very beginning of developing such practice. And given this, it is more likely that prejudices and beliefs can be uncovered from the beginning.

Another consideration of the action research model is how it is in fact a philosophical match between theories of learning and development that underpin the beginnings of adventure therapy as emerged from outdoor education. The notion of action research was first conceived by Kurt Lewin (1946) in research looking at group dynamics. The key aspects of an action research cycle then led to the development of Kolb's experiential learning cycle (1984), and it is such a model that underpins facilitating learning and development in outdoor education. This poses the question of adopting a research approach that is inextricably linked to the principles of experiential learning (and in this case therapy) in practice.

5.7 Ethical approval

The ethical approval for the study was approved by Liverpool John Moores University Ethics Committee (*see* Appendix Five for a copy of the original ethics application). This process led to the need to obtain permission from each woman's GP (Doctor) to take part in the study (*see* Appendix for a copy of the GP consent form). This requirement obviously served to address any physical or mental health concerns or risks in taking part in the intervention, however, the implications of this requirement in terms of the feminist approach adopted are discussed later (*see* Chapter Seven, p.129). All of the women who expressed an interest to be invited to take part in the study were sent an original information sheet (*see* Appendix Six) and signed an informed consent form upon commencing in the study (*see* Appendix Five).

Given the action research and, thus, developmental nature of the intervention it was inevitable that some of the original plans as to what would be done in the intervention and research changed over time to it was fit for purpose. These changes to the original protocol were ethically agreed. As discussed throughout the thesis, a range of further ethical dilemmas were faced as the intervention and research was undertaken. A range of these ethical dilemmas are discussed throughout the thesis (e.g. from a practical point of view how to address food intake during the intervention and from a research point of view deciding not to contact the woman post intervention to ask for verification of the interpretations made from the data analysis).

5.8 Issues of data analysis

5.8a An overview

Data analysis is not necessarily a discrete phase of the research process, confined to the moment when data collected is analysed that is, for example, when an interview transcript is read for the first time. The previous and current experience of the researcher undertaking the research will influence the ways in which the data

analysis process is undertaken and, thus, the possible interpretations and conclusions drawn from the data. Furthermore, the researcher's own biography – their social, political and personal biography - adds a reflexive dimension, which from a feminist research agenda is an essential component of the data analysis process. Given all of these issues it is clear that the research data analysis process is probably one the 'most vulnerable spots' of the research process (Mauthner & Ducet, 1998) and, therefore, the data process undertaken in any study requires descriptions of decisions made and the ways in which any conclusions from the data are arrived at.

In analysing data there is always a concern as to whether the data has been analysed in the 'right way' and at what point it has been analysed 'enough'? This is especially so for qualitative data as the conclusions reached from such data are based on subjective interpretations made by the researcher(s). There are different suggestions as to how best approach qualitative data analyse systematically, all of which offer guidance as to how to undertaken data analysis (e.g. Miles & Huberman, 1994). Yet, the approach taken to qualitative data analysis is often an iterative process that requires immersion in the data, and recognition that the process is often dependant on the data collection methods, approach and research setting, and the researcher themselves. Thus, it can be difficult to fully articulate the data analysis process is one linear, logical and sequential process that is merely one simplistic step after another – the process is often more subtle and complex and a wide range of factors can influence ways in which meaning is drawn from narrative texts (for example, the theoretical perspective adopted to the study may mean that different interpretations about narratives are made).

5.8b Undertaking the data analysis in this study

In this research setting as a researcher I had worked with the women over six months and had been witness to their experience and moments of therapeutic change, which I had made notes of in my field diary. Also, during the intervention

the therapeutic team made judgements and conclusions about the ways in which the intervention had impacted upon the women, making further observations of change – again some of these were noted in my field diary. For example, a woman's change in cognitive processing, as evident during IPR, as she participated in a ropes course activity was discussed with the therapeutic team as a clear indication of change for the woman concerned. Although, this wasn't captured in a journal or interview by the women concerned, it did provide evidence of the change process in action for this individual.

Given these observations made throughout the intervention, when I arrived at analysing both the interviews (focus group and individual interviews) and journal transcripts, I had already been analysing the women's change process throughout the intervention. Although I was reading their transcripts for the first time the data wasn't necessarily new as I had bought tactic knowledge from the intervention to this data. Thus, I was triangulating their journal and interview transcripts with previous observations and conclusions made by myself, the therapists and, in fact, the women themselves, that had been made outside of these data collection methods. For note, someone else transcribed the interviews and focus group (namely for speed) and I transcribed the journal entries. It could be argued if I had transcribed the interviews and focus group data myself I may have immersed myself more fully in the data. However, because I had worked with the women during the intervention, I felt relatively immersed with the women's experience to date so I didn't feel I needed to familiarise myself more fully with their experience in that instance -reading the transcripts themselves would be sufficient for the data analysis process.

In terms of the therapeutic team focus group I had many field work notes about the process of the programme development and the team had undertaken many differing conversations about the processes undertaken and insights gained. Thus the focus group with the therapists was a clarifying of these emerging issues, alongside identifying any further issues that hadn't been identified. So when I arrived at analysing this data, many conclusions relating to this data had already

been made - again the data analysis process had already started prior to reading the focus group transcripts and the notes made in the field work diary supported analysis of this data.

5.8c Analysing the data transcripts

Upon transcription of data I spent time reading and re-reading the data transcripts. I read them first as a whole to gain a general sense of whether any changes (positive or negative) had been evident for each individual woman. From this I made some initial conclusions about any evidence of change. I then re-read the data transcripts a number of times and highlighted anything that seemed to be significant. For example, whether a segment of the narrative was related to troubled eating, an insight, a moment of change, and or the experience of taking part in the outdoor activities. I did this process a number of times for each transcript. I then had a list of sub-themes for each woman and these sub-themes were collated into more general themes. Thus the data was categorised through an iterative process of identifying, grouping and regrouping the data for each individual woman. From this process overall key themes related to the women's experience of the intervention were identified. These themes had relevant data narrative segments from the journals and/or interviews. For note, it didn't seem relevant to bring the themes for each woman together as I wanted to report on each woman's individual change process.

The description of the intervention itself meant that as well as reporting on what psychological change any of the women may have experienced, the women's experience of different aspects of the intervention were also important. I had to make a decision as to how represent the development of the intervention from the women's experience of this, alongside the women's experience of actual change. I decided, therefore, to relate the themes and associated narratives from the women to these two different aspects. The data was, therefore, accordingly allocated to either one of the two sections, as is evident in Chapter 7 (Developing and analysing the

adventure therapy intervention) and Chapter Eight (The women's experience: The evidence for psychological change). Examining the related experiences of the women to the different intervention components seemed an important aspect of the action research process, i.e. ascertaining more clearly what seemed to work effectively in practice. Alongside this, aspects of the outdoor activities that seemed to be most significant to the women were also identified and discussed in detail as part of the later section of Chapter Eight.

In allocating different data in this way I was aware of some biases, mainly that of some of the women's voices being more prominent than others, especially in Chapter 7. This was partly because some of the women offered more data than others as they completed their journals daily. Inevitably, this meant it was easier to report on their experience of the intervention. More detailed attention to the collection of data for all women during the intervention itself, e.g. things commented on during the intervention, would have helped overcome this possible bias.

I did encounter other dilemmas during the data analysis process, for example one woman provided over two A4 folders full (approximately 300 pages of handwritten text) of a daily diary. In this she mainly spoke of what she eat and what she did during her day. As well as being a lot longer, this was also a different type of narrative account than the other woman's account. Given both the length and this difference, the dilemma was to how best approach analysis of this data. Rather than transcribe the whole journal, after reading and re-reading the journal, I decided to transcribe those parts relevant to the intervention itself. I was cautious of this decision as it could overlook important data and hence meaning making. Upon reading the journal a number of times I came to the conclusion that overall the journal entries didn't signify change as a result of the intervention. However, the journal entries did offer rich narrative examples of her troubled eating and how this affected her day to day life, some of which were used to illustrate her story in

Chapters Seven and Chapter Eight. Overall, this dilemma raised questions about maintaining the voices of the women participants throughout the data analysis process and how to best represent the women's narrative in the study.

As well as the data taken from the journals being triangulated with the data taken from interviews (which was valuable as the time lapsed between journal entries and interview was approximately five months) this combined data was also triangulated with the scores from the Eating Disorders Inventory (EDI). A statistical analysis was not completed for the Eating Disorders Inventory Scores. Instead the apparent changes in scores were used to strengthen the qualitative judgements made in drawing conclusions about the severity of troubled eating for each woman and in making the subjective interpretations about psychological change from the other data. Furthermore, the EDI scores also pointed to some of the specific clinical aspects of troubled eating, e.g. changes in body image and bulimic behaviours.

As pointed out previously an ethical therapeutic decision meant that I did go back to the women to check with them the interpretations I had made about their change and experience of the intervention. This would have obviously been a valuable process as it would have helped to clarify the change for the women, and also if that change had been maintained (which would have been another point of data collection and raised a critical key question of longer term sustained change). In future research the ethical imperative of gaining permission from participants well in advance of needing them to check data analysis interpretations would be considered.

5.8d Reflexivity and data analysis

Given I had adopted a feminist approach the reflexive process in data analysis is an important consideration, as is partly discussed later in this chapter. The more detailed reflexive chapter that follows (see Chapter 6) offers some insight into how I found a way to locate my own social, political and personal biography. However, this doesn't necessarily go into detail about a reflexive account of the data analysis

process. I was aware of the need to maintain a reflexive agenda during the data analysis process, and the reflexive chapter provided a check point for this process in terms of my own ongoing biases. However, the data analysis falls short of a reflexive process mainly for the following reason.

Upon considering different feminist approaches to reflexivity I found myself considering a 'voice centred relational method' of data analysis, as described by Mauthner & Doucet (1998). This method of data analysis seemed congruent with the relational ontology position that underpinned both the therapeutic intervention and also the reflexive agenda The main premise of this approach is that individual narrative accounts are examined, "in terms of relationships to people around them and their relationships to the broader social, structural and cultural contexts within which they live' (*ibid*:121). There are specific steps in undertaking this process (as briefly described in Chapter 6), however the main premise is that a relational ontological position can be maintained throughout the data analysis process.

I was keen to actively adopt this approach as part of the data analysis process. However, adopting such an approach is relatively time consuming, as Mauthner & Docuet (1998) point out in their re-analyse of data from a study them undertook – it took them approximately 17 months to reanalyse data using such an approach. Although I wanted to adopt this approach, due to time restrictions I made a decision not to adopt this systemically as part of the study. From a feminist research perspective, by not undertaking such an approach this is a limitation of the data analysis process. However, by acknowledging such an approach it is illustrative of the ongoing debates in data analysis process, and I recognise that it is an approach that has potential to clarify a reflexive agenda across all stages of the research process and warrants further investigation in future research.

5.9 Trustworthiness in data collection and analysis

5.9a An overview

Good practice in the collection of research data is essential. A main way to develop good practice is to address issues of 'trustworthiness'. Trustworthiness is necessary both in the collection of data and in the interpretations and conclusions drawn from data analysis (Stiles, 1993). These are commonly referred to as reliability and validity, respectively. As Hillard (1993: 378) points out validity still, "remains one of the greatest challenges to single case research". A variety of techniques are used to address these issues. Triangulation is achieved with the use of a variety of techniques in the collection of data (Stiles, 1993). This was achieved with a variety of methods being used for example, women's journal entries, interviews, taping of therapeutic sessions etc. Other ways for addressing bias include:

- A diagnostic council
- Examining closeness and biases to positive data
- Catalytic validity
- Reflexive validity and reflexivity

Each of these approaches will be discussed below and reflexivity will be discussed in more detail (see Chapter Seven) as this was a key feminist research strategy and agenda throughout the research process.

5.9b Diagnostic Council

A 'diagnostic council' can be used to support validity (McLeod, 1994). This is where the members of a team all complete analysis of the data to identify the variety of interpretations and the consensus on the dynamics of the processes of change (Stiles, 1993). The processes of diagnostic council were in many ways implicit throughout the research, especially as the team were continually sharing assessments of psychological change of the women. Ideally, the main researcher would revisit this process with the team near the final stages of analysis to ascertain if they agreed with the conclusions made. However, for the purposes of this thesis, this was both time consuming and problematic. Thus, as the researcher I used notes

of assessment of change by therapists at the time to support this process. I also used the information from the focus group with the therapists after the intervention to include some level of diagnostic process from all therapists. Also, two of the therapists were asked for some clarification during the analysis process about interpretations made about the women's processes, but these don't necessarily clarify what the women themselves made of the interpretations.

The therapists were active members of the research in different ways. For example, due to time constraints which meant that myself as researcher could not interview all women at the same time during the closure meeting of the programme, the therapists as well as myself were interviewed the women at this point. It could be argued that this produces biases across the interviews. However, all the therapists were given the same guidelines for interviewing and the issues of undertaking a qualitative interview versus a therapeutic interview were discussed. However, a therapeutic agenda still needed to be managed at some level to ensure that any arising ethical issues were dealt with appropriately during these interviews. This represents another point at which the therapeutic agenda and research were linked.

In assessing whether the interpretations made match those as perceived by research participants it is also common practice to invite the research participants to review the initial findings of the study and report their reactions to the researcher. However, as noted earlier, in relation to this technique an ethical dilemma was faced during the research. As the researcher I had not completed a detailed analysis of the women's narratives by the end of the full intervention, so I did not revisit transcripts and the women's experiences of the intervention as interpreted by myself as a researcher. After the intervention had ended I then realised I had omitted this, especially in terms of addressing face validity. From a research perspective, I would have preferred to have discussed my interpretations with the women on their experiences.

Ethically, it was decided that because the research was so inextricably linked to practice, it would re-open a therapeutic process and the researcher could not accommodate this process by herself and the therapists were no longer available. As a result of this revisiting the women to achieve face validity was not achieved in this way. It was an example of where the ethical agendas of therapeutic practice were as essential to consider as the ethical agendas of research.

5.9c Closeness and biases to positive data

The process of data analysis also requires attention. As pointed out by Hill (1982:11) it is necessary to "ensure group data doesn't obscure individual data". By identifying what, "process of change occurs on an individual basis" we are then able, "to identify any commonalties amongst women rather than assuming commonalties" (Hillard, 1993:376). This was important, especially from a feminist perspective as, "women's backgrounds will affect how they feel about their bodies, eating, sex roles and social expectations, and must be taken into account in our work" (Brown, 1993:129). Thus, throughout the results section the results are discussed both in terms of individual women's experiences and also the overall conclusions of the group of women as a collective. In data analysis issues of closeness to data need also be acknowledged. Throughout these accounts it is also important to note that any analysis of change processes also requires the researcher not to maintain a biased attention to the most supportive individual cases, thus there was also a need to search for negative instances (Stiles, 1993:614). Openness to evidencing negative impacts has been addressed throughout the programme development and through the reflexive process and negative incidences are cited.

With any collection of research data, especially qualitative research, there is always a risk of collecting too much data. This issue became evident in the amount one woman wrote in her journal. She provided 2 A4 folders of writing for her journal – this equated to over 300 pages of handwritten text. The dilemma became one of how much should I assess her narratives in this journal. A lot of this data contained

information of her eating behaviours. Some data may, therefore, become redundant. However, I needed to be aware that I was making such a choice to focus on some of the data provided and not necessarily all the data, and be mindful of the reasons behind such a choice. For example, her narrative offered a lot of information about her cognitive thought processes on how she related to food, providing a detailed food diary, but this did not necessarily offer any information as to ways in which the intervention had impacted upon her, unless of course the content and style of narrative changed (which it didn't appear to have changed).

5.9d Catalytic validity

The extent to which research participants feel empowered has been termed by Stiles (1993: 611) as "catalytic validity". This agenda is of particular significance considering the aims of the research project, both from a feminist and a therapeutic point of view. In relation to this research 'catalytic validity' can be assessed in relation to all the women's experiences and narratives. The reader can assess the levels to which the research process has impacted upon participants in these ways. However, a critical perspective on this needs to be maintained, so as well as what worked and why, what did not work and why is also considered.

To promote catalytic validity, it is necessary to challenge research, and knowledge-generating practices, that refuse to acknowledge that power relationships are inherent within the research process (Bannister, 1994). Recognising these power dynamics allows the relationship between the researched and researcher to be seen as one of the core factors that impacts upon how knowledge is generated. Stanley and Wise (1993: 228) identify that, "recognition that who a researcher is, in terms of their sex, class, race and sexuality, affects what they 'find' in research is as true for feminists as any other researchers". Consequently, the researcher's own "frameworks of understanding" must be held to the same critical examination as the researched (Lather, 1995: 301). The researcher needs to ensure that she herself and her experience alongside the people being studied in the research are put into scrutiny and analysis.

5.9e Reflexive validity and reflexivity

Reflexivity is the process used by researchers to examine their own position and role in the construction of knowledge, ensuring that they attend to the relationship between the researcher and researched (Hall, S., 1996; Humberstone, 1997; Steier, 1995; Reay, 1996b). 'Reflexive validity' relates to "how the researcher's way of thinking has changed" (Stiles,1993: 612). By engaging in the reflexive process the researcher can begin to make transparent their own values, interpretations and biases and also critically examine how they interact with the theoretical perspectives being examined. Reflexivity can be located on a continuum between "benign introspection" and "radical reflexivity" (Steier, 1995). This allows a distinction to be made between simply revealing what the researcher did (benign introspection) or achieving a more extensive critical analysis of the theoretical concepts being examined and/or developed (radical reflexivity).

In a radical reflexive approach the researcher's own frameworks of understanding and self would need to be clearly located and critically reflected upon in order to examine the tensions and contradictions that they experience as they negotiate the research process. For example, the feminist researcher examining the theme of body-identity would need to continually reflect on her own embodied self (for example, her lived experience of her body within different cultural meanings) (Bell, 1997:147; Davis, 1997). This embodied self would impact on how she viewed theoretical perspectives and conducted the research. For example, her own experience of her physical self would influence her interpretations of research data and understandings of body-identity. The reflexive process also allows an examination of 'gender related praxis', enabling the researcher to articulate what the experience of completing research was for herself (Hall, A., 1996). This can, in part, also be linked to the term 'reflexive validity' (Stiles, 1995), whereby validity is achieved by establishing how the researcher's way of thinking has changed as a result of the research.

As could be expected, the reflexive process is both complex and problematic. It requires the researcher to examine the boundaries between their own experience and the research process, thus maintaining a high level of conscientious self-reflection and a process of self-awareness (Bannister, 1994; Reason & Rowan, 1981). As pointed out by McLeod (1994: 189) it is interesting to note that, "most therapy is based on the pre-supposition that both the client and counsellor are able to reflect on their personal experience, yet in the past [therapy] research has been conducted in a way that denies reflexivity". Even though personal experience is at its core, there is also a caution in the personal experience becoming the only focus and thus overlooking other perspectives. As suggested by Reay (1996:64) the problem for feminist researchers is, "to try and find a space between theoretical standpoints which does not address the specifics of their own experience." Guidance on how to manage this process, however, is still relatively limited. If a reflexive approach is to be used in the research process the researcher should have access to appropriate supervision. For example, strategies should be put in place to enable the researcher to be supported in this process, whereby the key principles of reflexivity are managed appropriately and the emotional impact on the researcher is monitored to ensure that the emotional well-being of the researcher is protected. It would not be unusual for components of reflexive processes to lead the researcher to experience emotional distress.

The reflexive process and consequent narrative in which I engaged in as part of this thesis is described in Chapter Six. This gives examples of how my thinking changed and in particular was being influenced by adopting a feminist position. It can be seen how as researcher I have reoriented the ways in which I view and understand the world. Although this section is a stand alone chapter it does not imply that the reflexive process is a separate process to the research undertaken. This reflexive account was informed from a reflexive diary written throughout the study and is presented in one chapter for ease of representation in the thesis. It

takes into account aspects of the programme development and the components of the 'HOPE' model, and in doing so examines from a reflexive point of view some of the key theoretical perspectives that underpin the key aspects of the thesis.

Chapter Six:

Critical Feminist Reflexive Research:

Exposing the Narrative(s) of a Relational, Embodied and Gendered Self

6.1 Chapter overview

This chapter will examine the ways in which my changing self as a researcher was central to the development of the adventure therapy intervention for women with eating disorders. The chapter will illustrate how, as a researcher, I developed a critical feminist reflexive approach and its related process. I do this as way of bringing together the range of perspectives that are brought to this thesis. The parallels drawn will uncover my own narrative(s) of a journey 'out of anorexia in the outdoors', to 'a gendered self out-of-doors', and into a 'healing space in-doors'. This will highlight how theory and practice emerge from the different 'selves' of a researcher, along with the ways in which reflexivity, theory and action are all inextricably linked. Furthermore, it is an attempt to make transparent the relevant biases that I brought to the project as a researcher.

The decision of how to manage and represent a reflexive process was problematic – how do you collate all the reflexive processes and notes in a way that is coherent and represents the feminist principles being researched? This question presented an ongoing dilemma. However, in order to make the reflexive component manageable for the thesis I decided to write one main reflexive chapter which, as well as linking to some of the main theoretical components in the study, also served to support the deconstruction of current dominant discourses in outdoor adventure, in particular those of psychological development, the body, and emotionality. However, this reflexive chapter is not meant to be a stand alone chapter - it is meant to be viewed alongside and with all other aspects of the thesis.

6.2 A feminist reflexive agenda in the outdoors

In his work on sport, Sparkes (2000: 25) highlights how "narratives of the self have the potential to challenge disembodied ways of knowing, and enhance empathetic forms of understanding by seeing our 'actual worlds' more clearly". The ways of knowing in outdoor adventure remain predominately disembodied and in doing so perpetuate the dominant discourse of masculine perspectives. This is because women's bodies provide a central site of oppression and gendered meaning, and the outdoors is not exempt from these (*see* Allin, 2000). Further, the social context of women's embodiment features heavily in the construction of eating disorders and becomes a central feature of any eating disorder intervention. As Brown (1993b: 128) points out:

> "the body is an arena through which women's struggles and conflicts are often expressed in Western society today. Women are speaking with their bodies, and until this voice is heard, most women will continue to need to speak through the body and eating".

Thus, an aim in sharing my own narratives of the self is similar to that of Sparkes (2000) in sport. That is to bring an embodied – and a relational and gendered - construct of self-identity into the discourses of outdoor education and adventure therapy.

In adopting a feminist perspective to research I recognise the social and political significance of being a woman. As a white, working class, heterosexual woman I am in continual negotiation of my experience of a gendered and social reality. I will not necessarily have awareness of all of the dynamics of this reality and I may in fact deny parts of this reality. However, I cannot easily escape the ways in which the world imposes a gendered and social reality upon me. As a result I provide a site of knowing for understanding and unravelling some of the processes

and practices of both oppression and empowerment. Yet, these experiences impact upon how I view other women's experience of oppression and empowerment. For example, as a white woman I will never fully understand what it means to be a black woman. The best I can do to try to understand her reality is to allow her to validate her experience of the world rather than question it against mine. This illustrates how power relationships between women is a central premise of feminist research, whereby a key aim is to foster egalitarian relationships amongst the diverse social and gendered identities we hold (Gill, 1994).

In taking a feminist stance I recognise how I am a woman who is searching for her own 'voice' - which for a number of reasons has become a key endeavour as a woman completing research in outdoor education and adventure therapy. I have chosen to take responsibility for my own voice by openly navigating the meanings of this search. This enables me to develop a process of self-awareness that then allows me to evaluate more fully the ways in which I move in and out of my own narrative. However, as I disclose parts of my personal position in the context of my own narratives of the self I find myself in somewhat of a 'double bind'. On the one hand, as suggested by Reay (1996b: 64), the problem of feminist researchers is the need to try and find a space between theoretical standpoints which "does not address the specifics of their own experiences". In exposing my narratives(s), however, I am in fact interweaving my own lived experience with theoretical meaning. In doing so I am able to consider more fully the 'places' at which I do and do not meet with the area of study under investigation. As I do this I suggest it places me in a position to view components of the research process more objectively. This represents a central component in feminist research in that it aims to bring together "subjective and objective ways of knowing in the world" (Jarantyne & Stewart, 1995:228). As a researcher I am, therefore, not outside the research, nor am I solely inside the research.

The combination of subjective and objective ways of knowing is illustrative of how feminist researchers actively aim to breakdown traditional dualities. This is because the maintenance of many dualities provides a place in which dominant perspectives serve to oppress 'other' perspectives, as one side of the duality tends to remain more powerful over the 'other' side, for example: male over female; public over private; outcome over process; strong over vulnerable; and mind over body. What is in action for a feminist researcher is the deconstructing of such dualities with the pursuit of an active rhythmic movement between them. From a therapeutic perspective, the breaking down of dualities within a rhythmic process of change provides a central premise in feminist counselling and psychotherapy (*see* Chaplin, 1988).

In being reflexive along my research journeys I have found it important to work towards developing appropriate research strategies to manage my ongoing process responsibly. Further, by actively identifying where the key theoretical concepts meet with my own lived experience I am able to place the women's diverse voices that I aim to access through research in a space in which they can hopefully be heard more fully. This is because I create more of an open and, in some ways, contained place in which my story is heard. This reduces the risk of my 'silent' voice being expressed through the voices of other women, and allows the ways in which my 'voice' can and does influence other 'voices' to be evaluated and positioned more honestly.

6.3 Reflexive questions of the self

The critical feminist reflexive process has faced me with many dilemmas, tensions, insights and questions. For example, what levels of self-disclosure do I choose to take and what significance do such choices mean both politically and therapeutically? Further questions I have and continue to pose include:

- How is knowledge gained from this narrative endeavour and how do I challenge the claim that this is simply a self-indulgent pursuit?
- How is writing this narrative a process of 'reclaiming' my identity as a 'female' outdoor educator and as I do this what theory of self-identity am I proposing?
- In what ways do I use my research as a way of accessing my authentic self and how do I manage this process with self-awareness?
- What decision-making process underpins what I choose to share and what I choose not to share - what are the social and political reasons for such choices?
- How do I navigate dominant discourses in outdoor education as I write this and what are the dominant discourses that I am in fact challenging?
- What self-protection mechanisms are put in place as I expose my narratives and what does this imply about the construction of 'voice'?
- What impact do I intend for these narratives to have on the reader?
- What is the therapeutic significance for me as the writer of these narratives and should this be a goal of feminist research?
- How do I use these narratives as a reflexive platform during data analysis and interpretation of the women's voices from the research I complete?

The above questions illustrate how critical reflexive practice is an ongoing effort. This is indicative of the personal and professional commitment to developing such approaches to research. It also raises the question as to how research practices are active in supporting such processes. I note here that I have engaged in my own reflexive process without appropriate supervision. Although managing this process by my self has provided me with 'emotional gifts' it has also had significant 'emotional costs'- as I will discuss in more detail later.

6.4 Setting the scene to an adventure therapist researcher's reflexive process

Having discussed elsewhere in this thesis aspects of the development of adventure therapy research and practice for women with eating disorders I explore further the ways in which my own personal reflexive proces is related to the bringing together of the key research and practice components: eating disorders, outdoor adventure, and therapy as introduced at the beginning of the thesis. In doing so, I consider the boundaries between myself, as a researcher, and the emerging theoretical framework that underpinned much of the research and practice of this thesis.

It is not coincidental that I arrived at this area of study – my own personal journey led me to seek out ways in which outdoor practice could be developed to address disordered eating for other women. Two contrasting poems that I wrote approximately ten years ago – one about my experience of anorexia nervosa (an anorexic soul) and the other about the meaning of my own mountaineering pursuits (an outdoor soul) - highlight the significance of my own personal history. Although written at separate times I place these next to each other as the main premise of my narrative is the exploration of my relationship between disordered eating and the outdoors. Further, even though it may not necessarily be immediately evident in the poems a relationship did exist between them both - an 'outdoor soul' allowed freedom from an 'anorexic soul'. This indicates how the outdoors served as a central component in my own recovery from anorexia nervosa.

An Anorexic Soul

Tragedy it was of an infested image
A power to determine my future emotions
A burial of happiness
A figure of a perfect body
Became born within a shattered mind
Torn between instincts and imposed shadows
Just seeking for mine to be listened to
A journey to decrease that changing number
A destination where a deadly silence was heard
Two voices challenging every mouthful
And that fateful balance deciding the next meal
Calculations of every taste
A sum of death
A world evolving around an outer shell
Dependent upon the inner core
One mouthful away from that poisoning void
and I came to reign.

Those armies of purpose still battle
each day I wake, each night I sleep
I need no longer an enemy, but an ally
I can not forgive the enemy
So will I ever arrive at peace?
(Kaye Richards, 1992)

An Outdoor Soul

I sit in waiting as the mountain gods summon my pace
My mood anchored by their shadows
My future destined by their moods
I swallow their identity
And monitor their fortune
A moment of time
Yet, an eternity for me
Searching for their hope I journey into their unknown void
An enlightenment of life
Not a darkened hollow
Questions of uncertainty now need no answer
(Kaye Richards, 1993)

In correlating my own narratives with the development of an intervention for women with eating disorders I have come to see how each of the key realms – eating disorders, outdoor adventure, and therapy – are reflected in three phases of my life experience. I note here that I exclude my own early childhood narratives. I do recognise the significance of these, especially in the context of psychotherapy, as it is such experiences that form the basis of personality development. However, the more recent narratives I share here bear relevance to understanding the social and cultural dimension of personal change processes in the outdoors. They are also illustrative of the rhythmic process between the personal and political, and the objective and the subjective, that I have navigated during the feminist research process.

The first narrative - 'out of anorexia in the outdoors' - highlights how my initial experience of outdoor education impacted upon my healing from anorexia nervosa. The second narrative - a 'gendered self out-of-doors' - then provides a comparison between my healing experiences of the outdoors with my professional training as an outdoor educator. The third narrative - 'a healing self in-doors' – is when my awareness of my journeys of 'out of anorexia outdoors' and a 'gendered self out-of-doors' became most heightened, and I started to pursue an in depth therapeutic historical exploration of my self. It is also the time in which I completed the research and developed the adventure therapy intervention, and when my professional development as an adventure therapist was in effect 'in action'.

If the model of the research intervention as introduced at the beginning of the thesis is now compared with the reflexive process (See Figure 4) what can start to be uncovered is the parallel process of myself as a researcher. Upon exposing some of the points at which my self is interwoven with eating disorders, outdoor adventure and therapy, the relevance of these experiences becomes evident, in relation to the theoretical perspectives that underpin a model for adventure therapy for women

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Figure 4:

with eating disorders. This includes a relational and embodied perspective of the self, Cartesian dualism, and identity politics. From a research perspective, upon revealing these relationships appropriate reflexive strategies can then be put in place. In relation to my own narratives the reflexive strategies that have emerged include embodied fieldwork / reflexive bodywork, relational ethics / a reflexive relational self, and a therapeutic reflexive self.

In engaging in a reflexive process Ribbens and Edwards (1998:14) highlight how the researcher is "poised on the threshold" between the different experiences of the public, private and personal spaces of people's lives and their own lives as researchers. I acknowledge this dynamic process by situating my own narrative within each of these different thresholds. Thus, as a feminist researcher it is important to give recognition to the fact that there is a complex process by which private and personal lives are transformed into public meaning and are set against a social backdrop. At all stages of the research process a feminist researcher needs to not only take these into account she also needs to act reflexively about these.

The narratives I share are initially posed as questions. I do this as a way to invite the reader to consider how I might have felt in these situations. I use this as a strategy, for evoking a personal reaction and hence a 'felt sense' of my narrative(s), which is obviously contextualised in the narrative of each reader. Further, I use 'her' and 'she' instead of 'I'. I do this as I speak from a gendered self of 'female' and consider this as another way for the reader to be reminded of my gender identity.

6.5 Narratives of an adventure therapy researcher

6.5a Out of anorexia in the outdoors

> Stories of recovery from anorexia contain important understandings about 'reality' and 'knowledge'; especially about the ways we come to know, and about the role of the body in this knowing.
>
> (Garrett, 1998: 173)

Imagine an anorexic woman in an outdoor wilderness space. In what ways did she express her physicality as she climbed a mountain? How did her attention to eating and self-starvation change as the needs of bodily function, life goals and movement were different from her everyday lived experience? In what ways did her self-control through self-starvation shift to a control of self in an outdoor environment? How did experiencing extreme fatigue on a glacier during an expedition enable her to re-evaluate her relationship between body, food and self- and address a somewhat extreme duality between mind and body? What metaphor did having to eat represent for her in this setting? How did the she manage a reconnecting process between self, mind and body? How did she project images of her relationship with her body and self onto the wilderness landscape? What did nature represent to her as a form of a relational connection? How did her experience of a transcendence of self create a space in which expression and self-identity were transformed? What was the process by which she redefined her embodied self? How did feelings of self-esteem emerge that enabled a valuing of self to develop? How was success determined by her relational competence with other people? How did she redefine the boundaries of her anorexic space and her own self-identity?

6.5b A gendered self out-of-doors

> Bodies are not simply abstractions, however, but are embedded in the immediacies of everyday, lived experience. Embodied theory requires interaction between theories about the body and analyses of the particularities of embodied experiences and practices.
>
> (Davis, 1997:15)

Imagine a woman entering an outdoor education training programme who had been on a journey of 'out of anorexia in the outdoors'. In what ways did a shift from a predominately all female group to a predominately male group experience of being in the outdoors impact upon her sense of self and bodily identity? What did she feel when she became labelled as someone who would not perform physically? How did she feel when she was participating in technical outdoor skills courses and she was given obviously easier technical outdoor tasks to complete than those of her male counterparts? What pressure did she feel when she never felt quite good enough to attain the physical performance at the so-called required standard? How did she cope when a physical injury meant she was unable to maintain a physical presence in her professional development and compete in conversations of physical performance and achievement? How did she manage to negotiate a space in which she felt unable to express her vulnerability and feelings? Why did her body size literally double during this time? How did she feel when her values of personal development and personal change become silenced within a forum that was supposedly claiming personal development goals? Why did she feel unable to be both vulnerable in her feelings and access her physical power as a woman? Why did she hold outdoor qualifications, yet still question her competence and confidence in holding these? What coping strategies did she put in place to deal with all these processes? How did these emotional difficulties impact upon her physical and psychological health? What happened to her self-identity as she negotiated a different space to that 'out-of-anorexia outdoors'? How did these experiences

impact upon on her ongoing recovery from anorexia nervosa? In what ways did her previous experience of 'out of anorexia in the outdoors' feel silenced in a 'gendered self out-of-doors'?

6.5c A healing self in-doors

> Personal and professional goals and one's source of self-esteem may be related to the project undertaken or the manner in which it is conducted. We want to emphasise that in research on therapeutic practice, knowledge of the substantive domain as a function of personal experience with such practice is a major determinate of the perspective brought to the study.
> (Hoshmand & Martin,1995:36)

Imagine this woman now trying to promote healing out-of doors. How did her experiences of anorexia out-of-doors and gendered-self outdoors influence this process? What was the process of self-empowerment she was now faced with? How did developing an identity as a feminist researcher inform such a process? How did competing in mountain marathons represent a way of maintaining a physical identity and a sense of personal empowerment? What awareness of her relationship between her body and self did she experience in these events? How did she feel when she labelled herself as a feminist in what had become a male dominated culture for her? What aspects of her knowledge did she then find herself experiencing being silenced? Ask yourself why she turned to healing in-doors? What did she learn when 15 years later she revisited her experience of 'out of anorexia in the outdoors' through a process of 'healing indoors'? What psychological depth and understanding did she now bring to these outdoor experiences? What questions did she then ask herself as she compared her own healing in doors with her initial healing outdoors? What frustration did she feel as she tried to place this new found emotional and vulnerable self in what she had now come to understand as a gendered self out-of doors? How did she feel when she started to recognise the ways in which she had been oppressed? What

was the impact upon her psychologically when no one was validating the connections she was making? How did she feel alienated? What did she start to realise about the significance of being a working class woman in a traditionally middle class environment? How did she deal with reading theoretical perspectives on eating disorders that matched her lived experience? How did her relationship with food and eating change during this time? How did her relationship with other women who had troubled eating impact upon her relationship with troubled eating? What did she feel when her expression of emotion was viewed as a symptom that needed to be dealt with by medication? How had her readings of feminist approaches to women's mental health enable her to challenge and resist such assertions? What identity crisis did she experience when she could no longer sustain physical activity due to a physical illness? How did she regain her sense of self-empowerment? What did she learn about the functions of physical embodiment in the outdoors? What relief did she feel when she found what felt like a theoretical answer to why she had experienced out of anorexia outdoors and then found herself struggling with a gendered self out-of-doors? How did all of the above insights impact upon her own continuing healing journey and her ongoing journeys in the outdoors?

6.6 Challenging dominant discourse in outdoor adventure

6.6a Out-of anorexia in the outdoors: reconnecting with a relational self

How did she redefine the boundaries of her anorexic space and her own self-identity?

What did nature represent to her as a form of a relational connection and self?

There is a stark difference between the narrative of 'out of anorexia in the outdoors' and a 'gendered self out-of doors'. As the research and practice unfolded I was

always curious of trying to find an answer to why this difference had occurred for me. I recall my experience of healing in the outdoors as feeling empowered as a female group member – I felt able to fully access the outdoors on my own terms. Physical achievement, although significant, did not represent the whole experience. There was another process in action that had been present - what was this? Why had the changing relationship between myself, others and nature proved significant?

As I started to read the theoretical literature on the concept of a 'relational self' (see Jordan et al.,1991) I gradually became overwhelmed at the resonance this theory had for me. I suddenly felt as if I had, in part, found some answer to why the experience had shifted so dramatically from 'out-of-anorexia in the outdoors' to a' gendered self out-of-doors'. I can clearly remember the moment at which I made this connection at an identity level - it just fitted. For me this was a significant therapeutic moment- it had reconnected me to part of my authentic self that had felt so clouded for so many years in the outdoors. It became clear from this point onwards how my healing outdoors had reconnected me with my relational being. Yet, as I moved into a gendered self out-of -doors this relational self had become denied. Obviously from a critical perspective I pose certain questions as to why this was so.

6.6b Relational psychology and self-development

A relational model of the self takes into account the ways in which being in relationships is central to feeling good about oneself and enables psychological growth to occur with the maintenance of self-esteem (Jordan et.al., 1991, Surrey, 1984). Its premises hinge upon ideas such as relational confidence and relational flexibility. An ability to attain and be able to sustain healthy relational contact and movement with others is central in particular to women's internal valuing systems (Jordan, 1994). A denial of this valuing system, therefore, impacts upon women's feelings of self worth. It is argued that situations that create poor self-esteem are in

fact characterised by relational non-responsiveness (*ibid*). However, a contrasting view of the self is still a dominant view in western psychology and is often sought through outdoor education experiences. This is a view that continues to over value an autonomous and independent self, whereby separation from others rather than interdependent behaviour, self-control and mastery are seen as a necessary function of healthy psychological development and approaches to personal development.

My ongoing experiences of a 'gendered self out-of-doors' were based upon a traditional western model of development whereby mastery, control, achievement, separation, and an autonomous / independent self were emphasised. Further, the spiritual and transpersonal relationship I had with the outdoors was not acknowledged. Thus, the core sense of self I had been allowed to both experience and nurture, and hence serve in my recovery from anorexia nervosa had in many forms become invisible and denied for me as I continued on my outdoor journeys. This provided a challenge to me feeling able to maintain a development of self-esteem enhancement that had previously been in action. This was, in part, a result of a psychological denial of a core component of my internal valuing process.

As I grew more attuned to this link I started to ask myself how a relational knowing could be developed as a central premise both in the research and practice that underpinned my work in adventure therapy. This was a turning point in my theoretical understanding and led me to recognise the significance of a relational ontology, and hence relational ethics, in the research process (*see* Busier et.al., 1997). I also correlated this connection to theory of the aetiology in eating disorders for women, as is highlighted by Sesan and Katzman (1998:81):

> *"Eating disorder pathology develops as a response to the confusion and 'crisis of connection' that girls experience around the loss of their relational world as they come of age within a culture that does not value these types of connections with others."*

In making such a link between relational psychology, the intervention of eating disorders and research approaches, the central feature of feminist research was developed, whereby empowering other women became a central feature of the research process. As I started to adopt a relational perspective I started to reflect more critically on my relational being with the women on the intervention. I became more curious and critical of the ways in which I had kept myself out of relational connection with the women and the ways in which I could actively enhance relational movement. Reflexively, I recall noting down a sense of psychological disconnection with the women when I interviewed them. It was interesting how one woman in the final interviews after the adventure therapy intervention commented that she would have liked to have been more in relationship with myself as a researcher and that she had felt disconnected with me. I had noted in my reflexive notes how my focus on the research process had impacted upon my ability to feel in authentic relationship with the women during the intervention – I was aware that I was negotiating a power relationship during this time. These were part of lived experiences of the significance of relational ethics in the research process and represented a key link of how theory was correlated both with therapeutic practice and research practice. As is highlighted in their research on the psychological development of adolescent girls Brown and Gilligan (1992:8) comment, "we predicted that it was the relational nature of our conversation with girls that was responsible for the effects we had observed – clinical improvement, developmental progress, a strengthening of voice in relationship".

6.6c A gendered self out-of-doors: Negotiating an embodied self within a discourse of cartesian dualism

Why did she hold outdoor qualifications, yet still questioned her competence and confidence in holding these?
Why couldn't she be vulnerable in her feelings and still access her feelings of physical power as woman?

Given my experience of anorexia nervosa it is inevitable that the body and its links

to physicality have been a central feature of my narrative. However, this has been accentuated given the function and role imposed upon women's bodies in the outdoors. In those times of finding it hard to feel I could maintain a connection with my authentic self I now see how my physical disempowerment was an element of this difficulty. My body was not only a central site of power for me in terms of my relationship with anorexia nervosa, it also grew to become a central site of my oppression as a woman in the outdoors. Although I was physically competent and extremely enthusiastic to develop my technical outdoor skills, over time it felt very difficult to feel empowered in this. I became labelled as someone who would never be able to attain my ambitions for physical achievement in the outdoors. I embodied what it meant to have a woman's body in the outdoors and I perpetuated this myth as a result of my personal / social history. As Hepworth (1999: 100) highlights "the regular practices that individuals carry out on their bodies become a form of discipline of the body, on a docile body, which is produced by constitutive of the politics and economics of society". The list is endless of the incidents that I recall that now resonate with me as a social control on and over my female body. I also discovered a link that reinforced this thinking in another research project I completed whereby other women in their accounts of negotiating a 'gendered self out-of-doors' had in fact developed disordered eating as a coping mechanism (Richards, 1998). This suggests to me a very powerful expression of the experience of being disempowered as a woman in the outdoors and its manifestation through the body and eating. However, this is not surprising when one examines a feminist perspective to eating disorders. As Brown (1993a: 55) points out, "the ambiguous halfway point between the demands of liberation and of traditional femininity in which women find themselves, is such that controlling the body and eating behaviour is one of a few meaningful and promising ways to an acceptable sense of self".

Having realised at an identity level that I no longer felt I needed to starve myself, continuing to pursue a healthy relationship with the outdoors on my own terms felt an important component in continuing my recovery process from anorexia.

However, I then found myself with a double bind, on the one hand knowing there was a way out of anorexia through the outdoors, yet then being faced with oppressive dynamics that would make such a recovery even more problematic. It is here that my troubled eating then responded to the social circumstances that I was faced with, but I now expressed these differently in terms of my relationship with food – whether consciously or not I started to overeat. It is no surprise to me that over the period of my training as an outdoor educator within four years my body size had literally doubled. My anorexia had now been transformed into a different form of troubled eating, whereby this was a response to the circumstances of my experiences of training as an outdoor educator. I had to find new coping strategies to now deal with my oppression as a woman, but one that was not expressed through self-starvation, as my early outdoor experiences had given me a way out of anorexia.

6.6d Cartesian dualism and the body

The body and the relationships we have with our bodies are impacted upon by a discourse of Cartesian dualism – that is a discourse that reproduces many parts of ourselves as dichotomised. As Malson (1998: 124) points out "whilst the mind is privileged, the body is constructed as alien, as an enemy that threatens our attempts at control and must itself be controlled". This is not only permeated in western society it also exists in the outdoors. A discourse of cartesian dualism fuels a control of mind over body, which reinforces a hating of the body. Individuals, especially women, respond to this, as they are encouraged to pursue the goal of being 'thin', whereby 'thinness' signifies the minds triumph over the body and its desires (Bordo,1990). It signifies control and therefore integrity of the self.' (Malson, 1998: 129). I found myself still being faced with this discourse in the outdoors, and this proved problematic as I tried to continue in my recovery from an eating disorder. I was being required within this discourse to strive for the masculine ideal of the body over mind control. Yet, as I pursued such goals I was only faced then with clear messages that I should not even expect to reach the technical and physical performance equal to that of men situated in this discourse. I

was being told to strive for it, yet being denied it when I did. This was inevitably a way in which I was being oppressed as a woman and provided a dynamic that presented another negotiation of my search for my authentic identity and the redefining of my relationship with troubled eating.

On reflection I also recognise how a discourse of Cartesian dualism was also related to another difficulty associated with developing technical competence. I was a women who wanted to be both vulnerable in my sense of being and also be physically competent. Yet, it felt the structures were saying you had to be one or the other. Plus, the other that was being oppressed was the vulnerable and emotional part – the aspect of the self so frequently associated as a female trait. However, I continued to try to maintain my commitment to vulnerability and achieve physically. This at times felt an impossible combination to sustain - I experienced a resistance to being highly skilled in both the technical and affective domain. It was if they could not work together. I then ended up in a place of sabotaging my own skill level, my own ambitions for technical performance. So the end point was oppression of my potential as a female outdoor educator, female mountaineer etc, whereby my authentic self again became denied and imposed upon.

6.6e Identity politics and personal development in the outdoors

In continuing to ask myself of the ways in which my identity has been shaped by social structures and how these have led me to the feeling of not fitting into the outdoors, nor knowing what the unspoken rules are, I have inevitably asked myself about the significance of my social class. I have found myself many times questioning whether my experiences of the outdoors fit the model that is presented by the dominant meanings, and correlate part of this to my working class position. Many feminist researchers who have grown up in a working class environment note the sense of finding themselves in a process of class transition as they complete research. On the one hand they realise that they do not fit into the middle class structures, yet they also find themselves feeling unable to fit into the working class structures: a sense of being in 'no man's – woman's – land'.

My earlier outdoor education experiences between the ages of fifteen years old and seventeen years old included school expeditions, yet these were in an inner city, working class, comprehensive school. The model of expedition that such experiences were based upon were taken from a middle class structure of a popular youth expedition organisation in the UK. Yet, what was traditionally a middle class phenomenon was being made accessible to a working class group of young people. I argue that in the process of providing such experiences to a working class group of young people, the meaning of these experiences, although similar, was in some ways transformed. I am left asking myself now how much this social text of outdoor education created a reality for me that in some ways I still find difficult to access a voice for – the basis of my beliefs and values about outdoor education at times have felt silenced. It is as if my meaning ascribed to its processes is not matching the espoused dominant middle class structures – something remains silenced about my experiences and the way I make meaning from them – I cannot find a voice for them. Again, this provides a challenge to my sense of feeling unable to maintain my authenticity in outdoor education. Thus, wider social structures also interact with gender to add another dimension to the way an individual is 'allowed' to access, define and maintain their beliefs and esteem.

The social structures that currently determine approaches to outdoor education, coupled with the ways women experience their bodies in the wider social world continue to provide a place of difficulty for women to develop and maintain an authentic sense of self-identity. This is heightened in the outdoors, as the internalised messages women bring with them about their bodies and physicality enter into a complex set of interactions within many of the traditional mechanisms still evident in the field. What comes into focus upon considering a relational, embodied and gendered self is how the dominant self-esteem model in outdoor education continues to marginalize women, as it remains disembodied and in relational denial. Developing self-esteem based on achievement is fundamentally flawed. This indicates that self-identity has a political dimension and some of the assumed goals of participation in outdoor adventure - i.e. self esteem enhancement -

need deconstructing to identify what dominant groups they currently serve and how current processes keep a cycle of oppression in action.

6.6f Identity politics and reflexive processes

What I have determined from my own narratives and developing a feminist identity is that the politics of identity becomes a central feature of reflexive strategies. As my growing awareness of my own identity as a researcher has emerged I have found myself in a position to give more recognition to the political frameworks that determine self-identity – my own narratives interact with theoretical meaning making. Given my own personal journey I find myself easily agreeing with Griffiths (1995:82) that "an account of the construction of self needs to show how social circumstances, material circumstances (including embodiment), change and growth all come together to make a self".

It is with an acknowledgement of the political elements that come together to make a self that I am led to think about how these enter the research process. As a result I have become clear that an examination of power as embodied in research relations is one of the many reflexive agendas of researching eating disorders. I agree with Coffey (1999) in that we "experience fieldwork as embodied social actions", and I also agree with Moje (2000:28) in that "our bodies speak what our mouths are refused to speak". Thus, it has become clear to me that in order to act responsibly with my reflexive process, recognising how power relationships are transformed and expressed with and through the body is necessary. As pointed out by Moje (2000:39) because women have socially embedded relationships with their bodies "it seems especially important that women engaged in collaborative relationships – whether with other women or with me – think carefully about what their bodies and body discourses might mean for the production of power in relationships". Thus, embodied fieldwork becomes a central agenda in feminist research, and one that is fundamental to research aiming to provide an opportunity for both intrapsychic and social change for women. This feels even more heightened in the area of eating disorders, especially if adopting a feminist approach to researching therapeutic interventions.

6.7 A healing self in doors: developing a therapeutic reflexive self

What insights did she gain when 15 years later she revisited her experience of anorexia outdoors through 'healing indoors'?

During my own journey of 'healing in doors' I have revisited my earlier outdoor experiences that were part of my 'out of anorexia in the outdoors'. Although my outdoor experiences during this phase had resulted in a significant therapeutic impact – they helped me step out of anorexia - they had not been processed at any psychotherapeutic depth. What 'healing in-doors' provided for me was a place in which the meaning of these and the deep emotions attached to them could be expressed and experienced at a deep felt level. I was sat processing the significance of my outdoor experiences, but this time indoors and fifteen years later, and correlating them to my early historical narratives, a somewhat different process to the immediate reviewing that is traditionally used to make meaning from outdoor experiences.

The fact that I was revisiting these experiences fifteen years later does signify the therapeutic impact that they had upon my sense of self. However, attention to the psychotherapeutic meaning of these had not been given a process of self-expression and meaning making in the context of my own therapeutic self, nor what it meant to me in terms of my own behaviour change and personality restructuring. Although I knew those earlier experiences had been therapeutic, I also knew that they were not psychotherapy in the sense that I had not expressed or dealt with the deep intrapsychic impact they had upon me. My own personal psychotherapy helped to clarify this position for me.

What is difficult for me now, however, is the process of therapeutic change I am faced with in terms of overcoming the psychological consequences of what it meant for me to experience my self in a 'gendered self out-of- doors'. I find my self in a difficult process of determining what elements of my psychological experiences are part of my personal history, and what elements are part of the way in which the

social and political structures determine my psychological state. Thus, I bring an analysis of where the personal and political meet in my own process of psychotherapy. It is here that I come to understand more fully what both a feminist approach to psychotherapy (*see* Worrell & Remer, 1992) and an adventure therapy approach may consist of.

6.8 Therapeutic benefits of the research process

My own psychotherapy has enabled a reconnecting process to parts of myself that have become disconnected during my endeavours in the outdoors. Also, I have used this research as a way of engaging in this reconnection process. However, the therapeutic impact of the research outside of individual psychotherapy has also been evident. During the earlier stages of the research when I was familiarising myself with the literature of feminist approaches to eating disorders an intra-psychic change process, whether conscious or unconscious, was in action. My food behaviours changed as I began to make more active choices about how I viewed food, and what my relationship with food and my body symbolised for me now. My eating habits were changing and incidents confirmed this to me. For example, I was able to throw food away without feeling guilt, nor having a desire to eat it all. I started to recognise the ways in which I was having a more comfortable relationship with food and my body. My over eating tendencies started to reduce, and I started to lose weight – but not in the same conflicting relationship I had when I was in the mist of anorexia nervosa. This process was mainly fuelled by gaining more knowledge of how women's bodies are a site of oppression and the ways in which troubled eating is a reaction towards an imposed gendered identity. I started to gain a new sense of personal power and recognised in my new found choices around eating that I was in fact embodying the very social and political act of transforming women's identity, and allowing a more authentic relationship with my identity and body to emerge.

Given the feminist and therapeutic nature of the research I completed it does not appear coincidental then that I can note therapeutic benefits of this work and situate these in the process of my own healing from troubled eating. Yet, I believe that these processes eventually had a psychological toll due to the deep internal process of change that was embedded within a feminist framework and was occurring without any accompanying appropriate psychological supervision or intervention. The alienation that accompanied this was also reinforced by the gendered structure of the outdoors that adds to the resistance of emotionality being a highly prized goal.

6.9 Developing an adventure therapy approach

The lack of therapeutic space in the outdoors reflects a shift required of outdoor practice to move from a developmental process agenda to a psychotherapeutic process agenda working at psychological depth if it is to work in an adventure therapy context. It was difficult during the research practice to gain a sense of therapeutic community in the outdoors. I also experienced on numerous occasions a discourse of Cartesian dualism- it has to be either healing indoors or healing outdoors. I think the successful application of adventure therapy will need to include an integration of both approaches, as significant in depth work about outdoor experiences does not necessarily have to be occurring in the outdoors. Its psychological meanings and insights can be drawn from healing indoors – as my exploration of 'out of anorexia in the outdoors' through my own 'healing indoors' illustrates. Yet, as I suggest this there is the question of what would it have looked like to have the in-depth psychological processes evident in 'healing in doors' in the immediacy of the outdoor experience? This is perhaps a space in which an adventure therapy approach starts to emerge more fully, and a rhythmic process between 'healing outdoors' and 'healing indoors' can be developed.

In evaluating the purposes of critical reflexive research in adventure therapy the meaning of this from a therapeutic perspective, as well as feminist perspective,

needs to be considered further. Lees (2001: 137) highlights the relationship that naturally exists between reflexive research and therapeutic practices:

> "*It is well-suited to research in the therapy profession by virtue of the fact that many therapists have, in effect, been trained to think in a reflexive action research way; they are already doing it to some extent. In order to qualify what they are already doing as 'research' they simply need to research what they are doing in a rigorous way.*"

Although reflexive skills may be evident for therapists, it can not be assumed that these are immediately evident for adventure therapists - the identity of adventure therapists as of yet does not necessarily imply psychotherapeutic competence. However, being 'reflexive' will inevitably enhance the self-awareness of adventure therapists and consequently provides a mechanism for addressing the professional needs of developing therapeutic competencies. Addressing such competencies is important at this current juncture of development within the field of adventure therapy, as very little professional training to become an adventure therapist currently exists. Thus, the way in which research in adventure therapy is approached becomes as much a question about professional issues as it does about philosophical preference. This is one of the many examples of how research met with practice in the development of the adventure therapy intervention that these narratives speak from.

In adopting a feminist stance to research and practice, acceptance of the ways in which you are discriminated against, along with awareness of how you collude in this, is not an easy process to engage in. Its experiences can be highly demobilising. This is easily accentuated when there is no one to validate one's experiences, when there is an ongoing internalisation of other women's oppression, and when the research touches the very core of the researcher's personal identity and individual psyche. Yet, if as a researcher I can be reflexive around such experiences this contributes to understandings of gender related and adventure therapy related

research praxis, as it enables me to reflect upon what it meant to be a woman doing such research at this historical moment in time.

6.10 Conclusions

From the narratives I share I raise the notion that self-identity is a social and political phenomenon. In exploring the processes of identity formation critical questions need to be posed as to what are the current dominant views of self-identity formation in the outdoors? What, why and how are current 'projects' of personal development in both outdoor education and adventure therapy constructed? Who do they currently serve and benefit? Who do they exclude? Can they really embrace the healing of suffering for all? Also, what are the structures that research in the outdoors are built upon, and how do these structures determine the research undertaken and, thus, impact upon the potential for understanding and working with different client groups, especially from a therapeutic perspective?

The processes of developing an identity as a feminist researcher, coupled with the processes of developing an identity as an adventure therapist researcher, illustrate the complex matrix of meaning making in such work, along with the transformation processes that underpin such work. As all of these processes have the capacity to impact upon a researcher the ethical questions about how to supervise the researcher developing such skills need to be considered. For example, what structures need to be put in place in order to enhance the processes of critical reflexive practices, and provide professional emotional protection and support as researchers engage in feminist and therapeutic research endeavours?

The goal of developing the reflexive strategies I consider in my research are at the heart of adventure therapy feminist research and practice in providing a step towards a theoretical approach that embraces empowerment and change, along with self-healing and social healing in the outdoors. In conclusion for this chapter, I end with a poem that touches for me the change processes that as a collective group of women, who were part of the adventure therapy intervention, whether as a

participant, therapist, outdoor trainer, or researcher, we all experienced. It is a poem I shared at a time when as a group of women we were all sharing part of the intervention. It helped me to gain a sense of a collective journey that had touched the personal and political 'spaces' of all our lives as women on our ongoing journeys.

> *I am a raft without a rudder, a drift on a sea of pain.*
> *During these long months I have been peeling away like an onion,*
> *layer after layer, changing;*
>
> *I am not the same women, my daughter has given me the opportunity to look inside myself*
> *and discover interior spaces – empty, dark, strangely peaceful –*
> *I had never explored before.*
>
> *These are holy places, and to reach them I must travel a narrow road blocked with many obstacles, vanquish the beasts of imagination that jump out in my path.*
>
> Isabel Allende (cited in Joyce, 1996:7)

6.10 Post reflexive conclusions

The reflexive process, as detailed, above was written shortly after the intervention had been completed. Since the writing of the above reflexive process time lapsed and in continuing the reflexive process I now consider how I view this process upon completion of the thesis – ie has this changed in anyway now and if so how?

The narrative I provided in this reflexive chapter illustrates how I tried to locate my own personal, political and theoretical biography in relation to the study undertaken and its related theoretical and practical components. It also provides insight into what it meant for me to adopt a feminist approach to research – i.e. how it changed me in relation to a feminist agenda, the insights gained and how I related to the study undertake. The reason for writing this was so the reader could make judgements about the biases in which I bought to the study, how these could then impact on the

conclusions drawn, and also the ways in which the study changed my awareness. It also served as a way for me to understand how I had developed as a feminist researcher and the ways in which I expressed the relationship between the private, personal and public spaces as I developed an awareness of a reflexive agenda.

This process of making transparent the private, personal and public space is what I now consider as a first step in developing a feminist research identity and leaves me with some anxiety and uncertainty. This anxiety and uncertainty is whether the way in which I approached this was the right way, and I question whether it will be judged as irrelevant and merely a subjective narrative of myself that bears little, if any relevance, to the reflexive agenda or process. This is perhaps heightened as this chapter has been in the public domain as a chapter in book (*see* Richards, 2002). Looking back on this published chapter I wonder whether I actually want this now to be in the public domain, thus questionning whether making the personal public and political in this way is something I would now choose? But I am unable to revert this decision, so the anxieties remain with me. This scenario represents the dilemma of transforming private and personal knowledge into public knowledge and the sensitivities of this process, not only for myself, but also for those narratives of others that I make public. I am now left with questions of how participants may respond to having aspects of themselves made public and what real control and awareness do they have over this process and, furthermore, the political significance of this process. I was able to make my choices in what I made public and kept private, although in retrospect I might now make different choices. So given this, I am left with questions about how to effectively address making private knowledge public knowledge with more genuine concern for participants of the research process.

The confusions, dilemmas and decisions about developing a reflexive approach, especially from a feminist stance, were an inherent process of the study. Having penned the reflexive chapter I noticed when analysing the data that I was less concerned with wanting to find evidence of the intervention working and more concerned with finding and maintaining the true voice of the women. I can not say

that it is solely a result of the reflexive chapter, but by locating the subjectivity of my narratives I could then perhaps focus more cautiously on the needs of maintaining what was real for the women, rather than it being clouded by own narrative. For me that was what was important in the first stage of developing a feminist identity.

Being able to now see the reflexive chapter as a first step in developing a feminist research identity is helpful, yet I now see more clearly the further ways in which developing a feminist reflexive approach is required, as noted in Chapter Six. It is clear in this study that there is lack of reflexive detail of the data analysis process - I would approach the reflexive process at this stage more systematically in future research. For example, recording and analysing the relational, embodied and therapeutic reflexive incidents more systematically throughout the study, both during the intervention and also during the data analysis process.

Mauthner & Doucet (1998) point out that there are four key aspects to the reflexive data analysis process, including:

1) Locating ourselves socially in relation to our respondent
2) Attending to our emotional response to this person
3) Examining how we make theoretical interpretations of the respondents narratives
4) Documenting these processes for ourselves and others.

The reflexive chapter was a way of starting to address the above points, however, it didn't necessarily achieve this systematically during data analysis. This is what I now see as the second stage of developing a feminist research identity, as I now recognise that an active approach to maintaining a thorough reflexive process was somewhat limited during the data analysis itself. However, this was partly due to time restraints as previously identified in Chapter Five.

As was also noted in Chapter Five the 'voice centred relational methods' to data analysis was an approach that I wanted to adopt to maintain the reflexive approach during the data analysis process. As Mauthner and Doucet (1998: 126-132) point out this requires reading the data at four different levels:

One: Reading for the plot and for our responses to the narrative
Two: Reading the voice of the 'I'
Three: Reading for relationships: how spoke about interpersonal relationships
Four: Placing people within structural contexts and social structures.

What strikes me about this process is that this framework would actually be helpful in guiding a reflexive approach throughout all stages of the research process, especially from an action research approach as it would enable the reflexive dimension to be an embedded part of the process.

In conclusion, the reflexive account is how I made sense of a key feminist agenda. The main lesson I have learnt is how I would be more systematic in its process and link it more carefully to the data analysis process. I believe it is inevitable that the first stage of developing a reflexive feminist agenda gets caught up in the personal narrative of the researcher, as this is how to start to make sense of what reflexivity means both theoretically and practically. Following on from this first stage, as a researcher I can now move towards a more critically aware reflexive position that becomes more about the reflexive agendas of developing 'other' knowledge that seeks to transform the lives of marginalised 'others'. And although this process recognises my position in this process, I am able to handle my own narrative with more understanding of its appropriate function and place in exploring, understanding and more carefully representing the narratives of others.

SECTION TWO:
Developing Practice

Chapter Seven: Describing and analysing the adventure therapy intervention

7.1 Chapter Overview

This chapter will provide an account of the how the adventure therapy programme developed, discussing the different stages of the research and offering an overview of the intervention itself. The different related components of the intervention will be examined, along with the dilemmas and issues faced in working therapeutically outdoors and working with women with troubled eating in this setting. This will highlight key issues related to ongoing developments in adventure therapy practice. The processes in action and the women's corresponding experiences obviously go hand-in-hand. This will aid understanding of how decisions made directly relate to the women's experiences. Because of this iterative process, the data analysed are presented in a way that provides description of aspects of each of the five phases and what was learnt about working therapeutically, along with related accounts of the women's experiences. The women's individual experiences as related to evidence for psychological change as a result of participation in the adventure therapy intervention are analysed in Chapter Eight.

7.2 The general adventure therapy approach

The intervention developed in this specific research project was an adventure therapy provision, and initially represented a uni-modal, primary therapy provision. The programme evolved, however, to become a multimodal approach as, after the residential phase, some of the women engaged in other forms of therapeutic treatment. The aim of the programme was to create a therapeutic intervention for the treatment of eating disorders that encompassed a feminist approach to adventure therapy. Examples of quality adventure therapy practices are rare in the United Kingdom. It seemed important, therefore, that the development of good practice

needed to be the first priority. This was achieved by examining the practical relationship between outdoor adventure and therapy with a group of therapists, and by using a feminist approach to the research and the intervention programme, which ensured that ethical practice guided all decision-making. In bringing together outdoor adventure, therapy and eating disorders, a phased approach was implemented which created a distinctive intervention in its own right (*see* Table Three). The specific content and delivery of each of these phases emerged during the process, when the learning from one phase informed the transition to the next phase.

Table Three:
Adventure Therapy and Eating Disorders:
An overview of the five phases of programme development

Phase	Activity undertaken
1) Exploring Adventure Therapy Practice: *Brathay Hall Trust*	• Gaining ethical consent from participants • A residential weekend exploring good practice in adventure therapy with a group of therapists (all plenary sessions video taped). • Examination of the relationship between outdoor adventure and therapy. • Team alignment of outdoor trainers and therapists. • Identifying issues of working with an eating-disordered client group. • Consideration of the alignment of research and practice, with the piloting of research techniques. • Exploration of feminist principles in adventure therapy practice. • Main researcher's reflexive links between theory and practice.
2) Recruitment and Pre-Course Design: *Liverpool John Moores University*	• Exploring collaboration with eating disorder intervention provisions. • Recruitment of women to participate in the intervention. • Gaining ethical consent from participants to take part in the research • Six weekly sessions with women participants setting individual therapeutic objectives. • Aligning therapists and outdoor trainers. • Identifying and reflecting further upon feminist principles of eating disorder intervention and adventure therapy practice. • Completion of questionnaires and research journals by the women. • Main researcher's reflexive links between research and practice.
3) Adventure Therapy Residential Intervention: *Brathay Hall Trust*	• A week-long adventure therapy residential intervention. • Individual and group therapy, alongside participation in outdoor activities. • Identifying and exploring individual therapeutic objectives. • Inter-personal recall to access psychological depth during ropes course activities. • Audio-recording of group therapy sessions. • Completion of research journals during residential. • Completion of questionnaires at the end of the residential. • Main researcher's reflexive links between theory and practice.

4) Follow-On Course and Closure: *Liverpool John Moores University*	• Six months of bi-weekly / weekly evening meetings. • Transfer of therapeutic process to everyday life, focusing on addressing social change by examining the social construction of body identity. • Generation of self-supported healing. • Interview with outdoor trainer. • Completion of individual interviews, focus group and of questionnaires at closure. • Main researcher's reflexive links between theory and practice.
5) Developing and Reflecting upon Adventure Therapy Practice: *Brathay Hall Trust / Liverpool John Moores University*	• A therapist residential weekend in adventure therapy. • Team reflection upon adventure therapy approach. • Developing wider practice in adventure therapy. • More detailed examination of the processes of change in adventure therapy. • Therapist research focus group (completed at Liverpool John Moores University). • Main researcher's reflexive links between theory and practice.

Each stage of the five phases of the programme development are discussed and related themes and issues, as drawn out from the data collected, are examined. As identified in Chapter Four each one of these phases can be seen as an action research cycle and so the knowledge that emerged from each phase, both from the therapeutic team's point of view and the women participating in the intervention, is relevant.

7.3 Phase One: exploring practice in adventure therapy

A pilot adventure therapy weekend programme was run for women therapists, where they joined the researcher and outdoor trainers who would be working on the intervention in examining the issue of good practice. This group of therapists were all qualified counsellors/psychotherapists with a wide range of experience of working with clients in different settings, including eating disorders. One therapist had experience of working in an outdoor setting with from an eco-psychology perspective to practice, but none had direct experience of working from an outdoor adventure approach. At this stage an all-women group of therapists was chosen in order to support the exploration of a feminist model of adventure therapy. It was felt that the issues surrounding the processes of empowering women in adventure therapy would be more easily discussed in an all-women forum. However, it is

important to remember that simply providing an all-women's space does not necessarily create a feminist approach. Diversity and power relationships actively exist within any women's group, and addressing these requires continual implementation of feminist principles. During this weekend it was also important to test some of the research techniques in order to harmonise research methods with therapeutic practice. Thus, the pilot weekend was designed to achieve several goals:

- To enable a group of women therapists to explore the relationship between outdoor adventure and therapy.
- To enable outdoor trainers and psychotherapists to work together successfully.
- To explore feminist principles in action in an adventure therapy process.
- To identify issues related to eating disorders that might arise in an outdoor adventure setting.

The importance of applying feminist principles to adventure therapy required the team to look closely at two issues. First, to ensure that the experiences provided for the women were not so dramatic that they would get in the way of the women's own process (*see* Mitten, 1994). Second, to ensure that the safety requirements and the demands of leadership did not adversely affect the process of empowering women. As identified by Mitten (1994: 60), in adventure therapy there is a danger that, "the higher the risk or perceived risk of the program, the higher the client's initial dependency on the leaders. This sense of dependency gives leaders even more power over the client than in a traditional indoor therapeutic setting. The fact that these issues were confronted several times during the weekend served as a warning that they would need to be worked with constantly during the therapeutic intervention.

The task of working with an eating disorder client group raised fears and concerns for members of the team. The pilot weekend provided an opportunity for these fears to be discussed openly in a supportive environment. A number of findings emerged from such discussions. For instance, it became clear that some of the therapists had stereotypical views of the abilities, needs and body shape of women with eating disorders, highlighting aspects of the social construction of eating disorders. In addition, it emerged that some of the therapists also had a complex relationship with their own body image, weight, eating habits and food. Some described how, in the process of developing their practice as therapists, their relationships with food had altered, in that they engaged in eating for a sense of nurture to balance the emotional demands of being a therapist. These findings served as a warning to the team that the therapists' views and their own difficulties surrounding body-identity and food could obviously affect the therapeutic programme, unless the whole research team committed themselves to discussing these issues openly. Thus, throughout the intervention there was a crucial need for the team to "address their own unease regarding body size and weight" (Szekerly & DeFazio, 1993: 377). This awareness served to underscore the role that 'the self' would play in the intervention and highlighted a specific way in which a reflexive approach would prove significant throughout the research process (*see* Chapter Six).

7.4 Phase Two: recruitment and pre-course

7.4a The recruitment process

In order to recruit participants onto the therapeutic programme it was necessary to provide them and other potential collaborators (including eating disorder intervention centres) with a clear description of the programme itself and why it could be expected to succeed. Although, an overview of the general approach could be provided the team couldn't offer evidence to suggest it would be effective, the expected outcomes were speculative. This was not surprising granted the limited amount of research that has been done in this somewhat new area. In addition, most

of the groups initially approached worked in traditional medical settings and appeared sceptical about the possibility of linking treatment with an outdoor experiential-based intervention. This not only highlighted the contribution the research would have in developing future partnerships, it also had an influence upon the recruitment process. The final approach taken was to recruit women to participate in the programme through adverts in the local community.

Prior to the intervention taking place, a decision was made to move away from a medical model of eating disorders, in order to embrace the feminist perspective. This allowed the researcher to reject the DSM-IV diagnostic criteria (APA, 1994). Instead, the recruitment adverts identified common components of troubled eating, such as always wanting to lose weight, low self-esteem and food/weight preoccupation, as an invitation for participation. These adverts were placed in women's toilets on local university campuses, in order to ensure women privacy whilst they took details of the programme (*see* Appendix Four for copy of the advertisement). In addition, an article in a popular local newspaper invited potential participants to contact the team. In this way the team attempted to recruit to a wider, non-university population. However, it proved difficult to take anti-discriminatory practice further (*see* Lago & Smith, 2003).

One of the women identified how the novel approach that outdoor adventure therapy represented motivated her to respond to the initial adverts and gave her a sense of hope for her recovery. She had been struggling to find a successful intervention for many years and the approach suggested a new possibility that she felt was previously unavailable:

Brenda: "*First of all there was the advert, or the article in the Femail Page in the Echo [a local newspaper] and it was something that could actually catch my attention when I was on the slope of where, in fact, my attention was getting less and less. I was withdrawing more and more into myself.*

Therapist: *So it was something that stood out?*

Brenda: *So this was something that actually was different enough, or whatever one might want to call it, that would make me actually take some action, because I was in the position where I was taking no action...I was on the Prozac for the first time ever, I'd had to go and see my GP about depression, I had been diagnosed as being clinically depressed, I didn't much care about me or anything.... So then it was the coming together then, it was almost as though I was able to step off the slope, just across to have a look at what this stuff was, one foot on."*

(Individual closure interview)

Katy also commented how the outdoor components had appealed to her:

"Basically the Christmas before I'd probably been at my lowest point and I was really wanting to do something to get out of it, I suppose it's any opportunity that came up that might give help I was going to take it ... It was made all the more appealing by the fact that it was outdoors, I wouldn't have been so keen to go away for a week to a hotel or some intensive therapy or anything like that, it was mainly appealing because it centred on the outdoors ... I always felt very awkward but I knew I was going to go ahead and do it."

(Individual closure interview)

From this, it is clear that the novelty of an outdoor adventure therapy provision may have affected the women's motivation to engage in therapy. And inevitably a client's motivation to engage in therapy is an important ingredient for change. The requirements of the university's research ethics committee created a feminist dilemma. The ethics committee had stipulated that participants should seek permission from their doctors (G.P.) to take part in the programme (see Appendix Five for a copy of the Research Ethics Application). From one perspective this

represented a sensible protective procedure as people who are suffering from severe forms of troubled eating may run risk of an increase of cardiac arrest (Treasure & Smukler, 1995) and there may have been other health reasons why participation should be viewed with caution. However, from the feminist perspective the requirement to ask permission from a G.P. to take part in the programme demonstrates the ways in which medical power operates to take control over women's lives. It was quickly realised how this requirement for medical permission could negatively impact the women's experience of the intervention. The issue of G.P. permission was openly discussed with the women and actually presented an ideal opportunity to identify implications of adopting a feminist approach. Fortunately, none of the women had any objection to the requirement and no further problems were experienced. However, this episode served to raise the team's awareness of the range of issues that had to be dealt with when trying to achieve feminist principles in practice.

7.4b The women who participated

The group of six women who finally chose to participate in the programme presented a range of troubled eating, including self-starvation and bingeing/purging behaviour. Their ages ranged between 20 to 56 years old and the actual age of each woman is not provided as to protect their identity. Each woman had been experiencing forms of troubled eating for a number of years; four of the women had been in traditional counselling prior to the intervention.

Given the women had self-selected onto the programme this meant that some kind of assessment to take part was not appropriate. However, information was gathered from them about their history and related issues (*see* Appendix Six for a copy of information sheet women were asked to complete). Along with this as part of the research the women all completed the Eating Disorders Inventory (*see* Appendix Two for of a copy of this questionnaire). Table Four provides an overview of the scores from each of the eight dimensions of the EDI taken at the beginning of the

intervention. These scores indicate the levels of related symptoms, as discussed earlier (see Chapter Five), any score over 0 indicates that responses are in the symptomatic direction of that dimension. As can be seen most women have scores over 0, and the higher score range indicate a higher prevalence towards that symptom (*see* Appendix Four for a copy of EDI normative data and what scores represent in terms of clinical presentation of anorexia and/or bulimia nervosa).

Table Four:
EDI Scores at the beginning of the intervention

EDI Dimension	Katy	Andrea	Jackie	Brenda	Maria	Josie
Drive for thinness	19	24	3	6	15	5
Bulimia	16	19	0	15	4	0
Body dissatisfaction	27	27	7	22	25	14
Introspection	17	30	10	14	8	0
Perfectionism	14	15	0	4	5	1
Interpersonal distrust	2	15	8	4	6	0
Introspective awareness	15	24	3	15	4	0
Maturity fears	3	20	3	2	1	0

The women presented a range of eating issues – including bulimia and compulsive eating. Many of the women had taken part in other interventions and two women had previously been hospitalised. From a feminist view point all the differing reasons for choosing to take part were valid –all the women felt they wanted to address something that related to their troubled eating.

For some women the difficulties and distress associated with troubled eating were more prominent than they were for other women. For example Katy and Andrea had higher scores across a range of the dimensions, suggesting a chronic presentation of troubled eating. However, these scores do not offer an in depth overview of the women's distress or provide any insight into the different motivating factors as to why the women chose to take part in the adventure therapy

intervention. This information was gleaned both during the pre-course meetings, from the personal information sheets, personal research journals and interviews at the end of the programme.

The kind of troubled eating symptoms the women presented in their journal entries offered insight into eating relating thoughts and associated behaviours. Maria's journal entry illustrates how she used food as a way of dealing with emotions and how she felt continually dissatisfied with her eating. Feeling out of control and experiences of guilt were common feelings she experienced around food each day. She also indicates how her troubled eating was linked to her 'stuffing down' emotions with food:

> *"The past few weeks have been "out of control" as far as food is concerned. I have been eating loads of "rubbish", not so much bingeing all at once, but just eating more than I really need – eating to "stuff down" the feelings of stress, anger, fear, hatred, anxiety etc, which doesn't work because then I feel "stuffed" fat, horrible, angry again and GUILTY!*
>
> *I keep telling myself that it doesn't matter what weight I am for the programme, but I would still love to shed some by April. It will make me feel better about myself, more comfortable. (I suppose if I were really truthful, I would say that I am scared of being judged by the others, for the way I look – that's how it always is. I don't want to be that way anymore.*"

Brenda's journal provides insight into her bulimic behaviour and she also offers evidence of the associated emotional dimensions of her troubled eating patterns. She also points to what was common for many of the women, in that searching for eating solutions diets and specific eating regimes were common activity as strategies for trying to find ways out of troubled eating. However, it can be argued that such an activity only served to reinforce her troubled eating:

"I put on the TV on and realised as I got to the end of the food that I was putting food in my mouth when some was still in my throat. I then made 2 bagels with very low fat cream cheese and had a packet of crisps and a pear. I could only eat one bagel and I then made myself vomit and then a bowl of porridge and raisins with skimmed milk and had a coffee. I wanted more but didn't eat and instead started writing my journal.

I don't know what the feelings are I am experiencing. I feel alone, especially as I have been watching one of those American shows where people are 'helped' I feel lonely and needy and I am saying 'what about me?' and 'I hurt too'.

As I write this I start to well up because I have been afraid all of my life. I never feel safe. I am always on guard. I have never felt held by anyone....

I need to eat to make myself big enough to do everything. I need to eat to fill the loneliness I feel as everyone gets on with their lives. I need to be big so that I get noticed and people will hear me. I need to eat so I will not die.

I want to break this clay exterior and step out, but I suppose I might be vulnerable, like a new chick or baby turtle coming from its egg and not yet able to protect itself from the predators. I need to be safe while I grow. I am breaking the past now! I am sick of being trapped in it. I want to live. Having written this text, I decided to look at the food combinations plan to just make an intervention in the eating cycle I have been on forever it seem."

Andrea presented the most chronic form of troubled eating, whereby her cognitive processes about how she related to food and her body where extremely troubled. Her journal entries indicate how she was clinically depressed and how she was experiencing desperation with trying to cope with her trouble eating:

"I like myself more when I am thinner. But I worry that my eating will get out control again. Each day is a battle. At the moment I don't want to go out or see anybody. I hide under my waterproof coat – it is big and long. I dread the summer being fat. I want to hide away from everyone."

(Personal Info Sheet)

"I am disgusting. I can't stand myself sometimes. My body is so painful to touch as well – the fat parts are really sore to touch, they hurt and the fatter I get the more painful they feel." (Personal Info Sheet)

"Why do I turn to food and eating when I am so unhappy? I just can't seem to help it. I just feel the need to eat, it is a desperate feeling. It is not a hungry feeling because you are so full up. The fuller you are the more you shove into your mouth. The more I hate myself." (Journal)

"I have shut myself off from people. I get too depressed. I feel terrible most of the time. I have no confidence and feel useless. Just boring and a waste of space. I wish I was dead most of the time." (Personal Info Sheet)

From the personal information sheet the women completed at the start of the intervention it is evident that eating problems impacted on their everyday life in different ways, for example with work, daily activities other than work, thoughts, feelings about themselves, and personal relationships. For Andrea, the woman with the most chronic troubled eating indicated that her eating problems significantly interfered with all aspects of her everyday life all of the time.

Having recruited women to take part in the intervention, concern still remained, however, for the other twenty-four women who inquired about the programme. As always, those who do not choose to participate in intervention programmes present an interesting group. On the one hand, these figures demonstrate that there

are a significant number of women who feel they need help and, on the other, it alerts us to the problem of structuring adventure therapy provision in a way that enables people to avail themselves of it.

7.5 Phase Three: adventure therapy residential intervention – facilitating a therapeutic change process

7.5.a Addressing ethical concerns

Initially, the team made a decision, that during the adventure therapy residential, they would not encourage the women to undertake outdoor activities that required a large amount of energy expenditure. This seemed sensible in view of the likelihood that several women would limit their energy intake. (The programme that was developed in view of this consideration can be found in Appendix Seven, whereby the outdoor activities used are described in more detail). The team made this decision primarily because they were working with a relatively unknown client group and did not want to take unnecessary risks. However, this was an uncomfortable decision given the feminist approach to adventure therapy and the team recognised how it risked colluding with a medical and pathological model for eating disorders. Indeed, there is an argument that denying access to adventure experiences based on both a medical model and the socially-constructed fears of working with women with troubled eating, will maintain women's disempowerment and unnecessarily deny them access to adventure and wilderness journeys. This seems particularly unethical given that these experiences could provide a fruitful opportunity to address many of the dynamics of the women's troubled eating. Nevertheless, given that the outdoors is based on masculine models of development it is perhaps not surprising that an issue that is predominately presented in women becomes marginalised and overlooked.

7.5b De-emphasising food

Food intake or weight gain was not encouraged as a goal for therapy, in fact they were 'de-emphasised' during the programme (*see* Burstow, 1992). The women had complete freedom with respect to food intake. The intervention team accepted the women at whatever weight they were and took an approach that focused on the meaning and purpose of troubled eating for the women. It was important that the women's choices in eating were respected and that no conditions were imposed upon them. As Brown (1993:126) says, "feeling out of control is central to the experience of anorexia and bulimia, therapy that takes control away only exacerbates the problem". And some women expressed their frustration at experiencing therapeutic interventions that centrally focused on what they had eaten.

> *"I went to see one yesterday and I was very upset because I was meant to meet somebody and they hadn't turned up and they'd blamed it on me for going to the wrong centre, and he came along and he was sitting there eating a sausage roll whilst we were talking and I mentioned that a lot of problems is I've been really worried about my eating disorder coming back or getting worse again. And he went how much did you eat today then and my heart just sank."*
>
> (Katy final interview)

During the residential phase meals were provided at regular times, yet at the same time it was acknowledged that even though food was being de-emphasised the women were likely to have concerns and anxieties surrounding these times. These anxieties were openly discussed and the women were supported to negotiate meal times in whatever way they chose. As a group they decided to have a short session after each meal to discuss their experiences. In an effort to de-emphasise food intake and weight gain, the therapists did not encourage the women to direct attention to what they had eaten or evaluate what they would eat at future meal times. This de-emphasising of food impacted upon the women's experience of the intervention.

For example, Katy commented on the relaxed attitudes around food and how refreshing this was for her:

Katy: *It was "you can come have dinner if you want, you don't have to come and have dinner". There was never anyone who asked "have you eaten today?". It was all about our feelings, and our self-esteem– if we felt secure in that situation. And you were so casual about the food it was never made an issue.*

Therapist: *And that was something that really worked with you, was it?*

Katy: *Yes, it was great. You treated us like we were people, but when I've been to counsellors I've felt like they've treated us like people who don't eat or people who do and therefore they classify us. If I say I ate breakfast, I ate lunch, I ate dinner they'd say you're just a person with an eating disorder.*

(Individual closure interview)

Being away from home also took away some of the every day-to-day pressure that the women could experience around food. Katy noted that being away from home helped her as she did not feel pressured with eating and thus whilst she was away her eating was 'a lot more consistent' than normal, as she comments:

"Generally I had breakfast, lunch and dinner, whereas normally if I was at home I may not eat all day and then binge, or I may only have breakfast and then a piece of fruit at ten o'clock at night. I think it helped because whenever I eat at home or on my own I'm always scared I won't be able to stop eating, whereas I know there I'd have the opportunity to overeat a little bit.

So it did feel more secure because I knew I could eat a meal and it would be OK.... It's strange that even though I felt more awkward and I couldn't eat a lot of tea, it felt better than if I had ate a meal with my family, because I feel like they're always watching what I'm eating and they wouldn't understand if I didn't eat so much, there's just this whole pressure at home. I mean there was a different sort of pressure there."

Alongside Katy's feelings sense of feeling relaxed around food she still had eating associated anxieties during the residential and she managed these by eating in secret, as she comments:

> *"Yes [it made more anxious]. It's a feeling I always have but it was made worse in the situation. I always feel that if I've had a problem I've always had to prove to people who might think I'm being a fraud... It meant I ate a bit more in secret, I mean I could have eaten more at the mealtimes and I'd have felt OK with it because it was burning it off, so I had to eat a bit more in secret."* (Final interview)

In contrast, for Andrea she expressed how she can find it more difficult to control her eating when away from home because she feels she loses some control over her eating as she is not in total control of what food is available:

> *"I get more unsettled when I go away from home. I get confused. I don't like people cooking for me. When I go away and have to eat what is cooked for me I don't feel as if I have any control over my eating. I eat too much. Sometimes I make myself sick if I have eating puddings or bad things when I am away."* (Personal Info Sheet).

> *"I don't understand why this happens to me, this bingeing and purging and hating myself. I wish I understood. Why I get so distressed and unhappy when I go away and I feel as if I have to eat and eat."* (Journal)

These different experiences of eating illustrate the range of anxieties surrounding food. In de-emphasising food during the programme the aim was that the women could find strategies that felt most safe and comfortable for them in that setting. At no point was what they had eaten intentionally the focus of the therapeutic work, unless this was independently raised by them. From both the women's and the team's experience of the therapeutic working it seemed that the approach (of de-emphasising food) was a successful component of the programme.

7.5c Facilitating therapeutic depth during activities

During the residential programme it was tempting to think that most, or all, of the adventure therapy programme had to be outdoor activity based. Such a traditional approach would have put the focus on achievement. Instead the team wanted to create a process-orientated residential, in which there was an emphasis on therapeutic change. As suggested by Peeters (2003: 127) "all too often adventure activities are taken out of an educational, or even recreational framework, and presented and counselled in an almost identical and standardised way within an adventure therapy programme". We were wary about simply taking a developmental approach and thus combined outdoor activity experiences with the setting of therapeutic objectives, and a significant amount of time was spent processing the outdoor experiences at psychological depth. Both before and after the activities, individual therapy sessions were provided during the residential. These sessions gave the women an opportunity to focus solely on their individual needs and enable work at psychological depth to be facilitated. In addition the outdoor activities were facilitated therapeutically as they took place.

The personal accounts below from Brenda and Maria highlight the value of the combination of activity and therapeutic work with a therapist. These accounts highlight how the more traditional forms of counselling integrated alongside the outdoor activities enabled them to identify personally meaningful issues and thus make relevant links to some of the underpinning causes of troubled eating.

Maria:

"Before the rope work, we each had ½ hour with out individual therapists... This was extremely useful as quite a bit of "stuff" came up particularly the knot in my stomach which I feel when I get angry. The therapist asked me to close my eyes and focus on the knot, and to go inside it and try to describe what it looked like and felt like. The image that came to mind was of a 'roaring furnace', which we linked to me 'feeding the furnace (anger) with food'. The session ended with the therapist asking me to think about what it would take start putting the furnace out. I was able to cry in the session with her. Part of me wanted to do this, for the release and possibly also to let her know how bad I had been feeling. But another part of me felt very foolish and silly and completely ashamed of myself, but hopefully I am beginning to overcome this part of me, realising its just fine to have a good cry and "let it all go".

(Journal)

Brenda:

"I realise from talking with my therapist that I am doing without my share because I'm not sure how much is my share. I will 'eat up' others share if they leave them there when I should (there's that word again - leave them so that they can have them later. I reckon I am needy/greedy or else I would not have the need for finishing off bits that other's apparently don't want. I need to check with my self about what it wants, how much it wants, when it wants it and then, if it's enough."

(Journal)

7.5.d Addressing issues related troubled eating through adventure activities

Images of sexual abuse are, for some women, highly associated with troubled eating (Burstow, 1992). Given the strong link between childhood sexual abuse and the incidences of troubled eating it was essential to be sensitive to the use of touch and physical contact in our work in the outdoors. In activities where touching was

involved, as it often is with outdoor activities, it was important to be considerate of past physical and sexual abuse that could have been experienced by the women. Consequently, guidelines similar to those used with survivors of violence and sexual abuse were applied. For example, helpers needed to obtain the women's consent before touching, allowing the women to retain control over their experiences (*see* Mitten & Dutton, 1993; Webb, 1993). Addressing this relationship between troubled eating and sexual abuse highlights the complex therapeutic skills required in managing and working at psychological depth in an adventure therapy context.

One of the objectives of the outdoor activities was to enable women to develop a greater awareness and appreciation of their self and body, and of the underpinning dynamics of their troubled eating. Hence, some of the outdoor activities were designed to refer specifically to the dynamics of troubled eating. For example, a nature-focused outdoor journey was used to help the women explore their individual relationship with nature, in conjunction with their relationship with troubled eating. In part, this was a way of exploring a relational model of eating disorder through the process of reconnecting with nature. This was an important approach to the programme as it avoided an over-emphasis on task- and success-orientated activities, and actively tried to emphasise the relational aspects of the women's experiences. Art therapy was used in conjunction with this nature activity, providing the women with an alternative expressive medium, to help them interpret the meaning of their experiences (*see* Hogan, 1997). It was important that, having made space for creative expression, sufficient time was allocated to address the therapeutic issues raised during this process. The journal entries below from Brenda highlights how she made metaphorical meanings from this activity:

"Meanwhile, back at this adventure, I found a thing which was dead but which had supported life in the form of a lichen. I took it to represent that my old life was dead and gone, but that new growth had taken place. If I had a magnifying glass in microscopes I would see even more life on it as it was

probably teeming with microscopic creatures. This was the object of how I felt now.

When we went for the second object to represent how we wanted to be on Friday I could not find anything as I did not really want to feel different, however, is this because:

a) I am scared of change

b) I want to savour this un-experienced feeling of ok-ness

c) I don't know how else to feel.

I need to explore this with me therapist. I want to be able ....that the 'stick will get trampled underfoot by everyone in life. I want to change. I want to push these people and say "Whoa. Look at what you are doing to my stick. Look how you are trampling the life out if it and spoiling its beauty. It has needs and a right to live as parasites feeding on me., the host, until I am a dry stick too. Do I need to have to wait until then before I am left alone and my lichen can grow? Well! I am not going to let you. We all have to have responsibility for life, not just our own, but for others too. But it must be equitable – give and take.

As I sit here with my journal at 7.30am I am aware of profound insights into my life. In particularly, there is X, - which I see as a parasitic and polluting. I need to follow this further and will do so. My life must change. The wheel is turning and I will not be crushed under it. It is inevitable as the day will pass into night, so my life will pass into ....."

(Journal)

When more task-orientated outdoor activities were used, it was important that the dynamics of troubled eating should not be reinforced, for example, by the women not being able to listen to their bodies. It is the nature of high perceived risk

activities that they can encourage participants to overlook listening to the body, as they tend to require a denial of personal choice and can, "foster an attitude of 'pushing through' one's feelings to get to a 'better' place" (Mitten, 1994: 77). In order to avoid this, the team was mindful of how these activities were presented and therapeutic support was available throughout all the activities. The staff delivering the activities were continually mindful of how traditional ways of facilitating may be inappropriate in the context of addressing women's specific needs. For example, comments such as "go on you can do it" were not used because they encouraged a denial of physical self and personal needs. One activity (a high ropes course) was completed in total silence. This demonstrated how the women needed to determine their preferred way of engaging in the activity. Otherwise there would have been the risk of others in the group taking away individual control, and inadvertently reinforcing the underlying feelings of powerlessness that are associated with the development of troubled eating.

7.5.e Video work: developing personally relevant metaphorical meanings

Video work was used as a therapeutic tool to enhance the therapeutic meaning and depth derived from the outdoor activities (this technique was also used as a research method, see Interpersonal-Process Recall in Chapter Five). The women's participation in the ropes course activities were video recorded and then played back in individual therapy sessions. With the support of the therapist, the women were then able to explore in more depth the meaning of the ropes course experiences. In addition to meeting the research objectives, the video work also served to initiate a process of whereby participants could reflect more fully upon how they viewed and related to their body. However, it could not be expected that the women would easily let go of their negative body images. As suggested by Hutchinson (1994: 165) as women we, "have built our identities around the struggle between ourselves and our bodies. Letting go of negative body attitudes threatens the very foundation of how we see and construct our lives". Thus, the use of videos was challenging for some of the women, providing a direct visual image of their body. Hence, they were

not pressured to use the technique and, if they chose to, were supported in working through their concerns about using it. Three women chose to use the technique. This highlights how ethical dilemmas need to be carefully considered in all aspects of the research process. In addition, it shows that because negative body image exists for a large number of women, the use of video techniques may present a gender issue that needs to be carefully negotiated in outdoor experiential programmes.

The women who choose to use this IPR video technique reported gaining a greater awareness of what their issues and goals for therapy were. The benefit of this approach, from a feminist and therapeutic perspective, was that the outdoor activities generated metaphorical meanings that were of individual significance, rather than imposed. In general, the video work enabled the women to see the metaphors and expand on them and explore them more fully, enabling them to identify individual therapeutic objectives on which to focus during the remainder of the intervention. One woman, Brenda, who used IPR was able to understand more fully what her experience of the recorded event meant for her. She wrote in her journal entry at the end of that day how her experience of taking part in one element of a low ropes course (the enclosed net) had symbolised a process of rebirth:

> *"When it was the enclosed net (which I had not realised was enclosed, I realised that I was trapped). I could not push out with my elbows sufficiently enough it give me room and this was because my weight/gravity on my mass was greater than the force I could exert. As it narrowed I felt trapped and exhausted and was between two tree trunks. I felt able to ask the crew to pull the netting away from the tress to give me room. I wanted to be cut out and it and the encouragement and instruction from the instructor was not helpful but not unhelpful either.*
>
> *I was exhausted but had to consider my options. I could try and reverse or I could try and go on. I decided to try and go on and I took the time with my therapists assuring me I had 'all the time' I needed. Once I had my*

shoulders and arms free I was OK but exhausted –drained. I carried on however, and didn't feel as if I was pushing myself but only that it was the natural thing to do. I did not complete the very final push and did not feel that was necessary or that I had failed.

The experience was a birthing experience. I wanted to get out and I was trapped. I wanted to be cut out because of the harness and I had to make a decision to come out under my own steam as others couldn't do much to help, particularly the net. But I couldn't blame the net any more than I could blame my mother for my birth. It just was - history!

Did I need re-birthing? I think I have just done that on the ropes. I did it on my terms and in my time.

What I have learned (at end of day with activities)

1) *That I have to trust – I did trust and it was to the front of my mind*
2) *That even when we sort out the ground rules (about needing help and what help we need) we sometimes forget to ask. That is OK.*
3) *That sometimes you just have to feel the fear and do it anyway. Only I can do something's for myself. Trust that even if it is difficult and painful, I can do what it takes to make me safe.*

(Journal)

Brenda, who had been experiencing bulimia for many years, discovered how she was struggling to free herself from the excessive demands of dependent members of her family. As she took part in an outdoor adventure activity she developed a clearly felt sense of what that entrapment meant for her as she struggled to traverse a cargo net on a high ropes course. As her weight caused the net to close round her she experienced the entrapment created by her family and her binge eating response to them.

Another woman, Maria, also reported the significance of her experience of taking part in an outdoor activity. The use of IPR was particularly useful as this enabled her to acknowledge how she was becoming more self-accepting of herself and how therapeutic change was in action:

"Today we went on the high ropes I was anxious about it for most of last night and first thing this morning. I had agreed to go first, as yesterday I let (made) Jackie go first. This was doubly scary, as I could not see how anyone else coped with it, I just had to get on with it! (the fear of the unknown). When I got up to the first "obstacle" I became "frozen with fear" and could not move. I was "rooted to the spot" unable to go forwards or backwards and I started to cry at this point. I felt quite silly at first, but then I just let them flow and I felt a bit better for the release. With support and encouragement from the others, I managed to "move on" and complete the course. It was <u>really</u> scary, but I DID IT! And what a sense of achievement at the end. I can conquer the world! And was able to help the next member with the obstacles. It was worth going through the feat to feel GREAT!

I then looked back over the 2 videos of the rope work with the therapist [IPR].. It was a "strange" experience, because I felt so much empathy as I watched "Maria" go around the course. It was like had "stepped back" and "distanced myself" from "me". I have never felt this way before, I usually "cringe" at the sight (or even the thought) of myself on video, usually with much hatred and self-loathing – but today it was different; <u>nice, comfortable.</u>

I was also able to make some links between all my issues around "fear", feeling "trapped" etc and my eating behaviour but some of them still need exploring deeper. The therapist mentioned about going into the woods and "crying" with the emotion of its beauty. Because she struck a chord in me, the tears flowed yet again.

I feel like something is really beginning to happen, things are changing and for the better. And I feel I am finally making contact with the "real me", my "inner strength", my own healing forces. For me, this trip is proving to really successful to now."

(Journal)

Both of the women's experiences above represent significant therapeutic movement. It could be argued that it was only the combination of the ropes course activity, IPR process and skilled therapeutic interventions by the therapist who worked safely at psychological depth, that the women were able to process the significant meanings of the experiences. They are both profound examples of what adventure therapy looks like from the perspective of clients and their accounts offer some indication as to the potential that adventure therapy has for achieving therapeutic goals and facilitating psychological growth.

7.5h Critical feminist incidents

In trying to work in accordance with feminist ethics the theraputic team recognised that there were occasions when these standards were not achieved and led to a negative impact on the women. And in fact the incident described below was corroborated by what the woman wrote in her journal. Josie, had a specific health concern and was currently on medication for high blood pressure. Even though she had expressed her anxiety relating to this issue, the team for some reason had overlooked this and were not responding fully to her anxieties. Her concerns accumulated in her choosing not to participate in one of the ropes course activities. It was the related events to this specific incident and her experience of them that lead to her feeling relatively disempowered. Part of her journal entry for that day clearly expresses this:

"When I didn't do things I think my level of self esteem went down and I felt quite bad about not doing it, probably that's the biggest issue for me. I enjoyed doing things but that were well within my physical capabilities, I felt

really good about doing them and I really enjoyed doing them, I really enjoyed doing things. I think that would be important within the programme, that people realised that they were really going to be stretched physically. I would have to be very careful, I know the GP signs the things, but I don't know whether they just put their name to something, how well do they really know their patients, are they going to give them a bit of a check before they go, I doubt it, they probably just sign the form along with all the other things they've got to sign, I think you'd have to be quite careful.

Because I think the consequences of not doing them, because of your level of fitness and health problems you can't do these things, I think it's quite significant when you don't do them, as far as self esteem goes and how you feel about yourself, it's not just something you can brush off, it's quite significant really for your own self esteem and what you get out of the programme as well. It's very inhibiting and quite damaging really, damaging to your self esteem, in hindsight maybe I might have pushed myself a little bit more. I'm not sure, because I know my blood pressure wasn't very good and when I went back it was high, well not high but it was raised, I had to go onto stronger tablets, so I would say that people definitely need to check. It wouldn't be enough for the doctor to say yes I'm OK, I think if people have got problems then they need to look into that and they need to think quite seriously."

(Journal)

It is clear from Josie's reflections that the team had overlooked the ways in which the invitation to take part in the outdoor activity was in fact silencing her and exerting power over her and her body. At one point the instructor in fact told her 'we're going to require her to put on a harness at least, and to wear the equipment', so she spent the time of the activity in a harness. However, there was no need for any practical or safety reason why this was requested. Furthermore, the

opportunities for empowerment rather than disempowerment in this situation were not addressed, whereby participation in the outdoor activity took priority. Also, even after the incident the team failed to use this as an opportunity to examine concepts of empowerment and disempowerment, so the learning from the incident continued to be overlooked even further and it is clear that for Josie this was neither a woman-centred, or successful therapeutic intervention.

After this incident happened the therapist team considered ways in which they had not conformed to standards of feminist practice as they did look back at this incident and recognised the implications of this. Interestingly, on examination the incident linked back to an issue that emerged in relation to practice – that of maintaining effective therapeutic practice without adequate supervision and the ways in which the counselling aspect of outdoor therapy had been mismanaged. This issue is discussed further later in this section, however, in the meantime, to illustrate the concerns raised the dialogue of the therapeutic team during a focus group in which this was discussed is provided below:

K: What struck me there is about power, and body and if you think about the actual physical thing of putting on a harness.

V: :And what that symbolises in terms of body and power.

K: That's actually one question I want to ask, that's illustrative of it, is how there were episodes, for example like that, where the body and the way we worked impacted upon power with the body, so what were the times when the body becomes disempowering by the way we worked ...

B: There was another incidence wasn't there, when they were doing an activity and she didn't want to take part in to begin with ....

J: And also she used her power in not coming. To stand alone in that and not succumb to the pressure.

V: We never used that as a way of looking at issues did we, we never drew that as an opportunity to look at what it meant to be empowered, what the dynamics of that was.

B: Quite a lot of the time she wasn't very powerful, she stood aside and she was very cold, her hands were cold and she was shivering, it was cruel now I think about it, while everybody was working. She was doing odd things, like holding onto ropes when it was necessary, but they were things at the side, it wasn't central things, supporting others but not in big roles, not standing there and talking somebody through.

J: But if we'd had had the opportunity at the time to analyse like this, we could have changed something there and then. I don't think we looked after ourselves. For me I plunged in, I went whole hog, I was shattered for days afterwards, mentally and physically, in fact I was shattered for weeks afterwards, and I don't think we put enough in there to take care of ourselves to actually work out what was going on.

B: That would be a difficult thing to do if you have this picture of not having them and us, because in order to take care of ourselves we actually have to have time away, which we did, but that creates us as different.

J: Maybe because it was research we had to be different. Because we have got a different agenda haven't we, we need an outcome, whether that's positive or negative.

This incident points to the ways in which careful management of participation in outdoor activities and its related psychological processes need to be achieved. It also alerts us to the ways that the 'body' continues to be a site of personal and psychological meaning and how supervision could have enabled more immediacy in addressing such issues (this issue is discussed later in this chapter). Even when a team were actively working with feminist principles the incidents highlight how coercion can unnoticeably happen.

7.6 Phase Four: The post-residential follow-on and sustaining change

7.6.a Post-residential therapeutic adjustment

The maintenance of change is essential in knowing how successful an intervention is, and is often the area in which research in adventure therapy is limited. Examining how experiences are transferred to everyday life and how change has been maintained gives greater insight into the overall therapeutic process.

Throughout the intervention the women who had started experiencing change were concerned and wanting change to be maintained when they returned back to every-day life. Maria raises this in her journal mid way through the residential,

> *"I feel the whole experience is really helping me to "confront parts of myself" and "let things out / go". However, I am a little uncertain as to how I am going to "take it all back with me to the real work". I desperately want to do this, but I feel I will arrive home on Friday and just fall into my old patterns of behaviour. I just hope that ongoing support will be available, else all the hard work of the week may be in vain."*
>
> (Journal)

Brenda also raises her concerns about transferring the experiences to everyday life,

> *"All of these things that I have addressed and found in the journey of discovery through Adventurous Growth will be difficult to transfer into everyday life, but I'm sure if I communicate clearly, explaining my needs, set my boundaries and search for the 'how to transfer it all' manual inside myself, I will be able to d o it. It may be like constructing the MFI wardrobe and take some time to get it right and it may be flimsy, but it will be a start and I can construct the solid pine wardrobe when I feel ready ... Thank you all for allowing me to grow and find the 'me' who I recognise but which I thought was lost forever."*
>
> (Journal)

From an outdoor adventure perspective, Allison's (2000) analysis of post-expedition adjustment uncovers some of the dynamics of the return to everyday life, identifying how there is a grieving process upon return from expeditions. He suggests that, "it would be reasonable to understand post-expedition adjustment as a grieving process, perhaps the grieving of the environment, of the people and the community, of time alone or most likely a combination of these and other aspects of the expedition experience" (*ibid.*:34). From an adventure therapy perspective such a grieving process needs to be examined within the context of the therapeutic processes. The impact of any transition process may be a critical factor to manage when working within a therapeutic setting. For example, the client and therapists on the residential will have worked hard to develop a therapeutic alliance in the relationship, and thus, feelings of abandonment can easily be increased if this process is not carefully managed. This may be particularly significant, in this case, given the level of depth the therapists felt they were able to achieve in such a short amount of time.

7.7b Maintaining therapeutic change: Participants experience of Phase Four

The post-residential follow-on phase was comprised of a six-month programme of bi-weekly, or weekly evening meetings. As the aim of the whole programme had been to generate self-supported healing in the women, the objective of this phase was to ensure that the women were able to transfer the healing that had taken place on the residential to everyday life. If changes had occurred the women would then have to find strategies to maintain change, as troubled eating behaviours would not necessarily stop immediately. This process of trying to maintain change is illustrated by Maria:

> *"After residential: I did worry a little bit last week, about putting weight on, as I did eat rather a lot, I have put about 2-3 pounds on, but am not as concerned as I would be normally. However, I intend to try and eat when I am hungry, rather than 3 set mealtimes, and to watch the quality of my food rather than the quantity. I am hoping that I will not experience the urge to "stuff myself" with food, as it is no longer necessary to "stuff down all my feelings" or to be afraid of "letting out my feelings and emotions" ... Anyway, today I haven't focussed on food as I normally would, and am trying to eat when I feel hungry. I am also aware of the necessity of incorporating some exercise into my time. (For healthy reasons, not just weight!) so this morning I went for brisk walk. I am go for another one this evening, if the weathers nice and if I feel I like it!."* (Journal)

Also, some of the women did not want to prolong the emotional strain involved in working therapeutically, as Katy expressed:

> *"It became harder afterwards, in a way afterwards because I was feeling pretty good about myself, I didn't want to go back because I remembered how emotional it was, I didn't want to go back and bring up all those emotions.*

The other thing is that I was almost like I was happy to go along ignoring the fact that I have had problems, which I feel really guilty about now, I felt like I should have supported you more...And at the time I wasn't needing support anyway, I didn't want to risk going back and speaking to counsellors and dredging it all up."

(Final interview)

The re-adjustment difficulties some of the women faced highlight the importance of setting clear boundaries and contracts, in order to manage individual expectations of adventure therapy programmes. Also, simply thinking that dramatic changes at the end of a residential intervention have positive benefits might be an inadequate understanding of the complex processes of therapeutic change and healing. Coping strategies, such as disordered eating, may, in fact, be reinforced when these dramatic changes need to be integrated into everyday life, as was briefly referred to by one woman after the residential.

Katy: *I think it [my troubled eating] was the same if not a bit worse initially, because I'd lost the security of being in that environment... I was worse again when I came back without the support of the group.*

(Individual closure interview)

For Andrea, her experience after the residential reinforced her sense of loneliness in everyday life and her eating seemed to get worse as she found the experience of loneliness more difficult to cope with:

"I felt so good to be with you all in the Lake District. I didn't feel at all stressed and it was such a lovely feeling, I didn't feel any pressure from normal everyday life. It all came back as soon as I got home.
I feel really alone right now and since I came back. Everyone seems so far

away. I miss talking to people who really understand and care and with similar problems and experiences. I felt positive, full of hope and strong when I was with you all. I didn't feel stressed or under so much pressure. Now it has all come back being here. I don't know what to do, if I can be helped. I feel so alone and sacred. I don't like being me. I wish I wasn't like this. I feel desperately unhappy, my eating is getting worse."

Andrea's experience highlights how her awareness of the difficulty of her day-to-day life had been raised as a result of the intervention. She found it difficult to maintain these positive feelings back into everyday life. This raises a feminist question about how her social situation limited her capacity to integrate change into everyday life. Reading her personal journal in more detail provided an awareness of the difficulties and distress of normal day-today life activities– as soon as she returned home these patterns of behaviour, thinking and feeling returned.

The ability for participants to maintain therapeutic change is a key consideration of any intervention. It became clear that the opportunities for maintaining change were not as effective as they needed to be and the programme lost some of its momentum. Although, some of the women did maintain change (as is discussed in Chapter Eight). there was still a need to have developed more effective strategies in this area. Therapists recognised how the women may have felt abandoned in some way, as one therapist comments,

"I think she experienced me as having abandoned her at the end. I mean the relationship had an impact and then they just left."

The most ideal situation would be for the individual therapists to have continued working with the women in a similar way as on the residential. Given that the therapists had worked at psychological depth this could have been capitalised on more fully and helped the women in managing the transitions back to every day life.

As the follow on programme continued it was important to continue the theme of personal empowerment and consequently the follow-on period was seen as a time when the women would assume more responsibility for initiating, directing and sustaining their own recovery programme. In practice it was soon discovered that these objectives placed excessively high expectations on the women. In particular the feminist intention of empowering the women led to too weak a structure for the evening sessions. The lack of defined structure proved demoralising and disappointing for the women and affected their ability to transfer the gains made on the residential to every day life. Most of the women expressed dissatisfaction with this stage. For example, Maria commented how the group identity became fragmented:

> *"But it was all a good experience, it surpassed anything that I could have expected, the actual Brathay experience, but afterwards was disappointing because there was talk that there would be something else, it would go beyond Brathay, it would carry on and we could still keep that feeling that we had then. But it just flopped.*
>
> *... There was something very spiritual about it and I felt sure we could have taken that back with us and continued..... my expectation was that we'd carry on as a group, not in the way that we did, because the group seemed to disintegrate and drift, we drifted as a group."*
>
> (Individual closure interview)

Katy, comments how after the residential she experienced heightened feelings of loneliness and found it difficult to adjust without the high level of support and understanding that was on offer during the residential:

> Therapist: *And that experience of support, what happened to you when you got back off residential?*

Katy: *I felt it was all gone, I felt disappointed and let down, I felt that was just on a course. I could have done with someone to talk to a lot of the time really. Just going back to the meetings just felt so strange. Being there was brilliant and then you just get back to reality, but it seemed even worse than ever before.*

Therapist: *And that's really important to acknowledge that reality seemed more difficult after the residential than before. Was that because you'd experienced such extreme support and understanding?*

Katy: *Yes, because everyone was there for you. It was quite lonely coming back as well. You're on your own, everyone has gone. It just takes time to re-adjust I suppose.*

(Individual closure interview)

At the time the women were able to describe their dissatisfaction and, in response to their needs, a structured programme was devised around a series of relevant topics. The new programme included us all attending a picnic in an outdoor setting, workshop sessions on the development of personal coping skills, an examination of the impact on our lives of the social construction of the body, planning the creation of a personal video story and a final closure review session built around experiential activities and individual interviews.

There is no doubt in the therapeutic team's mind that the follow-on sessions had the potential to contribute significantly to the women's recovery. A number of them, however, fell short of achieving this for extraneous reasons. For example, the purpose of holding a shared picnic – to celebrate renewed relationships with the self, others, the outdoors and troubled eating – was not achieved because the occasion was not fully therapeutically processed within the context of the women's everyday lives in terms of societal influences. Nevertheless, the team learned

valuable lessons from engaging in the follow-on. We learned that, whilst the aims of feminist practice are undoubtedly essential, achieving them required a progressive approach, recognising the social and cultural barriers that may impede progress. Initially, the therapeutic expectations of the women were too high and, at the beginning of the follow-on programme, it was important to provide a high level of support that reflected both the therapeutic depth worked at during the residential and the women's continual need for structure. This highlights the difficulty associated with transferring the initial change from outdoor experiences into everyday life, which may be even greater with an adventure therapy process. Had the team had the knowledge and resources to continue to provide a therapeutic programme that matched the women's expectations and needs in the follow-on period, the whole adventure therapy process would have probably had a greater impact on the women who participated. As it was, the therapeutic impact of the residential was enormous but, as is the case so often, the effect was somewhat diluted once the women returned to their everyday setting.

During the final closure session the women, when the women were interviewed one-to-one, identified how they defined personal change and the ways in which they thought the adventure therapy intervention had aided such change processes. For the women that did not attend this session, interviews took place at other convenient times for them. The interviews had the dual purpose of helping the women to review their experience in more depth, as well as gathering important research data on the ways in which the experience might have impacted upon the women's troubled eating. The women also completed the EDI questionnaire for the fourth and final time.

7.7 Phase Five: Continuing developments in adventure therapy

The final phase of the programme involved sharing the learning that was gained from the intervention programme with a group of professional peers. The dialogue

with professionals also allowed us as a team to reflect upon the adventure therapy approach that had been developed and to consider the ongoing development of adventure therapy in a wider professional context. A selection of therapists and professionals operating in a variety of therapeutic contexts, including the outdoors, were invited to participate in an adventure therapy weekend.

The feminist, adventure therapy approach to the weekend was similar to that of the residential for the women with eating disorders. The team set a clear agenda for the weekend, which included an emphasis on therapeutic intervention, as distinct from personal development. The implication of this was that everyone who participated would be invited to work at a significantly deep psychological level. It was hoped that the participants' reflections on the impact of the programme for themselves and its relevance to their professional contexts would deepen our understanding of the change processes involved in adventure therapy.

The therapists' weekend differed from other parts of the intervention in that men were involved, which meant that the therapeutic team had to negotiate feminist issues in a mixed gender setting and, thus, this brought gender issues to the forefront. As female therapists working with men it was noted that we found ourselves reacting to the men in ways that were markedly different from the ways in which we interacted with the women in the outdoor adventure setting. We were more hesitant in trying to facilitate their processing of the experiences and, in general, we stayed a greater psychological distance from them. Overall, working with a mixed group meant we had many more complex processes to critically evaluate as we tried to manage an adventure therapy process and address gender-projected thinking (*see* Bonds-White,1996).

A number of additional issues were highlighted during the weekend. Although the aim was to work at a level of psychological depth, some participants found it safer to push emotions (like fear) out of awareness as they engaged with what can be

perceived as high-risk activities, such as the 'Pamper Pole'. These reactions gave an opportunity to observe the defences used by participants to reduce the impact that a full engagement with the outdoor adventure activities could produce. Several of the participants also found themselves uncomfortable with the notion that, as therapists, it is a professionally appropriate expectation that they should engage in their own process of developing self-awareness and personal growth. Thus, some of those who came from the worlds of development training, occupational- or cognitive-behavioural therapy had difficulty with the expectation that they should engage with activities in a way that was personally meaningful rather than using a goal-orientated, or task-accomplishment approach. The tendency to cheer people on and encourage them to accomplish tasks conflicted with the more therapeutic approach of enabling people to experience themselves fully in the novel settings.

Therapeutically, the aim was to help participants focus on their own process as they engaged with an activity and to engage in depth with the meaning that the activity had for them. It was important for participants to use the outdoor activities in ways that they found most growthful, rather than being chivvied into achieving targets set by others. All of these issues helped to distinguish the unique features of the adventure therapy process as described earlier, from other forms of outdoor experiential learning. It became clear that the acceptance of this personal therapeutic approach will be essential for future developments of adventure therapy.

Chapter Eight:

The women's experience:

The evidence for psychological change

8.1 Chapter Overview

Having provided some analysis of the implementation of the intervention this chapter will now consider more fully the women's direct experiences from a psychological perspective. It will examine what impact the programme had on the women and in what ways any identified impacts lead to sustained change – i.e. did the intervention work? An initial overview of change identified from the data analysis of each woman's experience will be discussed. As part of this, the scores across each dimension of the Eating Disorders Inventory (EDI) are also examined. The chapter then examines the key therapeutic ingredients that, from the women's perspectives, were present during the intervention, highlighting the ways in which these lead to any identified psychological growth. In conclusion, the chapter will provide an overall assessment as to the potential adventure therapy may have as an intervention for troubled eating for women.

8.2 An overview of change

Table Seven (below) provides an initial overview of the ways in which changes were evident for each woman. As can be seen the women had a range of presenting problems, along with differing evidence and perceptions of change. In the longer term key components of a successful intervention for women with troubled eating are changes in attitudes towards food, eating behaviours and patterns, and developing a more positive body image. There was evidence that the intervention made a positive impact on such behaviours for four of the six women.

The evidence in Table Seven is drawn from a range of data collection methods (as noted in the table and discussed in Chapter Five). The scores across each dimension

of the Eating Disorders Inventory (EDI) offer further triangulation of the qualitative data; in fact the changes on the dimensions of the EDI corroborated with how the women presented troubled eating along with their more detailed accounts of change. So although the scores from the EDI are not statistically examined, they provide another valuable data point, especially as they help to monitor change across a range of related dimensions. As previously identified (see Chapter Five) any score over zero on any dimension indicates some tendency towards that symptom, and obviously the higher the score the more clinically significant that tendency is for that woman. Also, it would have been useful to have had EDI scores from the women sometime before taking part in the intervention to have more confidence in what the scores represent.

There are gaps in some of the women's accounts, in that more research data were collected from some women and not others. As a result, there is a danger of bias created by experiences which have the most data. Where a lot of data is missing (i.e. for Jackie because she chose not to complete some of the methods) therapist observations are used for further triangulation. It could also be argued that those who had experienced most change/or most motivated to change might disclose more of their day-to-day experiences. However, this was not the case in this study - Andrea who did not offer evidence for any sustained change actually wrote the most detailed research journal.

Table Five: An overview of change identified for each woman

Woman	Research tools completed	Examples of troubled eating at beginning of intervention	EDI Score Changes	Themes of positive change identified from qualitative data	Individual perceptions of change	Perceived Negative impact
Maria	General Info Sheet Personal Journal EDI (at 4 time points) IPR End of programme interview End of intervention focus group	• Out of control eating and overeating • Stuffing down feelings with food • Feeling guilty about eating • High level of body dissatisfaction • Negative self-image	*Significant change:* * Drive for thinness * Body dissatisfaction *Some change:* * Ineffectiveness * Perfectionism *Slight change:* * Bulimia * Interpersonal distrust * Introspective awareness * Maturity fears	• Increased positive body image • Reduced troubled eating thinking and behaviour patterns • Improved self-confidence • Increased self-awareness • Increased relational connection with others • More positive outlook on life	*Personal change:* I feel not a completely different person but much different to the person I was just before the residential. (Interview) *A growthful experience:* It was like a turning point in my life, definitely … it was a big turning point for me, the whole experience, in terms of personal growth and in terms of eating as well. (Interview) *Accessing inner resources:* I feel like something is really beginning to happen, things are changing and for the better. And I feel I am finally making contact with the "real me", my "inner strength", my own healing forces. (Journal) *Positive life outlook:* And to think that two weeks ago I was so low, that I wondered what the point was to anything. I felt so lonely and afraid, I felt I had nothing. But now I have hope, and new friends, new confidence and whole new outlook on life and new plans and goals. (Journal) In general I am feeling quite happy, positive, hopeful and excited for the future – I think I'm finally beginning to live! (Journal)	**Follow on group disintegration - disappointment**

Woman	Research tools completed	Examples of troubled eating at beginning of intervention	EDI Score Changes	Themes of positive change identified from qualitative data	Individual perceptions of change	Perceived Negative impact
Brenda	General Info Sheet Personal Journal EDI (at 4 time points) IPR End of programme interview End of intervention focus group	• Bingeing and purging behaviour. • Bulimic episodes. • Eating to fill the loneliness • Needing to eat to make self big enough to do everything and to be big to get noticed • Need to eat so won't die. • Afraid and never feeling safe. • Never felt held by anyone .	*Significant change:* * Bulimia * Introspective Awareness * Ineffectiveness * Body Dissatisfaction (at end of residential and then started slowly increasing again) *Some change:* *Drive for thinness * Perfectionism	• Motivation for change • Increased self-reliance • Reduced troubled eating thinking and behaviour • Redefining of troubled eating to troubled relations • Using new skills in everyday life • Ability to extend and manage widened comfort zone more effectively • Courage to continue with personal change and growth • More positive outlook on life	*Significant changes:* In terms of pre-Adventurous Growth to where I am now, I suppose the change has been quite subtle in its way. I think if we were measuring where I was before and measuring where I was now, the change would be massive, but it's just been part of a day to day process of change and therefore trying to say exactly how that occurred is hard. (Interview) *Changes in relationships:* It has changed so many things it such a short time. My relationship with my family is different and I feel like the person is separate from them, but part of the group. It feels healthy (Journal – 2 days after the residential) *Cathartic experience:* I do very much feel that it was cathartic, so that was something that actually affected the change, if that hadn't have happened I don't think I would have even been where I was, because where I was on a downhill slope really. (Interview)	Follow on group disintegration and lack of intervention focus

					Finding inner resources: Between where I am now and then, the comparison is very different. (Interview) So I suppose defining the change which has occurred with Adventurous Growth would be really that it has been major change, but it hasn't felt too uncomfortable really and it was to do with Adventurous Growth enabling me to find something within myself to do that. So instead of me having people outside belaying, I realised that it was something inside me that could belay. (Interview)	

Woman	Research tools completed	Examples of troubled eating at beginning of intervention	EDI Score Changes	Themes of positive change identified from qualitative data	Individual perceptions of change	Perceived Negative impact
Josie	General Info Sheet Personal Journal EDI (at 4 time points) IPR End of programme interview End of intervention focus group	Moved along continuum of troubled eating to compulsive eating behaviour now being less. But still not a comfortable relationship with food. Still not entirely comfortable around food, although she no longer diets and no longer weighs herself, she constantly reckons up in her mind how much food she has eaten during the day. Her own experience of being in the outdoors in touch with nature, has previously led to a reduction in food intake.	Generally scores didn't indicate troubled eating symptoms and thus few changes reported, apart on one dimension. *Slight change*: Body dissatisfaction	• Reinforced changes already made in relation to compulsive eating • Increased feelings of reassurance about ability to manage eating in unknown situations. • Feelings of connection to other women left some feelings of empowerment	*Reinforced change:* I don't know how much Adventurous Growth in itself changed me, but what it did do for me was underline how I changed, reinforced the changes. (Interview) I don't think my eating has changed actually … Yes it did basically [reinforce what my changes have been]. So really I would say it underlined this metamorphosis if you like, in myself, that's taken place over all these years. (Interview) Feeling empowered: One of the things that struck me was how empowering being part of a women's group is, how you can feel empowered, the strength that comes from being with a group of women who have empathy for each other and know their situation, and how good that felt. (Interview)	Overlooked directly addressing issues of body image Overlooked other physical concerns that impacted negatively on self-esteem and reinforced low self-esteem. Follow on not maintaining empowerment from the group

Woman	Research tools completed	Examples of troubled eating at beginning of intervention	EDI Score Changes	Themes of positive change identified from qualitative data	Individual perceptions of change	Perceived Negative impact
Andrea	General Info Sheet Personal Journal EDI (at 4 time points) End of programme interview	• Clinically depressed, with some suicidal thoughts. • Bingeing and purging behaviour • Obsessive negative thought patterns about food • High level of body dissatisfaction	She had the most significant symptoms across all EDI dimensions. *Significant change*: Maturity fears *Some change*: Perfectionism *Some change during residential, but not sustained*: Introspective awareness	Positive experience of the residential, but evidence of sustained change.	No identified perceptions of change.	No impact Difficult to readjust when returned home.

Woman	Research tools completed	Examples of troubled eating at beginning of intervention	EDI Score Changes	Themes of positive change identified from qualitative data	Individual perceptions of change	Perceived Negative impact
Katy	General Info Sheet EDI (at 3 time points) IPR Personal Journal End of programme interview	• Bingeing and purging behaviour. • Bulimic episodes • Body dissatisfaction • Perfectionist tendencies	• Not sustained change across any dimensions. However, change in bulimia during the residential. • Some small increases on perfectionism and introspective awareness during residential.	• Some changes of eating behaviour initially • Indicator of small change in troubled eating thinking and behaviour • Increased self-confidence • Able to make more positive life choices.	*Improved troubled eating behaviours:* After the residential, a couple of months after, was probably the best I've been since the whole eating disorder started *Improved self-confidence:* I think I was desperate to get out of that cycle because I realised it wasn't getting me anywhere, but I think the residential gave me a lot of the tools to do it, even if it was subconscious, because a lot of it was, but it did give me a lot more confidence. *Normalising eating:* Well my eating pattern did change [during the residential] because I wasn't at home, it was totally different to how I would eat at home. I think it did make me realise that I could eat relatively normally, eat three meals a day, I felt comfortable *Positive life choices:* So now I'm looking for experiences that will help me in life, things that I'll enjoy doing.	Pressure on eating during residential and need for secretive eating Troubled eating initially worse immediately after the residential Pressure to continue with follow on meetings

Woman	Research tools completed	Examples of troubled eating at beginning of intervention	EDI Score Changes	Themes of positive change identified from qualitative data	Individual perceptions of change	Perceived Negative impact
Jackie	General Info Sheet EDI (at 3 time points) End of programme interview	• Self-neglect by not feeding self • Some level of body dissatisfaction	*Slight changes*: Introspection Interpersonal distrust *Slight increase during residential:* Introspective awareness	She provided no key qualitative data.	Individual perceptions of change from qualitative data not available	None reported.

8.2a Maria: An overview of change

Maria presented a range of troubled eating behaviours. These included out of control eating and overeating, managing feelings by troubled eating, a high level of body dissatisfaction and a negative self-image. When asked as to whether she had noticed any particular signs of change as a result of Brathay she made strong claims that the intervention had reduced her troubled eating:

> *"Definitely there has been. Going back to the food, there's a definite change, because before Brathay I was caught up in a battle of constant near-starvation, dieting, starving, and then obviously being hungry I wanted to binge and I am not doing that as much now.*
>
> *....Well I'm not bingeing so much because I'm not starving. I still feel that I'm eating too much, but I enjoy food. I still use food to comfort me but it's not as bad, not as desperate, and I have given myself more permission to relax where food is concerned."*
>
> (Individual closure interview)

A key aspect of being able to reduce her troubled eating was that she became more accepting of herself and experienced fewer associated feelings of guilt with eating.

> *"Oh yes [quite a move forward because it takes such a load off]. I still give myself permission to eat something when I'm feeling stressed. There was an example in work a couple of days ago, I just got myself into a bit of a state and the stomach was all knotted and my first thought was right, I'll go and get a bar of chocolate. In the past I would have been really*

angry with myself for having felt like that or I would have gone and got the chocolate and then I would have been overcome with guilt. But I recognised the need for the chocolate and where it was coming from, it was related to the stress and I thought sod it, let's go and have a bar of chocolate and be done with it. There was guilt, but it wasn't anything like it has been in the past. So that's a definite sign of change for me."

(Individual closure interview)

A key change for Maria was an increase in her self-esteem, where her focus moved away from managing her troubled eating to considering how to empower herself. There are many examples in her journal and individual closure interview of how she became more self-accepting and positive about whom she was. Her self-esteem became less hinged upon her body image, whereby she was able to be more accepting of who she was and thus her self-undermining cognitions reduced:

"I feel more confident about myself, in myself, more positive about myself. I still get the feelings that I'm useless and worthless, but I'm changing, I'm looking at myself differently."

(Individual closure interview)

As the adventure therapy progressed Maria was able to access her own inner resources:

"I feel like something is really beginning to happen, things are changing and for the better. And I feel I am finally making contact with the "real me", my "inner strength", my own healing forces."

(Journal)

In understanding how these changes occurred for Maria, an extract from her journal offers a glimpse into the process of change that occurred for her. Here she describes how she was becoming self-aware of what maintained her troubled eating and she was able to gain strength and compassion for herself through self-expression and self-acceptance. Consequently, her self-esteem became less tied up in her body image:

> *"On last day of residential: I have just been reading the entry for 2 March, I am aware that my feelings of physical self-consciousness have not been an issues at all on the programme. It seems my self-consciousness has been to do with "what's inside me" and now what's on the outside. I hope I can take this back into the "real world" with me. It's been the fear of "letting go" of what's inside and the fear of letting anything or anybody get inside me. But this week has proved to be a breakthrough, and I have let lots of "stuff" out, and taken in lots of "new stuff". I have cried so much, shown my feelings and emotions to all of the others – me crying in front of twelve people – and it was OKAY!"*
>
> (Journal)

It was evident that Maria was experiencing changes and the experience was transformational for her:

> *"It was like a turning point in my life, definitely ... it was a big turning point for me, the whole experience, in terms of personal growth and in terms of eating as well."*
>
> (Individual closure interview)

> *"I feel not a completely different person but much different to the person I was just before the residential."*
>
> (Individual closure interview)

And given these changes she had a more positive outdoor look on life:

> *"And to think that two weeks ago I was so low, that I wondered what the point was to anything. I felt so lonely and afraid, I felt I had nothing. But now I have hope, and new friends, new confidence and whole new outlook on life and new plans and goals."*
>
> (Journal)

> *"In general I am feeling quite happy, positive, hopeful and excited for the future – I think I'm finally beginning to live!"*
>
> (Journal)

The scores from the measures of the EDI correlated with the way in which Maria described her experience. At the beginning of the intervention she was towards the upper limit for Drive for Thinness and above the upper limit of Body Dissatisfaction on the mean scores of the normative date for anorexia nervosa on the EDI. Immediately at the end of the residential these scores had reduced (*see* Table Six for a comparison of scores). Her scores had now fallen within the means of normative data for the comparison group of college women (*see* Appendix Four for an overview of EDI normative data). This indicates a substantial reduction in her clinical symptoms from baseline.

In fact the intervention, although not as significant as the dimensions of Drive for Thinness and Body Dissatisfaction, had some impact on all the other dimensions. In terms of sustaining change the scores indicated that maintenance of change was evident for her. However, the scores on Body Dissatisfaction alert us to a possibility that over time body dissatisfaction is slowly increasing, but without longer term measures it is difficult to ascertain whether body dissatisfaction had maintained stability or not. For Maria the scores from the EDI, along with the qualitative data, provide evidence to

suggest that the adventure therapy intervention initiated significant change on key dimensions related to troubled eating and worked in many different ways.

Table Six:
Maria: Eating Disorders Inventory (EDI): An overview of change in scores from beginning to end of the intervention (a total of 9 months)

EDI Theme	Time point during intervention				EDI Normative Data	
	First meeting at Beginning of intervention	End of residential	2 months after residential	7 months after residential / at the end of the intervention	EDI Normative Data for anorexia nervosa	EDI Normative Data for College Women Group
Drive for thinness	15	2	1	2	11.3 ±7.0	5.5 ± 5.5
Bulimia	4	1	0	0	1.8 ± 3.5	1.2 ± 1.9
Body dissatisfaction	25	6	7	9	11.9 ±7.9	12.2 ± 8.3
Ineffectiveness	8	1	2	0	11.4 ± 8.4	2.3 ± 3.6
Perfectionism	5	2	0	2	8.9 ± 5.3	6.2 ± 3.9
Interpersonal distrust	6	2	1	0	6.9 ±5.3	2.0 ± 3.1
Introspective awareness	4	0	0	0	9.2 ± 6.9	3.0 ± 3.9
Maturity fears	1	0	2	0	4.8 ± 5.1	2.7 ± 2.9

8.2b Brenda: An overview of change

Brenda started the intervention having experienced troubled eating for many years, specifically bulimia. She had undertaken counselling at different stages of her life, but had not found a way to successfully intervene her bulimic behaviour. During and after the intervention Brenda identified changes in a range of different ways. After the intervention, troubled eating did not dominate her life as much as it did before the intervention - it was no longer the core of her sense of self. Instead thoughts and feelings associated with troubled

eating had shifted to a place within her self that were less consuming and more accommodating for other parts of her self-structure and this she had reduced obsessed thoughts about eating:

> *"My whole life has been focused on the eating and that it isn't now, and yet I still want to be slimmer and fitter. But even that is not an obsessional thing.*
>
> *... Yes it was central [troubled eating], whenever I was mapping out my life and problems, eating would have taken up most of the page and there would have been around the edge little bits squeezed in type of thing. Because the eating was the thing, I was convinced that it was the eating that needed the treatment, that change needed to be focused on. And I suppose in some way that is a stigma with change really, the fact that although it's still there and a lot of it will be old habits die hard as well, it doesn't seem to be the most important thing, or even as though it is something I have to deal with."*

The intervention clearly provided Brenda with a sense that she was undergoing psychological change. She was learning how to tackle relationships with others more effectively and she seemed to be spending less time thinking about eating and related troubled behaviour:

> *"Somehow or other I've got an innate feeling that all these other things that are being changed in my life, that I am changing in my life, that there's an inevitability to these changes occurring, so it's to do with relationships and how I conduct myself and about learning to be me, all of those things, that it's inevitable that the eating will change and it's almost as though somehow or other I'm so secure about that that I don't even have to consider it, I don't have to take it off the shelf...*

Before I felt the eating dominated me, but I don't feel as though I'm dominating it, so if in looking at whether it was off the page, if I think of the page being on a table, then the eating is somewhere across the table on the far corner, and the page is in front of me as I sit at the table."

(Individual closure interview)

Brenda's experience also seemed to be profound in the sense that it was a turning point in her life. Before the intervention she suggests that she denied her emotions and feelings, and did not feel that motivated for change (although she was motivated to take part in the intervention so she did have some level of motivation). After the intervention her outlook on life was very much more positive and she had been able to access inner resources that would enable her to effectively work towards ongoing change:

"Well where I was talking before about turning in on myself, I have almost an image of a flower dying or something and its petals closing in, but now I feel it's the entire opposite, it feels as though it's much more outward, that it's strong and it's healthy, that's more the feeling compared to before this rather wilting and nothing could be done feeling. I'm aware I suppose that things can be done and that I can do them. I think that bit of it comes really from the Brathay experience, it was the courage bit, it was finding the courage do things, also becoming aware that that was something that was intrinsic, it was part of me anyway, I just didn't know it was there ...It was about me. I found the courage in my higher self.

....So I suppose really the analogy there would be about rather than it just being this flower that was closing up and was dying it was also about the soil it was in and the lack of nurturing, the water, the things that were

needed to help it to grow weren't there. But now it feels like not just the flower but the plant and the soil is healthy, vigorous."

(Individual closure interview)

Brenda seemed to have identified her ability to initiate change and this had came about, because in her own words, she had been able to find 'courage' in herself, enabling her to have an increased sense of self-belief and self-recognition, and thus access her own inner resources:

"...I think that I really needed the courage to do the things that I've done in terms of life changes

.....So I suppose defining the change which has occurred with Adventurous Growth would be really that it has been major change, but it hasn't felt too uncomfortable really and it was to do with Adventurous Growth enabling me to find something within myself to do that. So instead of me having people outside belaying, I realised that it was something inside me that could belay."

(Individual closure interview)

Overall, her experience was very much a cathartic one:

"...I do very much feel that it was cathartic, so that was something that actually affected the change, if that hadn't have happened I don't think I would have even been where I was, because where I was on a downhill slope really."

(Individual closure interview)

Shortly after the residential Brenda also commented on how she was putting newly learnt skills into practice:

> *"I am surprised at how I am dealing with life by constantly putting into place the adventurous growth principles. I looked at the task I was fearful of, ascertained what was required of me, put into place the support I needed and stepped forward ... the carabineer is fast and I am safe .... I cannot be harmed as I am now sure of my own power and centeredness. I am no longer afraid and do not have to rely on others in most situations for my well-being and safety. Thank you A.G.!"*
>
> (Journal)

The scores from the measures of the EDI correlated with the way in which Brenda described her experience. At the beginning of the intervention she particularly scored highly on measures for Body Dissatisfaction, Bulimia and Ineffectiveness. Immediately at the end of the residential these scores had dramatically reduced (*see* Table Seven for a comparison of scores). In fact bulimic symptoms appeared to have been nearly completely eradicated and this change seemed to have been maintained 7 months later. The score on the dimension of Body Dissatisfaction had also reduced at the end of the residential, however, over time the score for this dimension slowly rose again and after 7 months was pretty much similar to what it was at the beginning of the intervention. This suggests that although after an initial high impact on this score Brenda found it difficult to sustain this level of change. This raises interesting questions about how to maintain a positive body image in a society that regulates what the ideal body image is.

Although not as significant as the change on the dimensions of Drive for Thinness of Body Dissatisfaction, the intervention seemed to also have some impact on all the other EDI dimensions. Her lower scores after the

intervention indicate how she has reduced below the means for patients with bulimia nervosa as presented in EDI normative data By the end of the intervention her scores fell within the mean scores for the comparison group of college women – apart from the dimension of body dissatisfaction (*see* Appendix Four for an overview of EDI normative data). This suggests her clinical symptoms from baseline had reduced. In terms of sustaining change these scores indicate that maintenance of change was evident for her, however as noted above maintenance on some scores proved difficult (i.e. body dissatisfaction and drive for thinness). Overall, the scores from the EDI, along with the qualitative data, suggest that the adventure therapy intervention had proved successful for Barbara, especially as her bulimic behaviours seemed to have nearly been completely eradicated.

Table Seven:
Brenda: Eating Disorders Inventory (EDI): An overview of change in scores from beginning to end of the intervention (a total of 9 months)

EDI Theme	Time point during intervention				EDI Normative Data	
	First meeting at beginning of intervention	End of residential	2 months after residential	7 months after residential / at the end of the interventio n	EDI Normative Data for Bulimia Nervosa	EDI Normative Data for College Women Group
Drive for thinness	6	0	2	0	15.0 ± 5.0	5.5 ± 5.5
Bulimia	15	1	0	2	10.8 ± 5.4	1.2 ± 1.9
Body dissatisfaction	22	9	14	21	17.9 ±7.9	12.2 ± 8.3
Ineffectiveness	14	1	6	2	11.0 ± 7.5	2.3 ± 3.6
Perfectionism	4	3	8	4	8.8 ± 4.8	6.2 ± 3.9
Interpersonal distrust	4	1	5	1	5.3 ± 4.5	2.0 ± 3.1
Introspective awareness	15	2	3	2	11.1 ± 6.8	3.0 ± 3.9
Maturity fears	2	3	0	1	4.4 ± 4.6	2.7 ± 2.9

8.2c Katy: An overview of change

Katy presented a range of troubled eating behaviours, including bulimia. She had previously received psychiatric treatment for these associated symptoms. She had also been to counselling previously, and as noted earlier, she had not necessarily experienced previous interventions as successful as they seemed to operate on a medical model treatment which concentrated on what and how much she ate.

Katy's changes were not as significant as those identified by both Maria and Brenda. There was some evidence that the intervention did have a positive impact on her across certain dimensions and that she had a positive experience which enabled slight changes. Mainly, during the intervention she felt her eating normalised in someway and she felt more comfortable with eating:

> *"Well my eating pattern did change [during the residential] because I wasn't at home, it was totally different to how I would eat at home. I think it did make me realise that I could eat relatively normally, eat three meals a day, I felt comfortable."*
>
> (Individual closure interview)

For Katy the process of change was still very much rocky at times, but her troubled eating behaviours did seem to reduce in some way. She commented that shortly after the end of the residential her troubled eating had been the least problematic since it had started many years earlier;

> *"After the residential, a couple of months after, was probably the best I've been since the whole eating disorder started."*

> *"Well it was initially worse or the same but then it did get better...sometimes I even forgot I'd got a problem with my eating, I could eat three meals a day and not feel bad about it and wouldn't think about*

running to the toilet and I wouldn't be counting every calorie and thinking I'd got to go for a walk for two hours or whatever."

(Individual closure interview)

What seemed to be of greatest value for Katy was an increased level of self-confidence and more positive feelings about what she could achieve. This enabled her to take action as she felt more equipped to make positive choices about her life:

"I know it did give me a lot more confidence in myself because I remember up until Christmas I was feeling really good about myself but a lot of that came from that week. It's only since then that I've had those more positive feelings about myself."

"I know that my feelings about myself were a lot different, I felt good about myself, I was happy about the relationship I was in and I suppose my whole situation was better, I was doing things, I was applying for university, I had more of an idea of what I wanted to do.

It has given me the support and the confidence in myself to go ahead and do something like that. The reason I've never done something before is because I haven't got friends to go with, I've never had the confidence to go and join a group."

(Individual closure interview)

The residential seemed to offer Katy a chance to reflect on her current troubled eating and give her some tools to consider how to get out of the cycle of troubled eating, as she comments:

"I think I was desperate to get out of that cycle because I realised it wasn't getting me anywhere, but I think the residential gave me a lot of the tools to do it, even if it was subconscious, because a lot of it was, but it did give me a lot more confidence."

(Individual closure interview)

Her increase in confidence seemed to then motivate her to make positive choices about her life:

"So now I'm looking for experiences that will help me in life, things that I'll enjoy doing."

(Individual closure interview)

It is important to note that Katy did not complete a research journal, so there is limited insight into the day-to-day impact of the residential, or ongoing experience beyond the residential phase.

The scores from the EDI dimensions (*see* Table Eight) suggest that Katy sustained very little change across the dimensions measured. Her scores remained in the upper limit of the means of normative data for combined eating in the EDI (see Appendix Four for an overview of EDI normative data). There was some indication that at the end of the residential bulimic behaviours were reduced slightly for Katy, which reflected what she said in her interview – the different environment from her everyday life made it easier for her to avoid bulimic triggers. However, in returning back to everyday life, over time, her bulimic behaviour returned to its usual pattern. Katy's troubled eating was more chronic than most of the other women (her scores represent the upper limit of the means of normative data for combined eating disorders in the EDI), so similarly to Andrea she may have needed a longer adventure therapy intervention to initiate sustained change.

Table Eight
Katy: Eating Disorders Inventory (EDI): An overview of change in scores from beginning to end of the intervention (a total of 9 months)

EDI Theme	Time point during intervention				
	First meeting at Beginning of intervention	End of residential	2 months after residential	7 months after residential / at the end of the intervention	EDI Normative Data for Combined Eating Disorders
Drive for thinness	19	20	Q'aire not completed	17	14.5 ± 5.5
Bulimia	16	7		16	10.5 ± 1.2
Body dissatisfaction	27	27		27	16.6 ± 12.2
Ineffectiveness	17	19		19	11.3 ± 2.3
Perfectionism	14	18		13	8.9 ± 6.2
Interpersonal distrust	2	4		7	5.8 ± 2.0
Introspective awareness	15	18		19	11.0 ± 3.0
Maturity fears	3	5		3	4.5 ± 2.7

8.2d Josie: An overview of change

Josie arrived at the programme having spent many years personally addressing her troubled eating. She had not previously been in counselling, but had take inspiration to tackle her troubled eating from the earlier feminist movement in relation to women's bodies in the 1970s, as she explains:

> *"I don't know, because over fifteen years I still can't tell you I did this or I did that and that's what made it change, I don't really know quite how it has changed, I don't really understand it myself, I can't pinpoint anything. The thing that started to change things for me was Orbach's*

Fat is a Feminist Issue, not because I agree with everything that she put in it, but because it was revolutionary at the time, and that did make me look at things in a different way and that did help me at the time."

(Individual closure interview)

It seems that her change started by having her consciousness raised about feminist perspectives to eating and the female body, and this initiated a reduction in her troubled eating and body dissatisfaction. Given her previous experiences her motivation for participation in the programme was not necessarily about engaging in a change process, but instead it was about reinforcing the changes she had already made in her life (one could argue this is in fact a process of change as it has related psychological processes and outcomes). Given the goals she had, her motivation for taking part in the programmes were in some way different to the other women participating. She wanted to establish whether the previous change she thought she had made in relation to troubled eating was in fact now stable and had been sustained. Thus, from her point of view her experience was more about reinforcement of change, rather than a direct change in itself. From this perspective she felt that from the intervention she gained the reassurance that she wanted about her ongoing recovery from troubled eating:

"Reinforced changed like I said before, it must have taken me about fifteen years to turn my troubled eating around and find other coping strategies. So going up to Adventurous Growth was a new experience and it was away from home, there was nothing familiar there, I was with a group of women I didn't really know, having only met them really briefly, and it was certainly going to highlight whether I had left a lot of my troubled eating behind or not. I mean it would have been a classic situation for me where I probably would have turned to food in order to cope, and I didn't, so really I would say it underlined this metamorphosis if you like, in myself, that's taken place over all these years."

(Focus group)

It seemed that for Josie she felt empowered being part of a women's group and that the experience offered her reassurance in being able to manage her troubled eating in more stressful situations. However, she felt that she could have benefitted from a greater focus on relationship with her body image, suggesting that this was still an area in which she had some level of distress and was motivated to address more fully:

> *"I didn't think about eating that much when I was up there, and I didn't really feel that we touched a lot on actual eating issues or body image, because body image is something that is one of my, maybe hang ups is too strong a word now, but I think Maria said it. I still have this thing of looking in the mirror every morning and turning this way and that way and I'm still maybe over careful about what I wear and what I feel that I look in that. I see other people who are bigger than me who are wearing things and I think I'd never wear anything like that, I just wouldn't be able to show that part of my body.... So we didn't really address that.... Yes, it could have been, just because that is one thing that still plays on my mind. I still can't be one of these people that say I don't give a shit, I'm going to wear what I want."*
>
> (Individual closure interview)

Josie's EDI scores reinforce her motivation for taking part in the programme (*see* Table Nine). She scored zero on five of the EDI dimensions (Bulimia, Interpersonal Distrust, Ineffectiveness, Introspective Awareness, and Maturity Fears), relatively low scores on two of the dimensions (Perfectionism and Drive for Thinness), and scored somewhat higher on only one dimension (Body Dissatisfaction). These scores fit the means of the normative data for the comparison group of college women on the EDI. This indicates that Josie presented without clinical symptoms at baseline (*see* Appendix Four for an overview EDI normative data). Her EDI scores are also illustrative of the fact she had overcome many of her troubled eating behaviours prior to the

intervention and that she was not looking for change across many of the dimensions identified on the EDI. Given this, it is not surprising that signs of change are not evident across most of the EDI dimensions. There is one dimension - body dissatisfaction – that indicates some change had taken place. This was the dimension that Josie was most troubled about, which also matched how she described her.

Table Nine
Josie: Eating Disorders Inventory (EDI): An overview of change in scores from beginning to end of the intervention (a total of 9 months)

EDI Theme	Time point during intervention				
	First meeting at Beginning of intervention	End of residential	2 months after residential	7 months after residential / at the end of the intervention	EDI Normative Data for Comparison Group of College Women
Drive for thinness	5	3	1	2	5.5 ± 5.5
Bulimia	0	0	0	0	1.2 ± 1.9
Body dissatisfaction	14	8	7	7	12.2 ± 8.3
Ineffectiveness	0	0	0	0	2.3 ± 3.6
Perfectionism	1	3	0	0	6.2 ± 3.9
Interpersonal distrust	0	0	0	0	2.0 ± 3.1
Introspective awareness	0	0	0	0	3.0 ± 3.9
Maturity fears	0	0	1	1	2.7 ± 2.9

8.2.e Jackie: An overview of change

Jackie had different reasons for taking part in the programme and these were least similar to all the other women. Jackie's troubled eating was related to her early childhood experiences of basic neglect (i.e. not being fed adequately).

Jackie struggled to eat and take care of herself, and in some way her troubled eating was in sharp contrast to the way the other women's troubled eating manifested itself. Although it was not possible to gather all the research data required for Jackie and there is thus very little associated data for analysis, as she only completed the EDI questionnaire and took part in using IPR, change was still evident. Therapists can easily recall moments of change when she used IPR following participation in ropes course activities – she moved from repeatedly saying 'I can't do it' to facing challenges and then being able to say 'I can do it' – which indicated changes in her cognitive self-belief patterns. At the end of the programme she joined an expedition group and went on a 3 month outdoor expedition to a remote part of the world. She also initiated ongoing personal psychotherapy after the intervention. These can be seen as positive outcomes from the programme and reflected her motivation for taking positive action in her life.

Jackie's EDI scores, match how she presented her troubled eating. For Jackie some associated symptoms of troubled eating were apparent, but they were not as chronic as they were for the other women – her scores were relatively low for those that she did indicate a tendency towards (*see* Table Ten). In comparison with the mean scores of normative data from the EDI she didn't present symptoms of either anorexia or bulimia nervosa and her EDI scores predominately fell with the means of the comparison group of college (*see* Appendix Four for an overview of EDI normative data for both of these forms of eating disorder). There were some minor changes evident on dimensions at the end of the residential (e.g. reduction in Ineffectiveness and Interpersonal Distrust). There was also one score – Introspective Awareness - which was significantly higher at the end of the residential. The therapeutic explanation for this is unclear, and it could have a variety of explanations.

Table Ten:
Jackie: Eating Disorders Inventory (EDI): An overview of change in scores from beginning to end of the intervention (a total of 9 months)

EDI Theme	Time point during intervention				
	First meeting at Beginning of intervention	End of residential	2 months after residential	7 months after residential / at the end of the intervention	EDI Normative Data for Comparison Group College Women
Drive for thinness	3	3	4	No q'aire completed	5.5 ± 5.5
Bulimia	0	0	0		1.2 ± 1.9
Body dissatisfaction	7	9	7		12.2 ± 8.3
Ineffectiveness	10	6	7		2.3 ± 3.6
Perfectionism	0	0	0		6.2 ± 3.9
Interpersonal distrust	8	5	5		2.0 ± 3.1
Introspective awareness	3	7	1		3.0 ± 3.9
Maturity fears	3	2	1		2.7 ± 2.9

8.2.f Andrea: An overview of change

Andrea was experiencing high levels of distress with her troubled eating and was being treated for depression. She had been experiencing symptoms for many years, and these had more recently accumulated in her so that she was not able to work. At the beginning of the intervention she was awaiting referral to a local eating disorders specialised centre. Her symptoms of troubled eating and depression were the most chronic of the women, as her journal entries below indicate:

> *"I feel so terribly fat I can't cope with anything. I find life hard to cope with but when my eating is out of control living seems so hard sometimes*

impossible, I'm so scared of getting fatter and fatter and fatter and never being able to stop eating. I know I would definitely kill myself. I couldn't cope with the situation. That battle would be too hard for me to fight. I don't think I'd have the strength to carry on. It would be too hard. I know I give in too easily, but after so many years of this torment and fear you get so tired of trying so hard and failing all the time. You get so scared of not being able to control your cravings for food, I used to fight them first but I give in now. If I crave something I first have it, but sometimes it last for months, you are so out of control and the weight piles on, you first seemed to get trapped. Like being on a fairground ride and you can never get off, it just keeps going on and on forever on this continuing nightmare. I don't want to be part of the nightmare forever. That is why I went to the doctors for help. I was going to kill myself, my depression was getting too much for me to deal with, my life is a mess. I feel so sad all the time. I don't want to get fatter anymore. I just want to die so everything can be better again, and I don't have to fight this anymore. Just want to be at peace with myself.".

I am disgusting. I can't stand myself sometimes. My body is so painful to touch as well – the fat parts are really sore to touch, they hurt and the fatter I get the more painful they feel. (Personal Info Sheet)

Why do I turn to food and eating when I am so unhappy? I just can't seem to help it. I just feel the need to eat, it is a desperate feeling. It is not a hungry feeling because you are so full up. The fuller you are the more you shove into your mouth. The more I hate myself.

(Journal)

As well as the journal entry above, other journal entries indicate that Andrea's clinical depression was a factor in her presentation of troubled eating:

> *"I can cry and be unhappy in my bedroom in the dark and I don't have to pretend to be happy to anyone when I feel so sad and alone and worthless."* (Journal)

> *"I just feel as if I don't want to be here. I get angry at God for making me live instead of thanking him for my life. I know I should try and make the most of it. But when you feel so terrible, I don't know where the feelings come from – you just can't seem to make them go away. It's like getting smothered in a black cloud and it's killing you, you just can't find a way out. It has to go away on its own- you can't make it go away." (Journal)*

> *"I have shut myself off from people. I get too depressed. I feel terrible most of the time. I have no confidence and feel useless. Just boring and a waste of space. I wish I was dead most of the time."* (Personal Info Sheet)

It was evident from Andrea's journal that participation in the programme was beneficial in terms of it being a positive experience whereby she felt and experienced support, and she was away from the everyday stresses she experienced from day-to-day:

> *"I felt positive, full of hope and strong when I was with you all. I didn't feel stressed or under so much pressure.*
>
> *I wish I felt strong like I felt sometimes at Brathay Hall. It was so lovely to have everyone's help and support...*

...I felt so good to be with you all in the Lake District. I didn't feel at all stressed and it was such a lovely feeling, I didn't feel any pressure from normal everyday life. It all came back as soon as I got home....

...I felt really privileged to be part of AG and to be with everyone at Brathay Hall. Thank you Kaye and everyone else for all your help and support throughout the week. Words cannot express how I felt on the last day. It was a very overwhelming experience I miss everyone and I miss having nice people around me." (Journal)

There is no doubt that aspects of the intervention were in some ways a therapeutic experience for Andrea in that during the week she felt 'positive, full of hope and strong' and she felt relief from the pressures of everyday life. However, she also expressed how she found it difficult when returning home from the intervention, and that this time heightened her feelings of loneliness.

"I feel really alone right now and since I came back. Everyone seems so far away. I miss talking to people who really understand and care and with similar problems and experiences. I felt positive, full of hope and strong when I was with you all. I didn't feel stressed or under so much pressure. Now it has all come back being here. I don't know what to do, if I can be helped. I feel so alone and scared. I don't like being me. I wish I wasn't like this. I feel desperately unhappy, my eating is getting worse."

Andrea found it very difficult to attend the follow up sessions. She noted in her journal how she found it difficult to motivate herself to attend as she found difficulty with the journey and felt overwhelmed with the place and general people she would pass when arriving at the venue. In her journal, she often apologised to the group for not being able to attend.

Andrea spoke about her day-to-day experience of troubled eating in depth in her journal. She reported her daily routine in detail and listed what she ate and her associated struggles with eating behaviours. She continued to write in depth about her experience throughout the intervention. Her journal offered a rich insight into how she lived a life with troubled eating and how she was unable to find a way to make changes in her day-to-day life. At times, her narrative was unsettling to read as it illustrated, not only how the intervention had not had an impact, but more worryingly how she seemed to be deteriorating over time. The concerns for her welfare were discussed with some members of the therapeutic team when the journal was being analysed. Because she had been seeing her GP and had a referral to an eating disorder treatment centre it was felt that her welfare was being taken care of at that point. But it did raise an ethical dilemma, and again illustrated the link between research and practice.

Andrea's EDI scores reinforce her narrative descriptions – that there is no evidence of sustained change (*see* Table Eleven). Her scores across all the dimensions of the EDI are all above the upper limit of the means of the normative data scores for anorexia bingeing and purging. She represents an extreme clinical presentation of eating disorders. So as well as the EDI scores representing the extent of related symptoms, the scores also indicate that the intervention had no sustained impact - her scores remained at the upper limits of means of normative data scores of the EDI (*see* Appendix Four for an overview of EDI normative data). Although, the residential did seem to have an initial impact on introspective awareness, on return to everyday life, over time this scored returned its original score, suggesting no sustained change on this dimension. Again the EDI scores correlate with other data collected, especially her research journal whereby she often reported on how difficult she was finding life. The chronic nature of Andrea's troubled eating again raises questions as to how the intervention could have been more tailored to meet her therapeutic needs and aid in her recovery more successfully than it did.

Table Eleven:
Andrea: Eating Disorders Inventory (EDI): An overview of change in scores from beginning to end of the intervention (a total of 9 months)

EDI Theme	Time point during intervention				
	First meeting at Beginning of intervention	End of residential	2 months after residential	7 months after residential / at the end of the intervention	EDI Normative Data for Anorexia – bingeing and purging
Drive for thinness	24	24	18	27	15.0 ± 5.6
Bulimia	19	14	15	18	8.9 ± 5.8
Body dissatisfaction	27	27	27	21	14.4 ± 8.5
Introspection	30	29	27	30	13.1 ± 8.7
Perfectionism	15	10	10	8	9.5 ± 5.1
Interpersonal distrust	15	14	17	11	7.3 ± 4.9
Introspective awareness	24	13	23	21	12.0 ± 7.5
Maturity fears	20	6	9	9	4.6 ± 4.9

8.2g Conclusions about psychological changes

Overall, the intervention did impact on the women in some way, however, the level of impact and the dimensions of change were different for each woman. For some women there is clearly sustained change across a range of symptoms, whereas for other women there is less evidence for change, and for one woman there is clearly no evidence of change (*see* Table Twelve for this general overview).

Table Twelve:
A general overview of change

Participant	Overview of change
Maria	Valuable sustained change
Brenda	Valuable sustained change
Katy	Some sustained change
Josie	Reinforced change
Jackie	Some sustained change
Andrea	No sustained change

For those women that did experience change, different aspects of the intervention provided opportunities for personal growth and development. This then lead to changes in the following areas:

- Reduced troubled eating thinking
- Reduced troubled eating behaviour patterns
- Reduced body dissatisfaction
- Improved self-confidence
- Increased self-understanding
- Increased self-acceptance
- Greater sense of self-reliance
- Increased relational connection with others
- Ability to extend and manage widened comfort zone
- Courage to continue with personal change and growth
- Redefining of troubled eating
- Acknowledgment of troubled relations
- Using new skills in everyday life
- Increased motivation for change and hope for the future
- A more positive outlook on life

8.3 Key ingredients that facilitated change

At the beginning of this thesis the theoretical considerations of working with women with troubled eating were discussed. These considerations presented challenges to current dominant perspectives to working outdoors and the claims for associated benefits. The argument of this thesis was that by offering participants a more women-centred approach, whereby psychotherapeutic approaches were successfully integrated into working outdoors then women could be offered a therapeutic intervention that meet their needs more fully.

It is evident from the women's experiences of the intervention that for some of them the adventure therapy experience was transformational and they were able to maintain change. Given that the intervention seemed to work for some of the women, and even though not all the women, it is important to consider what were the key ingredients that facilitated such transformation, and consider these in light of the theoretical basis of adventure therapy.

8.3a Outdoor adventure ingredients

Several key ingredients are often identified as developmental components of outdoor adventure experiences (as discussed in Chapter Four). Some of these ingredients were identified by the women as having therapeutic qualities. These included finding personally relevant metaphors, expanding individual comfort zones, the ability to manage personal and psychological risk more effectively, experiencing achievement in a non-competitive environment, experiencing trust and accessing a range of personal resources (e.g. courage and self-reliance). More detailed examples of these processes in action, as expressed by some of the participants, is discussed below.

Regardless of whether working therapeutically or not, risk taking and expanding individual comfort zones is cited as a key benefit of the adventure experience (See Gass, 1993). The ways in which this process was in action for the women

and the associated impact, for example on cognitive processed and self-esteem,

was clearly expressed by some of the women. Brenda found that these experiences enabled her to feel more equipped to manage a range of everyday life risks (e.g. relation risks):

> *"And I have done it! It was marvellous and I managed to feel free and safe. I did it by having fun, making the others (and me) feel OK by joking, ignoring those around me and concentrating on myself and then just going for it. I would do it again. My comfort zone is widened.*
>
> *I am skilled up now and know what to takes to get very situation I encounter which causes me difficulty, into my comfort zone. What I really mean is I am prepared to take risks within reason, to feel the fear and to deal with it. In this way, I will extend my comfort zone until I fear nothing. I have my adventurous growth kit with me at all times, stored neatly inside of me, easy to find because I use it frequently.*
>
> *Now how can I transfer this to my other life? Well I could have fun and make jokes so people would feel happy. I could ignore others needs (although I can hear them) (Perhaps I should acknowledge that I hear them) I have got my 'me' focus right and when we've done all that not to consider the odds but just for it – Geronimo! Now of course my comfort zone is widened so where's the next challenge? I guess putting all of this into practice is the circuit of everyday life."*
>
> (Brenda: Journal)

A key goal of the intervention was for the women to access their own inner strength and capabilities, feeling that they had more personal resources to engage in change and able to feel more self-reliant beyond the initial adventure therapy residential. There are numerous accounts from the women as to how they accessed this personal courage and the ways in which this had a positive

impact on their self-esteem. As Brenda comments:

> *"I'm aware I suppose that things can be done and that I can do them. I think that bit of it comes really from the Brathay experience, it was the courage bit, it was finding the courage do things, also becoming aware that that was something that was intrinsic, it was part of me anyway, I just didn't know it was there.*
>
> *I think that where I was before Adventurous Growth was really that I didn't know I hadn't the courage then, it didn't even occur to me, so I didn't know I didn't have it if you know what I mean, there was no consciousness that it could be something that existed, this feeling."*
>
> (Individual closure interview)

> *.... It was about <u>me</u>. I found the courage in my higher self".*
>
> (Journal)

And Maria illustrates how her completing the high ropes activity enabled her to feel empowered and recognise that she could achieve goals she previously had doubted in herself:

> *"Then it was the V-ropes and I bloody did it. It was the most incredible feeling. Climbing the ladder was okay, until I got to the top. I managed to get from ladder wire and was okay, until I got to the top. I managed to get from the ladder wire and to stand and look at Barbara – I couldn't look down. We kept constant eye contact and "leaned on each other". I was really worried in case " I let Barbara down, but not giving her enough support (physically or verbally) or maybe even "falling off" and spoiling the whole experience for her. But I didn't let her down and she didn't let me down – <u>WE DID IT!</u> . It was really special!*

Then we did the pole" – I didn't make it the first time, and felt disappointed and frustrated. But with support and encouragement for the others I DID IT the second time! It was truly amazing I surpassed my own goals and found inner strength and courage that always been there - just couldn't reach it.

I watched the video later and still can't believe I did it. Or maybe I should start to say "yes, I can believe I did it!."

(Maria: Journal)

Although an increase in self-confidence has been associated as a positive outcomes of participation in outdoor activities, as discussed earlier (*see* Chapters Two and Three) this is often underpinned by an achievement model. In this study self-confidence was very much related to self-understanding and relational processes, whereby achievement in activities was only one of many aspects of the experience that enabled psychological growth and understanding, and this often had a relational component amongst the women. So even though achievement was a useful component of the experience, it went hand-in-hand with self-expression, self-understanding and developing relational capacity. The reflection by Maria (from her final interview) is evidence for how self-understanding was facilitated during the adventure therapy programme and how this then impacted on her gaining a more in depth understanding about troubled eating behaviour:

Maria: *I feel more confident about myself, in myself, more positive about myself. I still get the feelings that I'm useless and worthless, but I'm changing, I'm looking at myself differently.*

Therapist: *How do you do that?*

Maria: *How it's happened or the process?*

Therapist: *How it's happened?*

Maria: *I think at Brathay I let the lid off all the stuff inside. It's like X said, it was a catharsis. I knew I had to open up and let something out because I was like a big pressure cooker, ready to explode. I've let stuff out and I've been able to look at what's come out and it's not as bad when it's on the outside.*

Therapist: *So it's less troublesome holding it, because it's out?*

Maria: *Yes, it's more troublesome trying to hold it in and keep it down and cover it up with food, that's what I was doing. But I'm letting it out and I'm letting myself have these feelings, whether it be anger, sadness or what have you. Instead of trying to run away and hide from it."*

(Individual closure interview)

8.3b Psychotherapeutic and feminist ingredients

Other components that seemed of therapeutic significance were those more associated with feminist and psychotherapeutic goals. These included commonality of experience, shared women-centred experiences, relational connection, self-understanding, self-acceptance, and self-exploration at psychological depth. Bloch & Rubenstein (1980) identify nine therapeutic factors of group psychotherapy : 1) catharsis, 2) self-disclosure, 3) universality, 4) acceptance, 5) altruism, 6) guidance, 7) self-understanding, 8) vicarious learning and 9) instillation of hope. All of these factors were evident in many different ways during the intervention, many of which have already been described in previous accounts of women's experiences.

The women expressed how they valued working with others, indicating how relational connections and movement was positive for them. This fostered equitable relationships and empathy for other participants, which then enabled them to feel empowered:

> *"Maria followed and I offered support and we did it together. I felt that she was even more scared than I, so I was saying 'lean on me. Lean on me'. In spite of her terror she had the strength to care for me and sacred "And you lean on me". This felt so beautiful. It was equitable relationship. We communicated, we planned and we co-operated."*
>
> (Brenda: Journal)

> *"The strength that comes from being with a group of women who have empathy for each other and know their situation and how good that felt.."*
>
> (Josie: Individual closure interview)

> *"Next we had a session "raft reflections". This was me and Andrea and Katy, with the therapist, I hadn't cried in front of the therapist or worked with her therapeutically. I did cry, however, (I've cried in front of everyone now!) and this session was really special for me. This is because I could relate to Andrea and Katy in so many ways, such deep empathy for them and so much compassion., They are both such beautiful people I their own different ways (everyone on the programme is beautiful, including the therapists!!), but deeply, deeply, troubled. I feel I really want to reach out to them and help them, and take away their pain. (I feel so strongly about it, that I am beginning to cry it, as I write)."*
>
> (Maria: Journal)

"I have also experienced some tremendous compassion for others this week something I thought I had already experience, but never really had. That sense of wanting to take away the pain and suffering of others without self-aggrandisement."

(Maria: Journal)

"One of the things that struck me was how empowering being part of a women's group is, how you can feel empowered, the strength that comes from being with a group of women who have empathy for each other and know their situation, and how good that felt."

(Josie: Individual closure interview)

For those women for whom that the intervention was most successful noticed key changes in how they related to others:

"Now I can see how my projections have been affecting other relationships in my life, and can now see how I can overcome them."

(Brenda: Journal)

Commonality of experience was also noted as a valuable component of the intervention:

"That was what made it safe [the commonality], I didn't feel such a freak, not a freak, but everyone's got the problem... Yes it was the commonality of that but I suppose it could have been people with the same depression or self esteem problems, not just eating disorders but they'd have had to have had problems ....In a way it was reassuring because a lot of it was very similar to me."

(Katy: Final Interview)

"I was talking to Katy and Andrea, as we discussed our "eating issues". This was a useful exercise and it also gave the three of us the chance to open up a bit, which we did. This was really therapeutic for me, just hearing how others share similar problems – it made me feel much better."

(Maria: Final Interview)

For some women having time for themselves was novel and also liberating, as Maria comments:

"Referring to the entry dated 2 March I can now express how I felt during my first time way from my family. I was surprised at not feeling guilty for not being there for them, and I didn't miss them half as much as I thought I would, Yes, I did feel liberated, free, elated, excited, I JUST FELT!!"

(Journal).

From a research perspective it was also noted how even though it was a research process they did not feel as if they were just subjects for the research, arguably reflecting that the attention to feminist research principles had in some ways been translated into practice, as Maria comments:

"I appreciated the support you've given us a lot. You weren't out just to get your PhD done, you've thought beyond just getting the writing, you've made it more personal, we mattered as people not as subjects, which I was a bit worried about, that we were just subjects, but you've not treated us like that".

(Maria: Journal)

And finally, the intervention provided an unique opportunity for women to be able to reconnect with themselves in ways that previously they had denied themselves:

> *"Thank you all for allowing me to grow and to find the 'me' who I recognise but who I though was lost forever."*
>
> (Brenda: Journal)

Overall, the outdoor therapy environment (with its attention on a wide range of issues from all aspects of the three key areas of the HOPE model – outdoor adventure, therapy, and eating disorders) created a setting which was therapeutic and healing for some of the women. As Brenda describes, the experience offered an opportunity to experience and examine different aspects of the self, that she had previously been psychologically defended against. This led her to greater self-understanding:

> *"It's given me an opportunity for the first time ever it feels to really examine those things, take them out, as though I was sitting on top of a jar of something and I could see those things in and put in my hand and pull them out and have a look and think gosh that's there, or sometimes they're not so much nice things and maybe I want to put them back then."*
>
> (Journal)

It was recognised that group therapy could be effective in the treatment of troubled eating, as the women would be able to share and identify commonalties of experiences and their relationship with eating (Brown,1993). Throughout the intervention women recalled the ways in which they valued this and how they developed relational capacity with the other women participants. As Jayne noted,

> *"One of the things that struck me was how empowering being part of a women's group is, how you can feel empowered, the strength that comes from being with a group of women who have empathy for each other and know their situation and how good that felt."*
>
> (Individual closure interview)

Obviously, both aspects of the adventure therapy experience, the outdoors and therapy, impacted on how the other was experienced. For example, in the process of identifying personally significant metaphors it was not just the outdoor activity alone that facilitated this – it was the way in which the experience was psychologically processed from a therapeutic perspective. Also, a non-competitive approach to participation in activity underpins a more women-centred approach to participation in outdoor activities. The accounts from Maria and Brenda below are examples of the change processes that these experiences accumulated in:

Maria:

"Looking back over the first journal entries, I hardly recognise that old person anymore and feel nothing but sadness and compassion for her. It also seems strange to think how much I was worried about the trip to the Lake District. I thought I should be slim a bit, I thought my clothes weren't good enough, or not baggy enough to conceal my huge bum, hips, and thighs, and feared everyone's judgement. I feared speaking up in front of anyone / the group, feared expressing myself, I feared voicing my opinions, I feared asserting myself, I feared challenging others, I feared opening up, I feared looking inside, feared "letting go" and I feared crying in front of anyone/ the group., I could go on listing my fears, there so many. But the amazing thing is I touched them all, smashed though them all and conquered them all. And not once did anyone notice or say

anything about my size or my clothes. What's more I never worried about my size or my clothes. They are both unimportant. What really counts is what's inside people, its about relating and communication with others, reaching out and helping others, its about LIVING!! I have also experienced some tremendous compassion for others this week something I thought I had already experience, but never really had. That sense of wanting to take away the pain and suffering of others without self-aggrandisement."

(Journal)

Brenda:

"I have been wearing a large and heavy suit which I can now unzip and shed ... I need to nourish me both nutritionally and emotionally and no more. I have the power to deal with life and living and will be free to every moment that is good and to experience those when it may be perceived as bad. I have no need of my protective armour of fat. I am magically, endowed with a light which is crystal clear and enables me to see what I need and what others need to, but not at expense and loss."

(Journal)

8.3c Peak experiences

The relational connections and the development of the therapeutic milieu accumulated in what can be described as 'peak experiences'. Peak experiences are often associated with being in wilderness settings and are described as those experience when individuals transcend the ego and have some sense of spirituality (*see* Csikszentmihalyi & Csikszentmihalyi, 1999). However, on this occasion the peak experience was not just about being in a natural environment. It could be argued that it was the accumulation of a woman-centred piece of work that up lifted women beyond the limitations that society has imposed upon them and this is best described by three of the women in their journal accounts:

Maria:

"After lunch we had a creative" session during which I made a rather colourful collage, around the theme of hope". At one point I went to the loo and for some unknown reason I was overcome with emotion. I don't know where it came form, but it wasn't anything negative, but something powerful and spiritual, and again the tears were some kind of release."

(Journal)

I have just read the acknowledgement from others at Brathay. I was deeply moved by words of praise and at last I am beginning to glimpse the woman they are referring to. The feelings of love and empowerment I am feeling now are beyond everything I could ever imagine. Previously, when I have experiences positive and uplifting moments have been so small in comparison. Oh I wish I could find the right way to express it. Or maybe I can only express it in my actions, in the future".

(Journal)

Josie:

"Because I've read a lot of Maslow,, because I've related this to Maslow, not that I agree with all that he says, that sort of feeling at the end, I think you called it total humanness, that feeling of being totally human and having that feeling, I don't know whether you feel that entirely on your own at any point, it was just being with other people and in a group of women like that, feeling in charge of the situation, it's hard to explain really. That's what I took away with me, it was like a plateau expcrience, and that stayed for a few weeks."

(Individual closure interview)

Andrea:

"I felt really privileged to be part of AG and to be with everyone at Bratahy Hall. Thank you Kaye and everyone else for all your help and support throughout the week. Words cannot express how I felt on the last day. It was a very overwhelming experience."

(Journal)

In conclusion, what was noticeable at the end of the follow on programme was that the women redefined themselves, not as group of women with troubled eating, but rather as a group of women with troubled relationships – arguably revealing the core issue behind the troubled eating:

"I think certainly the work at Brathay was very much the catharsis for my change, although I had already realised I couldn't stay where I was and I'd sought help, at that time I wasn't having the help and it might well have been that the help I'd have had would have been going around the same old circuit of counselling again.

But something changed with me at Brathay. I think really the situation I am in at the moment is having an understanding of something that I've tried to deny I think in the past, and rather than it being troubled eating it's troubled relationships.

Yes. I'd forgotten in some ways that we'd initially come together because we were women with troubled eating, that was the ad wasn't it that got us there for the cure, it was all this issue about food."

(Brenda: Final focus group)

This account draws attention to the role that the adventure therapy process, guided by feminist principles, may have played in allowing the women to make the essential reconnection to the relational structure of the self and aiding a process of change. It also indicated that the goal of offering a more woman-centred intervention had in some way been achieved. From a theoretical perspective the approach that emerged was similar to a developmental-systemic feminist therapy approach to working with eating disorders (*see* Bryant-Waugh, 2000).

Chapter Nine:

Reflecting upon the development of the adventure therapy practice

9.1 Chapter Overview

This chapter will consider in more detail the overall process of the development of the adventure therapy intervention. It will primarily examine the focus group in which the therapeutic team took part after completing the delivery of the intervention (for an overview of the background and therapeutic experience of the therapists see Appendix Eight). Here the team were able to clarify the dilemmas and decisions made in developing adventure therapy practice and reflect upon their own experience as therapists. For example, the chapter considers how the therapists view their therapeutic practice outdoors in comparison to that of working in an indoor setting. Thus identifying what it was like for them to work with clients in an outdoor setting. Along with issues of working therapeutically, the chapter also identifies the ways in which feminist ethics influenced practice and issues related to maintaining therapeutic change. Along with the focus group, the chapter draws upon reflexive notes to identify key issues that have emerged in relation to providing adventure therapy interventions.

9.2 Developing the 'HOPE' model: An overview of practice development

From the team's experience of developing the intervention and with reflection on the five phases of action research, three key themes emerged in relation to developing adventure therapy practice and these were:

1) Achieving feminist ethics
2) Achieving therapeutic practice
3) Maintaining psychological change and opportunities for personal growth

Table Thirteen provides an overview of the issues related to each of these themes, and each theme is now discussed in more detail, enabling some of the internal workings of how the 'HOPE' model was developed to be considered.

Table Thirteen
An overview of the key issues in implementing the 'HOPE' model

General Theme	Sub themes
Achieving feminist ethics	• Empowerment to choose to participate versus assessment • Facilitating therapeutic empowerment • Disempowering incidents • Conflicts in invitation to be co-researcher and client at the same time • Overlooking other body relations • Successfully de-emphasising food • Addressing therapists troubled eating • Lack of supervision • Maintaining women centred practice in other outdoor settings
Achieving therapeutic practice outdoors	• Maintaining therapeutic process during activities • Enabling individual therapeutic metaphors • Moving from outcome to process focus in facilitating outdoor activities • Achieving both doing and being during outdoor activities • Maintaining therapeutic practice whilst managing risk in outdoor setting • Working with individual goals for change • Working at different therapeutic levels in a residential setting • Felling empowered as therapists working outdoors • Therapists taking ownership of outdoor space • Educating outdoor trainers on the therapeutic process • Managing therapists relationships/experiences in an outdoor environment • Moving from traditional outdoor therapy to relational outdoor therapy
Maintaining therapeutic change	• Meeting different therapeutic needs of individual women • Ongoing assessments of change used to inform therapeutic interventions. • Responding to/taking note of women's research journal entries during intervention • Not planning the ending at the very beginning • Abandonment in therapeutic relationships after main adventure therapy intervention • Sustainability of therapeutic interventions not adequately planned • Enabling women to access wider therapeutic services

9.3 Achieving feminist ethics

A key challenge from the beginning of the study was working out what feminist ethics meant for practice. As well as making decisions, such as de-emphasising food intake as a goal for therapy, the relationship between feminist research and practice also needed to be managed effectively. The therapists' recollection of their experiences of working with the women helped to uncover what was different from, and similar to, their usual ways of working in traditional therapy. The therapists' perspectives started the process of identifying what was useful about the adventure therapy approach. It also helped to reveal the ways in which the strategies for managing a feminist and therapeutic approach emerged in practice, for example, enhancing the therapeutic depth of the outdoor experience.

The team had to continually spend time considering how they would, from a therapeutic point of view, implement feminist principles, as well as considering the ways in which a feminist approach to outdoor adventure needed to be addressed. As was previously discussed the team recognised key critical incidents when feminist ethics were overlooked (e.g. when a woman clearly had a disempowering/negative experience). In looking back over the programme the team concluded that they had not necessarily always done the best they could have done in achieving a feminist approach. It was commented how difficult it was to achieve an equal alliance in the setting:

> *4: I don't think we did particularly well [in fully achieving feminist ethics, I think it was a them and us split, which is sad.*

> *2: I think by the very nature of they were being done to, and I think in any therapeutic alliance it's there, there's no getting away from it, if one person's the therapist and the other person's the client, the power relationship is there and I don't know how you get away from that unless you're in a therapeutic community where there isn't a therapist.*

4: I think you can do much more, you can be in a focusing way curiously interested, along with your client. So it's more of a continuum, whereas focusing is more of an equal alliance. I think we were a bit further away from it.

2: Yes, the focuser is the leader in a sense and the listener is the guide.

1: So how did the research, how did the outdoor adventure and how did the therapy impact on creating that them and us in many ways. I suppose that's the question.

4: We're experts here, we're experts here, and we've got expertise here. They're particularly not experts there and they're being done to in most of those areas.

1: Part of what we tried to do all the way through was look at how we could avoid the power relationships, maybe not as fully as we could have. I'd be fascinated to maybe draw out what created this and what we need to try and avoid it and what we could do differently next time.

2: On reflection, for me, we would go off and we'd plan the activities, and they were waiting, the structure wasn't there for them, they weren't part of the planning of the day. They would come and they were presented with this is what we're going to do today. That must have been very disempowering, waiting, and there are huge control issues with it. We were in our own place trying to get research, trying to do it, it was a kind of passive waiting for them, for the women.

(Please note protect the identity of which therapist made what reflections on the developing of practice each member of the therapeutic team is indentified by number 1, 2, 3 or 4).

It seemed that the therapists' behaviours did in fact impact on the women in this way. One participant, Maria, reflected on one of the times when a 'them and us' split occurred,

> *"At the end of the day the 4 researchers "went off" without examination, it was assumed by the group they were having a debriefing session. But a few group members (me included) felt a little like is was "them and us" situation and discussed whether this should be voiced to the researchers...Also, we were all equally surprised by the inclusion of the two Brathay employees, as they were allowed to sit in on the "eating" discussions – which felt quite threatening."* (Journal)

In trying to understand how the unintended 'them and us' split had occurred it became evident for the team that the overall infrastructure had influenced this and that some of the nuances of the process had at times been overlooked:

> 3: *I can see why we did it, it was very stressful, it was very demanding, it was our comfort zone, so we needed to hang together and I think we've also got this model of running workshops and weekends and you're one of those slick performers.*

> *2: We were working something like from 7 in the morning until 12 at night and we just went for it.*

> *3: But we didn't work tremendously as you say in an integrated way with them. I mean we didn't become buddies and sidekicks and friends and companions. But it's very demanding isn't it, with a big group of people.*

4: So should we have structured that more beforehand, we as a team, that we could actually do the daily planning with the whole group, rather than us planning it the night before, should that have actually been in place and almost presented as a menu to the group. As a group, from nine o'clock in the morning, how shall we do this. So there's ownership for everybody.

2: But that's very anxiety provoking, if as a group of researchers we want to see what the effect is, because they may say no way.

4: But then that's their choice isn't it. If we tried to stop those no ways, were we so much controlling that we were saying we didn't want them to no way, so when one did no way, and took her bucket and spade home, we all became a bit agitated by that...

In exploring the reasons why the somewhat inequitable relationships had happened the team concluded that it was somewhat unrealistic to attempt to create equitable relationships and that these issues of power dynamics should have been discussed more openly. These difficulties were partly due to the fact that the team was exploring new ways of working and none of the therapists had worked therapeutically in the outdoors before. Consequently, some of the valuable opportunities for exploring what empowerment meant for the therapeutic team and the women participants were overlooked. This is something which the team would address differently in future work, whereby the views of the women would be more actively sought.

2; I just wonder whether it's unrealistic in this type of research and this type of therapy for us to really think we can try and not retain some power, I think we can give away a lot of power, but it's always there.

4: Yes, I agree with you, I think it is always there.

1: Because it's difficult as well with adventure therapy to not retain the power.

2: I think it would be naïve to think we could, no matter how hard you work at that, in the hearts and minds of the people you're working with, the power is related to them, no matter how much you pretend that it's not for yourself.

1: It's not necessarily pretending.

2: It's tempting to move as far into their court as we can, but recognising we can't move entirely into their court.

4: And that suggests that we've got it to move one way or another. The whole notion of empowering someone suggests that you have the power in the first place.

2: I see it as walking someone's journey for them to unlock their empowerment, rather than you've got the power.

4: I feel very much at a loss, I want the women here, I want them to be a part of this because who knows where they are now, has this been an incredible experience for them, have things shifted, have things changed for them, or would they be sitting here saying well actually agree with you, you lot did have a whole lot of power and you used it or you abused it or whatever, or no this was quite an incredible journey for me."

Further difficulties in achieving feminist ethics were identified. The therapist team considered the ways in which power was inevitable as part of the therapeutic relationship. It was suggested that if the situation had been handled more clearly feminist ethics could have been achieved more fully. It was also pointed out that, from a therapeutic point of view, the women needed nurturing and holding psychologically at the same time, along with being empowered, and that this was a way in which the power imbalance emerged – if this dynamic had been recognised at the time it could have been managed more carefully. Finally, if the structure had been clear from the beginning it would have been easier to enable empowerment within a contained structure. Often the lack of containment that came with not knowing exactly how the programme would end, meant that at times decisions regarding the structure of the programme were offered back to the women. That is they were invited to tell us what would be best. In trying to empower them in this way some of their therapeutic needs were overlooked and the delicate balance mismanaged:

2: I think looking back the bit about the control and the power, but I think they needed to a certain degree to be nurtured into that situation and held. Because I remember thinking at the beginning of the week that people seemed little, like children, and by the end of the week I didn't feel like that at all.

1: And it's that balance that we've said before isn't it. That happened in the follow-on when we didn't have structure, so it was the structure versus empowerment and creating some boundaries, but making sure it's not too controlling. But it does impose power relationships in some sense. But that might not be a negative thing.

4: I think if the bigger structure was in and we were clear on that and our planning had been more effective in terms of what happens next, then it would have been OK just to give that information, but we just weren't

sharing the information, the waiting and the what's next. Which may in itself have been quite therapeutic, the feelings about trust or excitement or anticipation, but it depends on how you handle it and how you want to do it, because I think in the end even the things that we might be looking at, the negative, might have been positive. When a client comes to therapy and they've had an awful time in a relationship and they cry their heart out I think, great, and this is the therapy, and it's another bit of the process.

1: I wonder whether the difference was how we could have handled it with more clarity.

2: I think for me that goes back to the fact we didn't prepare ourselves beforehand, we didn't have that meeting up there and felt it.

9.4 Achieving therapeutic practice outdoors

A key aim of the programme was to find ways of working therapeutically outdoors. Even though outdoor adventure experiences have inherent therapeutic qualities, working at psychological depth was seen as essential to working in this context. Consequently, it was important to ensure that counselling and psychotherapy techniques were integrated within the outdoor experience.

As illustrated below, the ways in which the therapists felt able to work therapeutically in the outdoor setting changed over time. They moved away from an outcome orientated way of working (e.g. the focus being on completing the activity itself) towards concentrating more carefully on the psychological process at greater depth. This represented a move away from 'riding above feelings' in order to successfully complete

activities, to going into the feelings and working with them, with the focus being on how to maintain that psychological emphasis during participation in outdoor adventure activities:

1: I'm interested to know what shifted, if we think about what happened on the first weekend we ran to what happened on the last weekend we ran, what awareness have we got about what adventure therapy is that's different, from the beginning to the last weekend.

2: I'll tell you one which comes straight to mind, I remember the first weekend people were up doing certain things and they were shouting, come on, you can do it, and the final weekend I noticed that the volume dropped and the words completely changed.

3: I think we were more focused on process than outcome, which is different from developmental workers.

2: And it started off with us paying lip service to it's the pole rather than the jump, and by the end it really is, what do you want out of this activity.

4: And what's going on during it....

2: They ride above feelings [outdoor development workers] , whereas therapists go into them and work with them.

1: In the first weekend, maybe we working on that, above feelings, whereas at the end of the programme we were more going into them.

2: So it was achievement focused in the first week and later it was what's going on for you now. I always experience that difference working with teachers, when they come to learn tasking skills and they're awful, they're really hard work to work with.

3: I'm thinking that the outdoor people are out of contact in some ways.

In exploring the ways in which the work developed the therapeutic team examined how their work might differ from more traditional forms of counselling and psychotherapy. Here they identified that working in the outdoors was about 'doing' therapeutically, as opposed to 'being' therapeutically. This emphasised the experiential emphasis of an adventure therapy approach:

3: And what is the difference then between that context [the outdoors] and the context of a therapy room.

2: Well there aren't a lot of things in a therapy room. I mean pull up a chair and you won't die.

4: And I suppose a stark contrast for me, because strangely enough we came back from that and I was given a client who had trouble eating, so it was right in my face, it was like I invited a client to go inside and asked them to close their eyes. Out there it would be an invitation do you want to keep your eyes open to be a part of this, whereas this way was to close your eyes, block off this room and try and imagine this beautiful place.

2: Yes because there they've got to bring it in from outside, where we were it was there.

4: So my language with the client would be, I'd invite you to close your eyes, or that might happen naturally, whereas out there it might be, just be.

2: I think particularly up high where you've got that view across among those trees.

4: And I always remember, I don't know who it was at the top of the pole, but on one of these occasions somebody was up there and the moment before they jumped they closed their eyes and then as they jumped they opened their eyes into this experience, but it was like well if you're asking somebody to do that in a room, they would probably keep their eyes closed. So that that had a huge impact on me in the different environments.

3: Also, the whole notion of adventure in this context is about doing, and in a therapy room you're working at being.

1: And did we conflict with that? How did what we do integrate the being and the doing, was there a dynamic or was there more emphasis on one or the other.

2: No because there was an awful lot of reflection on the doing. When we went out for a walk it was about looking down on us and deciding how they were going to integrate it all.

4: It's like that stuff about talking the talk or walking the talk isn't it.

2: Another example I was thinking of was with Jackie, actually asking her to do things, asking is this alright. Which is doing therapeutically.

3: Like doing therapeutically rather than being therapeutically. Using therapeutic adventures to promote change isn't it, but knowing that's what you're doing."

Another important element was risk, as the therapist's comments below, in traditional counselling 'I pull up a chair and you won't die'. However, in an outdoor adventure setting physical risk needs to be constantly managed and ultimately death is a possibility if safe practice in offering outdoor activities is not maintained. Given this, physical safety needs to be managed at all times, along with therapeutic safety. However, at times physical safety has to take priority over the therapeutic process. So facilitating therapeutic work in an outdoor setting means that the impact on managing physical safety does need to be considered in light of the therapeutic process and at times these two processes may conflict with each other.

As noted above, the therapeutic team summed up the process of adventure therapy as 'therapeutic doing'. This acknowledged that even though outdoor adventure activities were experiential it was the emphasis on therapeutic process during activities that is essential. In trying to establish what had been different in the relational and adventure therapy approach developed, in comparison with traditional counselling and traditional outdoor adventure, the team compared aspects of the psychological processes of each approach (*see* Table Fourteen). This helped the team to reflect upon how they had achieved a feminist approach to adventure therapy.

Table Fourteen:
A comparison of the key goals of counselling, traditional outdoor adventure and relational adventure therapy

Traditional counselling psychology	Traditional outdoor adventure	Relational adventure therapy
Individuation	Self-sufficiency	Mutuality
Self-esteem by personal autonomy	Self-esteem by achievement	Self-esteem through relational competence
Understanding fears	Overcoming fears	Embracing fears
Challenging defences to autonomy	Challenging self to achieve	Challenging barriers to intimacy
Power from environment	Power over environment	Power sharing with the environment
Being therapeutically	Doing physically	Doing therapeutically

In continuing to examine how practice evolved the team pinpointed some of the ways in which their practice developed, including the ways in which they allowed themselves to use more therapeutically-orientated processes, such as focusing, as an aid to working at psychological depth:

> *2: I think our framing was different, our framing was much more around using metaphor and inviting people to use it. I mean on the second one we actually did a focusing input, we said this is a way in which you can work.*

1: So what was that about in terms of maybe the therapy, the shift.

2: It was almost a superficial framing, you can use this, this and this in such a way, but we weren't really into it, whereas on this, we're so into it that we're saying focusing is a tool you can use. Like on the ..... here there was an awful lot of argument about what we were supposed to do and we could actually work with the leadership and the roles, whereas on that first one we just went hell for leather for a competition.

1: So in many ways we did the activity and the experience, but on this one we were more alerted to the issues and the things that emerged from those experiences, they were more highlighted.

3: That was much much more outdoor led. A way that typifies it, we went out and fell into a competition. On this one we would have thought about it, why a competition.

4: Our language was very different.

3: I think some of that is about it's very familiar for us, so the power was really with the outdoors

4: Then we became more powerful ourselves as we became more familiar with the place and started to take our power.

In looking back at the women's experience the following extract from Maria's journal illustrates the ways in which the integration of the focusing technique enabled psychological depth and personal meaning to be achieved:

> *"Before the rope work, we each had ½ hour with our individual therapists – mine is Val. This was extremely useful as quite a bit of "stuff" came up particularly the knot in my stomach which I feel when I get angry. Val asked me to close my eyes and focus on the knot, and to go inside it and try to describe what it looked like and felt like. The image that came to mind was of a "roaring furnace", which we linked to me 'feeding the furnace' (anger) with food. The session ended with Val asking me to think about what it would take start putting the furnace out. I was able to cry in the session with Val. Part of me wanted to do this, for the release and possible also to let Val know how bad I had been feeling. But another part of me felt very foolish and silly and completely ashamed of myself, but hopefully I am beginning to overcome this par of me, realising its just fine to have a good cry and "let it all go."*
>
> (Journal)

In the research focus group with the therapists it was also noted how they were overwhelmed at the psychological depth they were able to achieve with the use of the IPR sessions. They also commented that the psychological depth that was achieved with clients during the adventure therapy approach would normally take much more time (up to 6 months as stated by one therapist) to achieve when working with clients in weekly therapy sessions:

> 4: *I think it was the intensity, the way of working where you were in that community. It was your community for those five days and I was able to get to a depth very quickly in my experience with the client, which would [normally] take me months to get to. The environment was very different; sitting in a room at University [counselling service] which is so un-therapeutically sound, with its grey walls and telephone. So with regards to getting to that depth, I think that*

worked exceptionally well, that's a part of the process that I feel was very valuable.

3: *For me, as transactional therapist who thinks in terms of assessments, diagnosis, treatments etc., I very quickly began to realise what people's script issues were, by observation of them interacting in a group. So that was remarkable for me. Now whether that would happen in any kind of residential situation I don't know, but there was so many pointers to people's script issues, their unmet needs, if you like, and what work needed to be done or how the work might go. So for me it was a total luxury being able to speed up the assessment process and work really.*

4: *Yes, I think that's pretty much what I was saying, the luxury of getting into that depth so quickly in such an environment.*

2: *I agree with what you've both said, I think another thing is there was a holistic view about it, there was a whole range. I'm thinking of the times when it was really funny and everybody really laughed, and that was therapeutic, with a big T, not a little t. Also really quickly working at depth and the business of shared experiences, very powerful stuff.*

3: *And talking about holistic, we were also addressing issues around food without actually talking about food.*

2: *And sharing ourselves, a bit of self-disclosure went on there, which I thought was really valuable.*

(Therapist focus group)

Through their reflections the team identified, however, ways in which the therapeutic approach they were trying to implement could easily become discounted when working with non-therapists (i.e. outdoor instructors/educators) in an outdoor setting. This was partly because professionals working in the outdoors have not necessarily been trained in psychotherapeutic principles and thus do not have experience of therapeutic facilitation in an outdoor setting– i.e. working with psychotherapeutic goals is not common practice across the outdoor sector. They also commented on their experience of being therapists in that setting. The therapists felt that power was being exerted over them at times and that the infrastructure to the setting meant that it 'belonged' to someone else and not to them as therapists. Consequently, their skills and experience were often discounted:

1; *It's harder in that space to maintain the way we worked.*

4: *Do you know that's the first time that's smacked me.*

2: *It's true. That's because that space, the outdoor space, belongs to Brathay.*

1: *Which is the fascination between these two here, because if you're going to step into that and manage it then you've got to process that whole dynamic, because that will take away from it.*

3: *So that's the threat of something I don't understand is encroaching on what I do understand and I feel threatened by that.*

2: *I think it's worse than that, it's we're outdoor ed people, we control this, you come in and we'll completely look after you, and you don't have any expertise at all.*

4: *That might be out of fear and responsibility and risk.*

3; *Yes it's oh my god, we've got this therapist coming up here and she's going to have them in overflooded ghylls or whatever, who knows.*

4: *I think that's where the control comes from in some ways.*

3: *And I think in all of this also is the fear of we're people and you know all the labels that go with us, you're not reading my mind.*

2: *And also I think it's territory, I don't really want to give up to you what I've spent ages and flogged through snow, wind and hail to hold on to.*

4; *And if they'd done their own personal work, they wouldn't have those fears.*

1: *And that's what outdoor education needs to do. And that's what it doesn't do, it doesn't allow people to engage in their own personal development. So the backlash about the model of outdoor therapy."*

Over time, however, the therapists found ways in which they could feel empowered in that setting, as a therapist commented,

> *"Then we became more powerful ourselves as we became more familiar with the place and started to take our power."*

This dynamic that the therapists experienced illustrates some of the barriers faced when trying to integrate psychotherapeutic approaches to working in the outdoors. The therapists questioned whether this dynamic had a gender dimension to it, in that in having to work therapeutically in this setting challenged some of the dominant

assumptions about outdoor adventure. Working therapeutically meant some of the more masculine ways of working had to be challenged.

Overall, the therapeutic team found it harder to maintain therapeutic ways of working in the outdoor setting. This illustrates that this factor needs further consideration to enable outdoor and therapeutic practice to work effectively together. For example, those from a more traditional outdoor education background require training in counselling and psychotherapy, so they are able to appreciate more fully how a therapeutic approach differs from a developmental or educational approach. This then points to the need for specialised training in adventure therapy in order to develop sustainable and ethical practice.

As a result of the team's enthusiasm to provide a successful therapeutic intervention, they worked from 7am until late in the evening every day. Consequently, this therapeutic support was available to the women during the whole week. However, in doing so as therapists, researchers and outdoor trainers, we were at risk of denying our own need for rest, nurture and supervision. Gradually it became evident that the model that was being offered by us was one of denial of professional and personal needs. It seemed ironic that unwittingly we were actively reinforcing the patriarchal ideal of 'superwoman', even as we were working to create an environment that sought to embrace a philosophy of providing nurture and support. This was highlighted by the fact that the team's need for supervision was not met. This was a lesson for indicating that we needed to develop ethical practice more carefully.

Supervision is a clear ethical requirement for any therapist and yet, although we had continual supervision in our work with individual clients outside this specific intervention, we had failed to place supervision at the core of

professional practice in adventure therapy. This in turn pointed to the ways in which our practice had been partly reflective of trends in the outdoor industry. Here the role of supervision is not seen as a necessary function of ethical practice or professional development. Indeed, professional practice often fails to address the emotionality and issues of burnout for practitioners (*see* Gray & Birrell, 2002). In particular, the lack of feminist therapeutic support was significant for the researcher who began to experience emotional burnout (see Chapter Six). This inevitably impacted upon the quality of the intervention provided and her ability to maintain a feminist approach. It also alerts us to the need for appropriate supervision for both researchers and adventure therapists, as discussed earlier.

The superwoman effort of the team also had consequences for the women's experience of the transition onto the follow-on programme. The intensity of the therapeutic support provided on the residential was impossible to maintain returning home. This raises the question of how to manage the transition from the residential phase to the follow-on phase. What became clear for the team is that supervision of some kind would have helped the team work through these issues, address them more effectively and possibly maintain a more even level of support for the women.

9.5 Maintaining therapeutic change

Many of the issues identified in relation to maintaining change have been previously discussed (see Chapter Seven). As noted in this section, the team had given a lot of attention to implementing the adventure therapy intervention residential itself, and the need for follow on support, although considered, had not fully taken into account the differing needs of the women. The team recognised that being able to offer some level of therapeutic intervention over a longer period of time in the context of this study had been problematic for a number of reasons, including resources available and adequate attention to the transition process

each woman was encountering on their return. For example, addressing the needs of the women that found it difficult to attend the follow on meetings, and thus the barriers to ongoing participation weren't necessarily foreseen. The team concluded that access to adequate ongoing therapeutic intervention, whether or not provided by themselves, would have ensured a smoother transition and enabled therapeutic momentum to be maintained.

Another lesson learnt for the team was that it would have been useful to use the research data collected more diligently during the actual intervention and thus offering information to better gauge how the women were experiencing the intervention. A clear example of this would have been using the research journals more fully to help the team identify individual needs so that they could respond effectively to them. The team had access to personal accounts from the women about the therapeutic process, along with the EDI Scores, but these were not used in any way to inform the ongoing process. One could argue that if they had been used in this way it might have prevented the women being as honest in their accounts. However, there was evidence that some women did make requests to the therapeutic team via the journals, and these were not always addressed when the women made them. Again this is an example how research and practice are inextricably linked and points to one of the many factors that contributed to the women's overall experience.

Chapter Ten:

Revisiting the 'HOPE' model and looking forward

10.1 Chapter overview

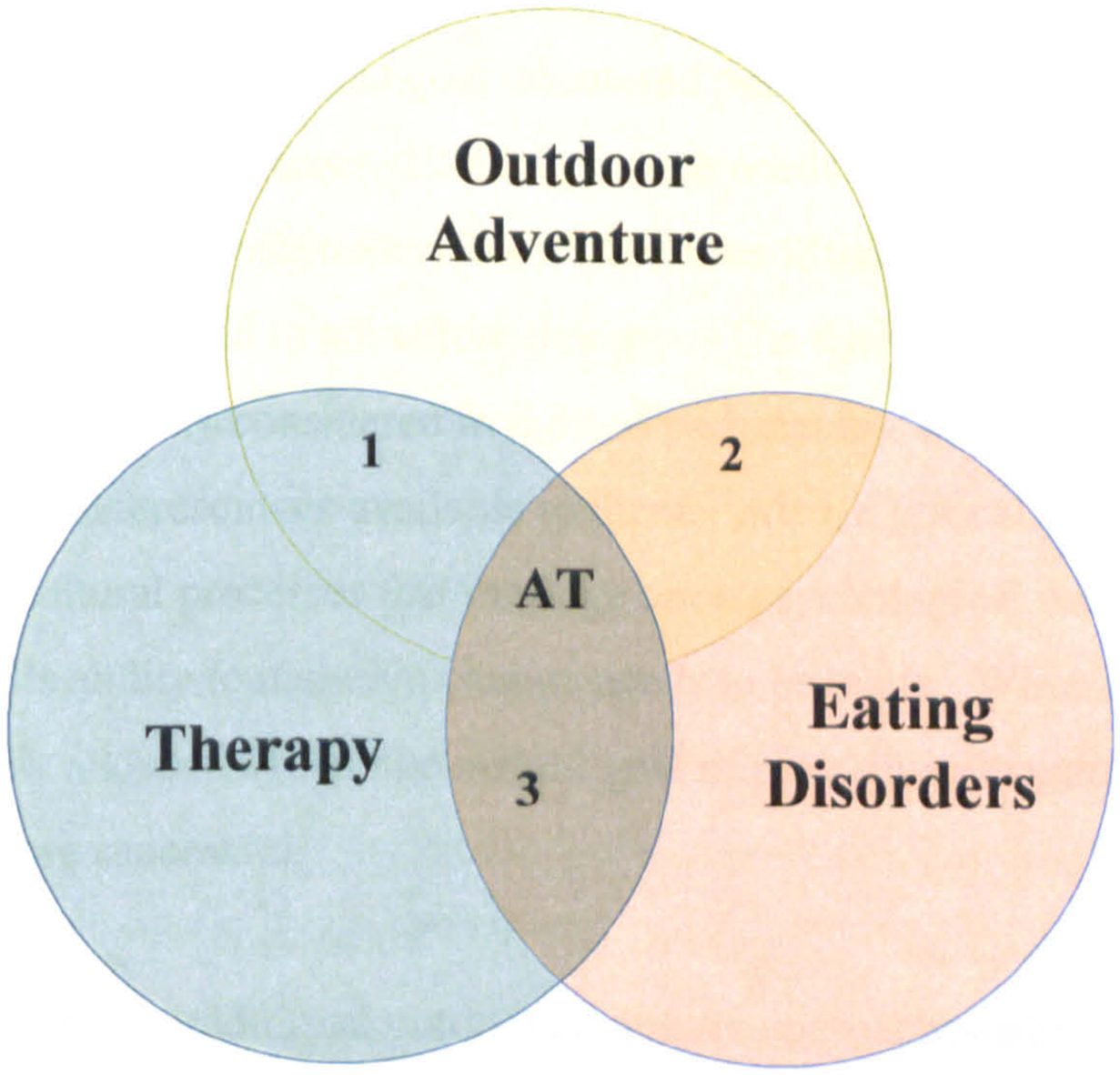
The final chapter will conclude by revisiting and expanding the 'HOPE' model as presented in Chapter One. Having completed the action research project the knowledge associated with the overlapping segments of the model, e.g. 'therapy and eating disorders', 'outdoor adventure and therapy', and 'outdoor adventure and eating disorders' have been understood. By examining these overlaps the central segment of the model 'adventure therapy for women with eating disorders' – has become realised in practice. Upon revisiting the 'HOPE' model this chapter will go on to consider some of the limitations of the study, as well as some of the many questions left unanswered. This will conclude the thesis by reviewing the lessons learnt from working to implement the 'HOPE' model into practice. This end point, however, represents a starting point for developing future research and practice in this area, and some of the key issues in continuing with such work are considered.

10.2 Revisiting the 'HOPE' model

Describing how this adventure therapy programme for women with eating disorders was implemented has allowed the complex relationships between gender, eating disorders, the outdoors, therapy and research to begin to be revealed. Earlier in this thesis, the 'HOPE' model was presented, outlining the aim of bringing the five components of the intervention in order to help women with troubled eating. At this stage it is now possible to reconsider the model with a greater understanding of how all these segments came together in practice and the processes by which 'healing outdoors provides empowerment to help overcome problem eating', or 'HOPE to HOPE' (*see* Figure Five).

Figure Five:
'HOPE to HOPE':
Healing Outdoors Provides Empowerment to Help Overcome Problem Eating

1 * Outdoor trainers and therapists in relationship as adventure therapists
* Accessing the risk of experiencing and expressing the self
* Managing the changing dynamic of the therapeutic alliance in an outdoor setting
* Achieving a dynamic balance between activity experience and therapeutic processing
* Developing adventure therapy as a practice of social action therapy
* Managing the post-residential therapeutic adjustment phase
* Providing ethical practice by the provision of supervision for practitioners



2 * Avoiding reinforcement model of eating disorders (e.g. control of mind over body)
* Questioning the basis of individuation models of outdoor adventure
* De-emphasising masculine models of adventure
* Addressing body projections as outdoor leaders
* Encouraging nurturance of self through
* Emotional and physical expression
* Developing relational connections with self, nature and others
* Addressing social & psychological interactions of eating and body identity

3 * Changing 'secretive eating issues' into shared eating issues
* Combining intra-psychic change with social change
* Examining the social construction of body image and eating disorders
* Working with a continuum of troubled eating
* Developing a relational model of therapy
* Actively addressing the power relationship between client and therapist

The 'HOPE to HOPE' model highlights key considerations of an approach to adventure therapy for women with 'eating disorders', for example, by avoiding a reinforcement model of eating disorders by emphasising a relational model of adventure therapy and working with a continuum of troubled eating. It also points to the need to manage the therapeutic alliance in an outdoor setting carefully and to find effective ways for therapists and outdoor trainers to work together to create an adventure therapy process. Within this there is a need to provide a balanced approach to activity and therapeutic processing, and to find ways to enhance psychological depth and meaning for participants throughout participation of all outdoor activities. To achieve this, masculine models of adventure need to be challenged and goal orientated practice needs to be replaced with a relational emphasis. Ethical practice needs to ensure that appropriate supervision of practitioners is offered, even if this is a challenge to have supervisors experienced in adventure therapy. The dynamic processes of change need to be carefully considered in light of participants' every day life, and social and personal resources available to them. Also, a critical evaluation of the social and cultural processes that impinge upon psychological well-being and an individual's ability to maintain change needs to be made. When all these factors are actively addressed then, the central goal of providing adventure therapy can be more successful.

At the start of this thesis traditional outdoor adventure approaches were evaluated to identify the therapeutic possibilities that they held. Having explored these ideas in practice and taken a feminist perspective, the notion of a relational approach to adventure therapy is now understood more fully. Overall, the aim of this research was to offer women the possibility for transformational experiences, and to this end the research achieved its goal as much as it could under the circumstances and constraints of the social context of the study (e.g limited funding). Obviously, lessons have been learnt that would inform future practice developments, including those about working with women with troubled eating as well as working therapeutically in an outdoor setting.

The study indicates that adventure therapy, as implemented in this study, has the potential to offer a successful intervention for women with eating disorders. For those women that did change as result of the intervention these changes were across a range of dimensions, including increased self-confidence, increased self-belief, accessing resources, reducing self-undermining cognitions, reducing self-destructive behaviours related with troubled eating, and ultimately moving along the continuum of troubled eating in a positive direction. The therapeutic factors that enabled such change included both outdoor adventure related factors and more traditional counselling and psychotherapeutic factors, arguably a model of adventure therapy

The use of IPR as a research and practice tool proved to highlight the potential of using this approach in both working with clients in this setting and also accessing insight into the therapeutic processes of change that underpin an adventure therapy approach. It was evident upon having completed the IPR sessions that these enabled the therapist to work at greater psychological depth with individual participants and participants were able to deepen their awareness of how they experienced the outdoor adventure activities. Consequently, this enhanced the therapeutic potential of participating in outdoor activities. This is a significant finding from this study as IPR has not previously been used with clients in this setting in this way, and yet it proved to enrich the therapeutic experience of outdoor activities considerably for those that used it. So IPR seems to be an effective technique in facilitating the outdoor adventure therapy process. Furthermore, audio-recording the sessions of IPR offers a way into analysing the possible moment-by-moment change process of participants taking part in adventure therapy interventions. This is a very much under-researched area of adventure therapy so using this technique in future research would be also be worthy of further investigation.

The multiple insights provided by the development of the HOPE model were achieved through the integration of research and practice. Furthermore, it was essential that the intervention was underpinned by a well-considered feminist critique of the theory, research and practice related to each sphere of the model. The therapeutic value of such an approach is expressed up by a short poem written by Katy during the residential:

Revealing our thoughts and learning to confide
Dealing with things from which we'd rather hide
Feeling hurt and pain we've always denied
Healing ourselves deep down inside

It seems that the intervention in its current form, however, was not successful for those women with severe and prolonged chronic symptoms. Given the short duration of the actual residential phase this is perhaps not surprising. This result suggests that for those women suffering from, more chronic troubled eating they might need a different tailored intervention to meet their needs. It could be that an intervention longer in duration (e.g. a wilderness therapy intervention) would enable key change to be initiated. However, the novel nature of the intervention did motivate these women to take part in a therapeutic programme and ways to maximise this motivation needs further exploration. But one could argue, especially from a feminist perspective, that the need for prevention strategies are key to avoid women presenting chronic symptoms to start with.

Limitations in the study are inevitable. The study was a small scale study and developmental in nature. There were also obvious gaps in the data - some women did not complete all the data methods and the key IPR tapes were unable to be transcribed – arguably a key data source, as this is where moment-by-moment changes as related to the processing of the outdoor adventure experiences could have been understood more fully. Furthermore, due to time restraints of the project not all data collected (e.g. video recordings of therapy sessions) could be analysed.

In order to be able to assess the usefulness of adventure therapy in comparison to more traditional counselling, the changes identified for the women here would need to also be compared with change for similar women who participated in other types of therapeutic intervention. This might indicate further what it was about the adventure therapy intervention that seems to be most helpful and ascertain more fully whether adventure therapy is more suited to certain clients with certain needs. Here the helpful and unhelpful aspects of adventure therapy would be a useful future research question. Other factors, such as the amount of time in traditional counselling needed to achieve certain levels of change in comparison with the time taken in adventure therapy interventions to achieve similar levels of change would be an area worthy of further investigation. The therapists involved in this study indicate that this might be a possible variable in adventure therapy as their experience was that working in the outdoors speeded up the therapeutic process.

The ways in which scores on the EDI dimensions changed over time, especially those that fluctuated and slowly crept up again after the residential, illustrate the value in using such measures over a period of time. In particular, taking a score at 2 month and 7 month intervals raised questions about women's ability for maintaining change on specific dimensions (e.g. body dissatisfaction). This raises questions about the social and cultural influences affecting women who are trying to maintain change. Inevitably, the social and cultural conditions of the women's everyday individual lives (as discussed earlier in Chapter Two) exert an influence on how they were able to maintain change and feel equipped to continue with taking part in therapeutically and growthful-orientated activities. For example, it could be argued, that given the social and cultural pressures in relation to women's body image, that it would be difficult to maintain improved scores for body dissatisfaction when in everyday life. This in itself is an interesting research question and, given the power of outdoor adventure experiences, this is a crucial question in offering participants the best opportunities for maintaining change. In pursuing this area further it might have

been useful to share the changes in EDI scores with women to explore their individual meanings of them more fully, however, this was not considered in this study, but it would be a useful consideration in any future research.

It could be argued that if the team implemented an adventure therapy intervention, having now done this work and given the learning that has taken place, parts of it would be different. However, it would also be clear which parts might stay the same. Yet, further research is required across a whole range of questions to ascertain whether adventure therapy would be beneficial to other women with troubled eating and in what ways - generalisations to an eating disorder population can not be easily made from this study, so more research on this is topic necessary.

From a more generic counselling perspective, in this study both a person-centred and transactional analysis modality were used by the therapists. There might be an argument that only certain types of counselling modalities are effective in an outdoor adventure setting, however, this is not a position that is taken in this thesis. As is demonstrated, adventure therapy is about enabling a deep therapeutic process to be initiated as part of the outdoor adventure experience and a range of psychotherapeutic approaches can be applied to processing experiences in the outdoors. But questions still remain as to what a developed theoretical model of change for adventure therapy is. Again, this is an important area for future work.

10.3 Looking forward: Practice and research recommendations

This is a study very early on in the development of such practice, therefore, it has to be seen as a first step in developing such practice and it cannot offer a comprehensive analysis of such interventions, as no more practice currently exists in the UK. Given this, any results from this study can only speak to the intervention in the local context of this study. It offers an initial understanding

of how to approach such work and it has ascertained that there is value in pursuing further work in this area – i.e. adventure therapy does offer therapeutic opportunities for positive change for women with troubled eating. Based on the findings of this study the following research and practice recommendations are suggested:

Practice recommendations

- Maintain therapeutic process during outdoor activities by integrating key psychotherapeutic strategies during activities.
- Provide adequate psychotherapeutic interventions for participants to process the therapeutic significance of outdoor activities both during and after outdoor adventure activities.
- Use one-to-one therapeutic interventions pre and post adventure activities to enable participants to identify personally significant meanings from taking part in outdoor activities, rather than those imposed by traditional outdoor development practices.
- Set detailed inclusion and exclusion criteria for inclusion in interventions and recognise that those clients with chronic symptoms maybe more resistance to change and thus there is a need to consider if and how any intervention will effectively address the needs of these clients.
- Ensure careful consideration is given to the ways in which certain clinical symptoms may be reinforced by taking part in outdoor adventure activities.
- Ensure that appropriate and adequate psychotherapeutic supervision is provided for all trainers/therapists during any adventure therapy programme.

- Be careful in balancing the needs of ethical psychotherapeutic practice with ethical outdoor activities practice - ensure that all clinical decisions critically evaluate ethical aspects from both approaches to practice in all aspects of the intervention.
- Therapists and outdoor trainers working together is an effective way of providing adventure therapy interventions, however, attention needs to be given to ensure that practice is fully aligned whereby counsellors and outdoor trainers respectively understand approaches to practice that either may adopt. Furthermore, to ensure ethical practice counsellors/psychotherapists and outdoor trainers should be qualified and accountable to relevant ethical framework and procedures of such practice.
- Combine established ethical frameworks in counselling and psychotherapy practice and outdoor education to help guide ethical adventure therapy practice.
- Enable therapists to feel empowered working outdoors so their psychotherapeutic skills and knowledge can more easily be integrated into an outdoor setting – tradition approaches to outdoor education maybe a barrier to this.
- Provide more training on psychotherapeutic principles and practices on outdoor education programmes so future outdoor educators can appreciate how to approach developing adventure therapy practice ethically and effectively.
- Examine further the ways in which key therapeutic concepts are impacted on by working in an outdoor setting.
- Develop an combined ethical framework that fully meets the needs of providing and practicing outdoor adventure therapy.

Research recommendations:

- Through an action research approach examine in more detail the application of therapeutic principles in action in an outdoor setting and how to achieve ethical outdoor therapy practice.
- Use action research as a methodological approach to developing outdoor adventure therapy practice and develop action research guidelines for adopting such an approach to research in this setting.
- Assess the change processes of clinical practice of therapists working in an outdoor setting – does working in an outdoor setting change their understanding of psychological change and their approach to practice in anyway?
- Assess the change process of training practices of outdoor educators working alongside therapists – does working alongside therapists change their approach to practice in anyway?
- Examine the benefits of certain activities for certain clinical symptoms, i.e. what outdoor activities word best for who and why.
- Use research tools that are commonly used in practice in a counselling and psychotherapy in a UK setting for example CORE-OM (Clinical Outcomes in Routine Evaluation Outcome Measure) to compare outcomes of adventure therapy with outcomes of mainstream counselling and psychotherapy.
- Examine the ways in which key therapeutic concepts are impacted on by working in an outdoor setting.
- Use mainstream counselling and psychotherapy research approaches to examine key aspects of the adventure therapy process. For example the Client Change Interview Protocol and the Most Helpful Aspects of Therapy (HTA) Form (see Elliott et al., in press)
- Develop more detailed reflexive processes and guidelines for feminist outdoor therapy research strategies.

- Examine further the role and use of IPR as a research and practice tool in emphasising and facilitating therapeutic change.
- Examine in more detail the moment by moment change of therapeutic change as experienced during outdoor activities and using IPR as a tool for examining such processes of change.
- Consider the ways in which research data collected during any intervention can be used to inform the intervention and direct work with clients.
- Examine longer term change post any adventure therapy intervention

From a wider perspective of taking a feminist perspective to adventure therapy practice the goal now should be looking towards finding ways of continuing to develop practice to providing interventions for more women with troubled eating. The study clearly indicates that women need interventions that meet their needs more adequately and realising the potential of such work is a serious feminist and mental health agenda: as eating disorders continue to rise, the need for both intervention and prevention strategies need to be urgently called for. So, it is hoped that this study in adventure therapy will help the outdoor field to contribute to strategic development by taking the needs of such a client group more seriously, enabling the potential of such work to be realised more fully.

If adventure therapy is to mature into a distinctive therapeutic approach, it can no longer be assumed that therapeutic change processes will occur naturally. As seen in this intervention, in-depth analysis is required to understand what the change processes might be and how they can be facilitated. One of the lessons learned in this analysis is that facilitation of therapeutic change through outdoor adventure requires innovative therapeutic practices that thoroughly link outdoor adventure and therapy with specific client's needs. It also needs a clear integration of research, theory and practice. This integration of adventure, therapy and research is a difficult process. The five-phased approach and some

of the research methods used in the intervention discussed here may serve as an initial framework that could be adapted and developed further, allowing practitioners to examine the therapeutic approach they might take in their own outdoor adventure contexts.

Adventure therapy is in its infancy in the United Kingdom and, consequently, we tend to look outwards to international practices for guidance. However, we need to initiate a more inward focus, exploring the boundaries of our own practice in the UK. As adventure therapy practice evolves in the UK, it needs to ensure that research is located within this practice, as this will be fundamental for both its credibility and the development of future provision. Such a move will allow us to focus on the development of quality and ethical practice and pay more attention to developing adequate theoretical models that underpin practice. Accompanying this, research and practice need to actively seek to break down the barriers of ignorance and oppression, by developing anti-discriminatory agendas and deconstructing current theory and practice to guarantee inclusive practice is achieved for all. This will ensure that adventure therapy in the UK not only contributes to international perspectives, but also builds a distinctive identity that reflects its diverse cultural contexts and the diversity of clients that present for counselling. In doing so there are five key strategic goals in the development of adventure therapy which future work will need to address:

1) Setting ethical and professional standards that ensure safe and good practice
2) Facilitating a critical forum to develop knowledge and understanding
3) Engaging with multi-disciplinary agendas and contexts
4) Developing international diversity of application and understanding
5) Developing evidence-based practice.

10.4 Conclusion

There are many research questions still left unanswered at the end of this study and the results of this study will not mean that adventure therapy will easily be adopted as either a recognised form of psychological therapy generally, or a form of intervention for the treatment of eating disorders – the evidence is not adequate enough to make robust claims to advocate for this. However, the study does provide an initial starting point for future and research development. It has illustrated the ways in which adventure therapy has therapeutic possibilities and provides some insight into how to approach work with women with eating disorders. The challenge for the future is for adventure therapy to develop itself into a more mainstream form of psychological therapy. To achieve this vision a research agenda, combined with ethical practice developments with a range of client groups is essential. This requires innovative training developments, as well as developing the infrastructure for initiating new practice. It is hoped that this thesis is one small step in enabling such a vision to begin to be realised, and that it will provide a platform for ongoing initiatives in adventure therapy in the UK.

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Appendices

Appendix One: DSMI –IV criteria for eating disorders

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Appendix One:

DSMI –IV Criteria for Eating Disorders

DSM-IV (19994) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. American Psychiatric Association.

Diagnostic criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

***Specify* type:**

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Diagnostic criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   (1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
   (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)
B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
D. Self-evaluation is unduly influenced by body shape and weight.
E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

***Specify* type:**

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Nonpurging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas

Appendix Two:

Eating Disorders Inventory (EDI) and EDI Normative Data

APPENDIX NOT COPIED

ON INSTRUCTION FROM

UNIVERSITY

Appendix Three:

Guidelines for Completing Research Journal

Personal Perspectives

The aim of this journal is for your to keep an account of your experiences. By writing down aspects of your experience you will help us understand more fully what the meaning of the programme is for. It will help us identify the value of the programme and what changes we should make for the developing further programmes. The information will remain confidential within the research team. However, we will make reference to case studies in the write up of the programme. However, you will remain anonymous and we will discuss anything we write up with you.

This journal is for you to write about any element of your experiences.

It may list concerns when they arise, questions you have, what the experiences mean to you, what relation they have to the eating issues you are working on.

<u>Other areas which may be relevant could include ?</u>

* Moments of personal insights ? - what encouraged these to happen ?
* What value do exercises / activities have in exploring your eating issues?
* Moments when you felt uncomfortable - what were these and why did you feel uncomfortable / anxious ?
* Experiences of frustration, fear.
* Exercises which made you feel good/bad - why did you feel good/bad ?
* What different exercises / activities meant for you ?
* What are your hopes/ aims for the programme / specific exercises ?
* Do you hopes / aims change ? If so when and why ?
* Moments of learning ?
* What was different to these experiences compared with other ways who have explored your eating issues previously?

These questions are only a guideline. The aim of this journal is for you to record what has meaning for, ranging from feelings, insights, concerns etc.

Please write whatever you want. We won't be judging them , they will help us in evaluating the course. Please do not write only the good things. It is important for us to know what doesn't work for and any possible reasons why ? Jenny, Val, Barbara and Kaye are also keeping there own journals alongside you. So we aim for you to join us in the process in evaluating the programme.

Thanks for any thoughts, insights.

Appendix Four:

University Recruitment Advert

EATING ISSUES FOR WOMEN AT LJMU

'Adventurous Growth', run by Kaye, Jenny & Val, at LJMU is developing a programme to work with women with eating issues.

DO YOU CONSTANTLY UNDER EAT
IN ORDER TO BE THINNER
and

* *Dislike your body image.*
* *Reduce food intake to lose weight.*
* *Often don't feel good enough.*
* *Constantly think about food and losing weight.*
* *Desire to be thin.*
* *Often feel guilty if you don't exercise.*
* *Often feel isolated and lonely.*
* *Often lack self-confidence.*

If these eating issues are relevant to you and you would like to work on living a life with out them, then join is in an 'Adventurous Growth' programme. If you have a friend who would benefit, please give them one of these leaflets. This programme is free and will run in **March 1999.** It will provide an outdoor and active set of experiences providing an opportunity to:

* Be part of a caring group of women from LJMU
* Feel supported in sharing eating issues in a friendly healing environment.
* Experience competence in outdoor activities.
* Reassess your values.
* Celebrate yourself and your body.
* Reconnect with the outdoor environment.

This adventurous growth programme will be first of its kind in the UK. We invite you to join us as we develop new ways of feeling OK about our bodies. If you would like more information regarding this programme please **contact Kaye Richards** by calling **0151 231 5239**, I.M.Marsh Campus, Barkhill Road, Aigburth Email: **K.Richards@livjm.ac.uk.**

You may have many questions and concerns about approaching Kaye, however be reassured that any conversations will be confidential within the working team of Kaye , Jenny & Val at LJMU. If you are interested in this programme, take a leaflet and contact Kaye, **before the 15th February 1999,** for a friendly chat and to obtain more information. If you miss this date please still contact us, as we would like to hear from you and we may run other courses.

Appendix Five:

Research Ethics Application and Consent Forms

LIVERPOOL JOHN MOORES UNIVERSITY

APPLICATION FOR APPROVAL OF AN INVESTIGATION FOR TEACHING, TESTING OR RESEARCH INVOLVING HUMAN SUBJECTS

This application must be typed

In designing a research, teaching or testing project involving human subjects, investigators must be able to demonstrate a clear intention to benefit society and the project must be based on sound scientific principles. These criteria will be considered by the Committee before approving a project or practical demonstration. Applicants are strongly advised to contact an appropriate member of the Ethics Committee to discuss their project before submitting an application.

1. Name and qualifications of Applicant: **Jennifer C F Peel, Ph.D., M.Ed. BA.**

2. Title of investigation:

An evaluation of the effectiveness of using Outdoor Education in the treatment of anorexia nervosa.

3. Is this (a) a research project? X
(b) a teaching exercise? ☐
(c) an undergraduate project? ☐
(d) testing on members of the public? X

Please mark an appropriate description.

4. Have the full details of the procedure been appended? **Yes**

5. Brief description of the ethical nature and purpose of investigation:

The purpose of the study is to develop and evaluate a new treatment regime for people suffering from anorexia nervosa. It has already been demonstrated that adventurous activities can provide an effective form of therapy for the treatment of psychological disorders. (Attran & Gault 1992, Gass 1993) In this study existing adventure therapy techniques will be modified to suit an eating disordered client group. The incidence of anorexia nervosa is increasing. It has been suggested (Button 1993) that 5 % of young women will be experiencing marked problems associated with eating and weight. The approximate figure in the early 1990's for the number of young women suffering from anorexia nervosa was 0.5 %. This may appear a low figure but it represents 1 woman in every 200 to be suffering from anorexia nervosa. In addition anorexia nervosa is renown for being a difficult and problematic illness to treat. Nevertheless there is substantial evidence to suggest that adventure therapy can be successful in bringing about change even in relatively intractable psychological illnesses. It is anticipated that this treatment programme will successfully address some of the difficult therapeutic issues in relation to the treatment of anorexia nervosa. For example increasing self- esteem and developing inter - personal relationship skills.

Ethical Issues: **voluntary participation of subjects, anonymity of data, safety of subjects.**

What benefit will accrue to society from this project?

This project will extend existing knowledge of the way in which adventure therapy brings about change in people suffering from psychological disorders. It will show to what extent adventure therapy can help in the treatment of anorexia and will provide clear guidelines for treatment plans.

6. (a) How will the subjects be recruited? (If subjects are to be approached by letter, please attach a specimen copy to this application).

Programme Participants

Eating disorder units will initially be approached by letter (See enclosed letter 1) and sent an Information Pack. The information pack will include a copy of the Ethics application, an overview of Brathay Hall Trust. If interest is generated from this then a meeting to discuss collaboration will be arranged. This meeting will identify in detail the aims of the project, design of the programme and research implications. The ways in which collaboration will be achieved will be negotiated.

Participants will be approached initially through the eating disorder unit clinician who is responsible for their treatment. They will then be approached by a letter and then given a verbal explanation. (See enclosed letter 2 and information pack). The letter will also be followed up by a verbal explanation. An induction will be provided to give potential participants an opportunity to gain a full understanding of the entire programme, therefore enabling them to make an informed choice regarding active participation. The induction programme will be developed in collaboration with the research team, Brathay Hall Trust and collaborating Eating Disorder Units. It is likely that the Induction phase will be a weekend outdoor based programme at Brathay Hall Trust.

Pilot Study & Control Group

Participants will be approached by letter to be part of this study. (See enclosed letter) and will be accessed essentially through undergraduate programmes at Liverpool John Moores University and in collaboration with Eating Disorder Unit(s).

(b) Number and type of subjects likely to be involved:

Programme Participants:

Number of Subjects: 20

Participants will be young females (aged 18 - 25 years) identified as suffering from anorexia nervosa (This age range is a perequisite for a substantial amount of funding) Only subjects who are well enough to undertake moderate physical exercise and who have their doctor's permission will be included in the programme. Participants whose percentage weight loss exceeds a predetermined amount will also be excluded. The figure for acceptable percentage weight loss will be established by participants.

Pilot Study / Control Groups

Number of subjects: Anorexic:: 30
Non Anorexic: 60 (2 different groups)

All participants will be female.

Group A; identified as suffering from anorexia.
Group B: Not previously identified as suffering from an eating disorder. This group will be female undergraduate students.
Group C; Not identified as suffering from an eating disorder and completing an outdoor education programme.

Pilot Study: Groups B,C
Control Group: Groups A,B,C.

It may be difficult to access an anorexic pilot study group. Therefore in order to minimise the risk of not obtaining this control group it has been decided that only

non anorexic participants will be approached for the pilot study. There may be some participants in the group identified as a non eating disorder group who do in fact demonstrate symptoms of eating disorders. If this is the case then a fourth group will be identified. It is felt that it would unethical not to address these eating disorders symptoms, due to the potential serious implications of suffering from an eating disorder. Therefore, the working team will feed back this in a one to one setting by a counsellor on the team. The possibility of this occurring will be identified in the overview letter provided to all potential participants. All participants will have the choice to withdraw from the project at any stage and they will also have access to the results of their questionnaires. All participants will remain anonymous and confidentiality will be maintained at all times.

<u>Programme Facilitators / Researcher</u>

The programme facilitators will complete both personal journals, semi- structured interviewing and hold focus groups at different stages of the programme. These will occur before / after the residential phase and after the completion of the follow up programme

(c) Age range of subjects to be recruited:

18 - 25 years.

(d) Are questionnaires to be used in this investigation? **Yes**

Have they been validated previously?

<u>Yes</u> : **Leisure Satisfaction Scale, Rosenberg self- esteem scale, eating disorders inventory.**
(These questionnaires have been recommended by Alison (1995). in the Handbook of Assessment Models for Eating Behaviour and Weight related problems.)

<u>No:</u> **Demographic Questionnaire (Adapted form Johnson 1984)**
(See enclosed questionnaire)

If yes, state by whom and when.

Leisure Satisfaction Scale: Beard & Ragheb (1980)
Self - Esteem Scale: Rossenberg (1965)
Eating Disorders Inventory: Garner, Olmstead & Polivy, (1983)

If no, please include copies of the questionnaire(s) with this application.

Copy of demographic questionnaire enclosed

(e) Will pregnant women be excluded? **Yes**

(f) Names and qualifications of personnel who will be supervising the project:

Dr Jennifer Peel	**BA, MEd, PhD**
Dr Pam James	**Cert Ed, BSc, PhD, Dip Couns**
Dr Allan Hackett	**BSc, MPhil, PhD, SRD Reader in Community Nutrition**
Prof.David Huddart	**BSc, PhD**
Kaye Richards.	**BEd, (MSc), Summer Mountain Leadership Certificate, Single Pitch Award, Kayak Instructor Award, Recreation & Emergency First Aid Certificate (at work).**
Aileen MacEachen.	**Youth Development Worker.**

7. Likely duration of project and location of study.

(a) starting date: **1 January 1997** end date: **31 December 2000**
(b) location: **I M Marsh Campus and Brathay Hall Trust.**

8. Specify the particular procedure which involves the subject's participation.

Programme Participants.

The programme will be co-designed and co-facilitated by Dr.Jenny Peel, Kaye Ricahrds, Ailenn MacEachen and another counsellor, not yet identified. The participants will experience five phases; recruitment, induction, residential treatment programme follow up and post programme evaluation. The programme is action based therefore clear procedures relating to the programme design will become evident as the programme develops. However, participants will experience a group therapeutic outdoor based programme. Data will be collected at different stages of these five phases:

Recruitment:	**Questionnaire Completion: Demographic (D), Leisure Satisfaction (LS), Self Esteem (SE) Eating Disorder Inventory (EDI).**
Induction Programme:	**Outdoor Developmental Programme (Approx. 2 days), Questionnaires: *Start:* SE, EDI *End*: SE Diary Journals**
Residential Programme:	**Outdoor Developmental Programme. (Approx. 7 days) Questionnaires: *Start* EDI, SE. *End:* SE, EDI, diary journals, group focus, interpersonal process recall, focus group, semi - structured interviews.**
Follow Up Programme.	**Outdoor Developmental Programme. (Approx. 2 days) Questionnaires: *Start:* SE. *End*: EDI, SE semi- structured interviews, focus group, diary journal.**
Post Programme: Evaluation.	**Repertory Grid, Questionnaires: EDI, SE, LS Group Focus.**

Long Term Possibilities: **The research team are open to the possibility of the group developing their own outdoor adventure club / expedition, to support their long term involvement in outdoor experiences / activities as a continuum for healing. If this does happen and further research is desired then the research team will submit a further application to the Ethics Committee, at the appropriate time. In this way participants long term involvement will b supported thereby extending the likelihood of long term healing.**

P ilot Group

Completion of questionnaires; Leisure Satisfaction Scale, Self- Esteem Scale, Eating Disorders Inventory at two weekly intervals over a period of six weeks. Repertory Gird will be completed at the beginning and the end of the six week period.

Control Group

Completion of questionnaires Leisure Satisfaction Scale, Self Esteem Scale, the Eating Disorders Inventory and the repertory grid technique at the same stages (time) as the programme participants. The repertory grid will be completed once for each person,

Programme Facilitators

The team of facilitators will keep a personal journal and will facilitate a group focus discussion at the end of the residential and follow up phases.

Structure of Interviews and Group Focus

The design and questions for these elements of the research will be developed in conjunction with the programme design.

Analysis / representation of all information collected.

The anonymity of participants and confidentiality with respect to the information gathered will be guaranteed at all stages of the research. The interview tapes will be destroyed after transcription. Presentation of results will include both individual case studies and collective analysis. The researcher will ensure that presentation of information is done in such a way as to ensure that participants are not identifiable.

9. Are any novel procedures involved?

No

10. State the potential hazards, if any, and the precautions to be taken:

A variety of ethical issues need to addressed. The Therapeutic Adventure Therapy Professional Group Ethical Guidelines will be adhered to at all times. (See Guidelines enclosed.) However with reference to an eating disorder client group specific themes need to be considered.

Psychological risk factors involved by eating disordered clients taking part in adventure activities and of an eating disorder have been identified in previous research. (Richards 1998) These include competitive attitudes, body image reinforcements, self-esteem reduction, exercise addiction and physiological responses. The team are aware that participation in adventure activities has the potential to be destructive. Therefore it is important that high levels of therapeutic support will be provided. The working team will adopt the following practices.

1) Touching & Dissociation

In any activities where touching is involved, as with most adventurous activities, practitioners should be considerate of the possible past physical or sexual abuse by the client. In being sensitive to those concerns, practitioners will apply to the same guidelines they might use with survivors of violence. For example practitioners will obtain informed consent from an individual before touching, expect the potential for client flashbacks, permit clients to retain control over their experiences, and be ready for outbursts of anger. For dissociating clients, staff may wish to verbally remind them of their circumstances, have them stamp their feet for grounding and encourage then to keep their eyes open to watch others and ask for help when needed. (Webb 1993)

2) Psychological Therapeutic Support

Lots of time to talk about thoughts and feelings will be built into the programme. It is not expected that the activities alone will bring about changes. Instead participants ill be encouraged to increase their learning through sharing their experiences in small group discussion sessions. These will be facilitated in an open and supportive manner. In addition practitioners will remain attentive to the impact of their comments on body language, as well as to those of the client and will maintain a warm manner and caring attitude through out.

3) Eating Issues / Nutrition

Several support systems will be in place, such as partner arrangement, where participants establish mutual contracts allowing them to monitor one another adherence to personal food contracts. Meal structures will be modified to address participants anxiety of being faced with large portions of high calorific food. Meals will be eaten together to reduce opportunities for participants to avoid eating and frequent breaks for snacks to increase calorific intake will be provided. However, the team are aware of the potential anxieties which may become evident in this aspect of the programme. These will be addressed and negotiated and decisions regarding active participation in relationship to calorific intake will be identified. An eating contract will be developed and negotiated during the Induction Phase.

4) Activity Structure / Provisions

Subjects will be involved in a variety of outdoor activities. For example gorge scrambling, hill walking, ropes course, water sports. Brathay Hall Trust holds an Outdoor Adventurous Activities Licensing Certificate, therefore all activities will fulfil these licensing regulations.(see enclosed Health & Safety Guidelines) All other necessary residential necessary Health and Safety requirements will be fulfilled. (See enclosed Guidelines for safe working practice.)

It is expected that constructive change will come about partly as a consequence of the impact of the activities themselves. The structuring of some activities will allow for this. Metaphors will be developed within activities enabling clients to focus on the issues surrounding body image and their eating disorder. Activities will be introduced with statements to encourage all clients to focus on their body images movements and their apprehensions before hand will be presented where appropriate. Activities will be introduced, facilitated and debriefed by facilitators whose approach to interpersonal relations has a person centred underpinning. Respectful support and encouragement will be provided. Accompanying this, respect for individual choices will be evident and the team will accept a participants decision not to take part in any specific aspects of the activities. Gender issues will be addressed where appropriate. Emphasis on physical achievement and physical competition will be avoided.

5) Screening Procedure

A screening procedure will be completed in the Induction Phase. This will ensure that all participants are medically safe to participate in the programme. This screening procedure will be developed in consultation with a medical doctor. Medical recommendations for programme participation will be obtained prior to the recruitment stage. These recommendations will be adhered to at all stages of the programme. These guidelines will be fed back to Ethics Committee when obtained. With a relapse between different stages of the programme then potentially some of these medical requirements may change, for example weight loss. Therefore these screening procedures will be revisited at the beginning of each phase. In this way the safety of participants who experience marked weight loss between different stages of the programme will be ensured.

6) Physiological Considerations

The physiological implications of working with an anorexic client group will be addressed. These considerations include energy expenditure, weakness of bones, extended hypothermia risks. All activities will be designed to minimise energy expenditure. For example activities will take place to close proximity to the residential base and participants will carrying only light rucksack. In addressing eating habits, an eating contract will be developed during the Induction Phase. It is anticipated that small amounts of food at frequent times maybe be more appropriate rather than a large lunch / large evening meal. This will ensure maximum food intake, with minimum anxiety. Appropriate clothing will be provided and detailed attention will be paid to subjects conditions during all stages of the programme. There will also be quick withdrawal of participants if adverse weather conditions persist and / or any other risk of hypothermia become evident.

11. State the degree of discomfort in terms of apprehension, pain, stress and disturbance in terms of alteration to routine:

Adventure therapy invites the willing participation of subjects into adventurous settings which are designed to arouse some level of fear and excitement. Substantial support, encouragement and nurturing is offered by other participants, trainers and therapists in these situations. The outcome of the activity is reviewed in such a way that a constructive, positive and empowering outcome is achieved. There is no such thing as failure on the part of participants in adventure therapy. There may be some anxiety generated as a result of meal times. However an eating contract will be developed during the Induction phase and opportunities to discuss theses anxieties will be available during the programme when required by participants.

12. State your experience or that of the investigator(s) in this type of investigation:

The investigating team is made up of two experienced and competent psychotherapists. They have proven competence as individual therapists, group facilitators and as therapy leaders who have worked with anorexic clients. Two other members of the team are experienced Outdoor Educators. Professor Huddart is head of Outdoor Education at Liverpool John Moores University whilst Kaye Richards has experience of working as an outdoor development trainer, working on youth at risk projects. She has also completed a research project examining the relationship between peoples' experiences of adventure / Outdoor Education and an eating disorder (Richards 1998). (This was given LJMU Ethics approval in 1997) Therefore she has had previous experiences of interviewing eating disorder sufferers. Dr Hackett is a state registered dietician and has completed several research projects on the nutritional and health status of young people. In addition Brathay Hall Trust has over fifty years experience of providing outdoor developmental training, for both adults and young people. (See Literature enclosed.) Aileen MacEachen a youth development worker from Brathay Hall Trust who will collaborate in the design and provision of this programme.

13. The Committee needs to know if similar work had been undertaken before.

(a) What other work do you know of that has been done in a similar subject and how does this relate to your proposed programme?

Adventure activities are a well established part of many treatment programmes. In addition, a considerable amount of research has been carried out on Adventure Therapy in the United States. (Gass 1993) Current practice and research shows that Adventure Therapy makes a positive contribution to the treatment of substance abuse, survivors of sexual abuse and domestic violence, post traumatic stress disorder, juvenile delinquency, emotional and behavioural difficulties and bulimia nervosa. (Maguire & Priest 1994) Studies have demonstrated its effectiveness in custodial setting psychiatric hospitals as well as in the education

sector. It is also used in therapeutic personal development work for women's and post retirement groups. (Cole & Erdman 1994) This means that there is a body of knowledge to be drawn on and that guidelines for the conduct of Adventure Therapy are in place. These need to be adapted for use in a European culture, with a specific treatment group.

(b) Please give a brief description of the parts of your study that are completely original.

The proposed study would be original in the following ways:

1. **While Adventure Therapy has been practised predominately in the United States for the past 20 Years , in the UK it has only come into use more recently and that mainly focused in the treatment of juvenile delinquents. (Reddrop 1997) This study would capitalise on some of the advances made in the United States making them suitable for a UK population, especially an anorexic client group.**

2. **Outdoor programming has been used as a relatively broad, unrefined aspect of treatment for eating disorders. (Maguire & Priest 1995) This means that the activities and treatment metaphors used would be specifically designed for this treatment group. Whilst this has been done for a range of treatment groups its application to an anorexic client group has been limited. This project seeks to demonstrate the ways in which this powerful therapeutic tool can be adapted and refined for use with anorexic clients within Great Britain.**

14. State whether the subject's informed consent will be obtained:

(a)	orally	**Yes**
(b)	in writing	**Yes**
(c)	in the presence of a disinterested third person:	**Yes**

Normally, consent should be given in writing and witnessed by a disinterested third party unless the applicant can show good reason why this should not be the case. Consent forms for adults (EC3) and for parents/guardians/carers of children/adults incapable of consent (EC4) are available. If an alternative consent form is to be used, please attached a specimen copy to this application.

15. Will the subject be subjected to any x-rays or ionising radiation's?

No
If so, how often?

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JMU

Liverpool John Moores University

26th March, 1999.

To Whom It May Concern

We are writing to you in reference to your patient, , who has demonstrated an interest to participate in a research programme. The research programme is an outdoor based programme, examining therapeutic benefits of outdoor activities. This is being implemented by Liverpool John Moores University.

A thorough ethics application procedure has been completed and accepted by Liverpool John Moores University Ethics Committee, in order to address all the physical and emotional safety needs of participants. Due to the nature of the research programme the ethics committed has requested we gain doctor's approval for the women's participation. This approval is purely required from a physical perspective, as women will be required to participate in low key outdoor activities. It should be emphasised that the activities will only last daily between 2 - 4 hours, over a five day period. These activities may include low level hill walking, rock climbing and ropes course activities. It is also important to note that excessive exercise will be avoided and the activities will not be overly physically strenuous, being implemented in accordance with individual physical ability.

If you feel that your patient should take particular cautions when participating in these activities , we would be grateful if you could inform your patient of these. We need confirmation of the physical well being of your patient to participant in the outdoor activities. If you feel able to provide this confirmation please sign below and return either to your patient or myself.

Confirmation of approval for ..... to participate in the outdoor programme as identified above.

Name .....

Signed .....

Address .....

.....

If you require any further information please contact me as soon as possible. Thank you for your time in supporting this request for information.

Yours sincerely

Kaye Richards

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Adventurous Growth

'healing the self in the outdoors'

EC3

LIVERPOOL JOHN MOORES UNIVERSITY

FORM OF CONSENT TO TAKE PART AS A SUBJECT IN A MAJOR PROCEDURE OR RESEARCH PROJECT

Title of project: An Evaluation of the Effectiveness in Using Outdoor Education In The Treatment of Anorexia Nervosa.

I, ...agree to take part in
(**Subject's** full name)*

the above named project/procedure, the details of which have been fully explained to me and

described in writing.

Signed..... Date.....
(Subject)

I, KAYE RICHARDS.....certify that the details of this
(**Investigator's** full name)*

project/procedure have been fully explained and described in writing to the subject named above and

have been understood by him/her.

Signed..... Date.....
(Investigator)

I, ...certify that the details of this
(**Witness'** full name)

project/procedure have been fully explained and described in writing to the subject named above and

have been understood by him/her.

Signed..... **Date** .....
(Witness)

N B The witness must be an independent third party.

* Please print in block capitals

Appendix Six

Personal Information Sheet

APPENDIX NOT COPIED

ON INSTRUCTION FROM

UNIVERSITY

Appendix Seven:

a) Residential Timetable

b) An overview of key outdoor and adventure activities that participants took part in during the intervention

LIVERPOOL JOHN MOORESS UNIVERSITY
12th to 16th April 1999
Course Opens: 13:00
Course Closes: 17:00

DAY	MORNING		AFTERNOON		EVENING	
Monday 12th April 99	09:00 – 12:00 Team meeting	12:00 – 14:00 Arrivals	14:00 – 15:00 Group: expectations, experiences being helped goals.	05:00 – 17:30 Whalers	18:00 – 19:00 Evening Meal	19:00 – 21:30 Processing: Food, Whalers Trust Activity
Tuesday 13th April 99	08:00 – 09:30 Breakfast Prepare Kit	09:30 – 13:00 Low level Activities / Ropes Experience and process	13:00 – 16:00 Healing in Nature, Low Level Walk	16:00 – 18:00 Process Eating Issues	18:00 – 19:00 Evening Meal	19:00 – 21:30 Processing: Food Framing: Pole
Wednesday 14th April 99	08:00 – 09:30 Breakfast Kit	09:30 – 13:00 The Pole: Individual Processing	13:00-17:00 Group Process Nature Solo Low Level Activity	17:00 – 18:00 Group Process	18:00 – 19:00 Evening Meal	19:00 – 21:30 Wider Therapeutic Issues Framing Challenge Activity
Thursday 15th April 99	08:00 – 09:30 Breakfast Kit	09:30 – 17:00 Challenge Activity (Gorge Walk / Rock Climbing) Frame Activity / Group & Individual Processing			18:00 – 19:00 Evening Meal	19:00 – 21:30 Frame High Ropes Group Focus
Friday 16th April 99	08:00 – 09:30 Breakfast Kit	09:30- 12:00 High Ropes Course	12:00 – 13:00 Group Process	13:30 – 16:00 Rep. Grid, Reflections, Follow on, Closure	16:00 – 17:00 Leave Site	

BRATHAY

09/04/99 JLW

M:\All MD and Youth Clients & Courses\Clients & Courses Youth 99\L\Liverpool John Moores Uni\12th to 16th April 1999\PROGRAMME.doc

* An individual therapist will be available during all times of programme.
* The programme team will meet each evening at 21:30pm

Appendix 7b: An overview of key outdoor and adventure activities that participants took part in

2) Whalers Activity:

Photo A: Individuals participating in the Whaler boating activity during the intervention

The whalers are rowing boats that can sit approximately 8-10 people and require at least 5 people to row the boat effectively. The whaling boats are kept on the shores of Lake Windermere on the edge of the Brathay estate and the activity takes participants onto Lake Windermere – an approx 12 mile long Lake in the heart of the Lake District. So both the task of rowing collectively and the environment in which the rowing takes place provides the basis of the outdoor adventure activity.

3) Ropes Course Activities

Photo B: Individual participating in a ropes course activity during the intervention.

The ropes course includes a low level ropes courses, a high level ropes course and the Pamper Pole. All of these activities are situated and purposefully built on the grounds of the Brathay estate. They are designed to offer activities that require specific physical challenge and techniques to complete the practical tasks that are included on the course. Photo B is of the end

of the pamper pole and illustrates the type of physical challenge that ropes course consist of. There are a number of physical challenges that look typical of an assault course. For example, there are activities which require climbing over obstacles, moving through and across nets, and also being at height above the ground that gives a sense of perceived risk. During all the activities individuals wear harnesses and they are attached to safety ropes to protect their physical safety during taking part in the activities. Some of the activities require the participant to do the activity alone (with the support of someone holding the safety ropes throughout), whereas other activities require participants to rely on others to complete the activity. For example, a high ropes course activity is the High V's. Two ropes make a V shape attached to trees, approximately 25 feet above the ground. Participants climb up a ladder to reach the centre point of the V. It is impossible to reach the other end of the V as the ropes are too far apart, but the goal of the activity is to see how far two people can get along the V ropes. The only way to move across the High V's is to hold onto each with their hands and – thus supporting each other and then each person slowly walking along one side the V ropes.

3 Gorge Walk/ Rock Climbing

These activities take place off the Brathay estate and for this intervention took place into two local Ghylls, which are mountain streams that are steep in places, have rock pools and waterfalls and require individuals to climb up relatively steep rock obstacles with water often following fast down the rock face. In the steeper sections participants are required to clip into safety ropes to ensure if the slip or fall the risk of injury is avoided. During this activity individuals needs to support each other to complete the more difficult aspects of walking up the gorge.

4 Nature Activity

Photo C: An piece of art work produced by a woman taking part in the intervention. The poem written around the side of the art work was:
Revealing our thoughts and learning to confide, dealing with things from which we'd rather hide, feeling hurt and pain we've always denied, healing ourselves deep down inside

This activity is set around taking a walk in nature, the emphasis is less based on physical challenge, as other adventurous activities are, but instead on connecting with the natural world in a way that is personally significant. The walk in nature is taken alone and allows for a more personal reflection process, which invites the individual to look for personally meaningful metaphors as experienced from the natural world. The personally significant meanings are then explored therapeutically to identify their relevance to each individual. As part of this activity the women were able to explore and express the individual metaphors that connections with nature represented to them in terms their troubled eating and related therapeutic process. An example of how therapeutic metaphors were made was recorded by one of the women in her journal see pg. 131). Art work was also used as way to encourage the women to express the meaning associated to the metaphors connected in nature. Photo C is an example of art work that was produced during this activity and the associated therapeutic meaning in terms of the accompanied poem written by the woman.

Appendix Eight:

An overview of the therapists' background and experience