FEMALE DEPRESSION AND THE ADVENTURE EXPERIENCE

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ABSTRACT

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This project investigated the effects of a combined support group and adventure experience on two depressed females between the ages of 18-30yrs. Data was collected through pre and post PHQ9 depression assessment surveys, focus groups, and participant observation. Results showed overall improvement on PHQ9 depression surveys and specific areas of depression such as suicidal ideation and self-harm. Focus group feedback revealed a benefit from peer connectivity and moving out of one’s comfort zone. Due to the small sample size, results yielded from this project cannot be generalized beyond this project. Further research is recommended with a larger and more diverse population.
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INTRODUCTION

Nearly 15 million Americans experience depression each year (National Alliance on Mental Illness, 2012). Major depression is the leading cause of disability in the United States and worldwide, because it can become severe enough to leave people unable to work, concentrate, learn, or care for themselves or their family (World Health Organization, 2012). Major depression is a serious medical illness that affects one’s thoughts, feelings, behavior, mood and physical health. Although treatable, depression is a life-long condition in which periods of wellness alternate with recurrences of illness. Left untreated, depression can lead to serious impairment in daily functioning and suicide (NAMI, 2012).

Women experience twice the rate of depression as men, regardless of race or ethnic background (National Institute of Mental Health, 2012). Researchers suspect that, rather than a single cause, many factors unique to women's lives play a role in developing depression. These factors include: genetic and biological, reproductive, hormonal, abuse and oppression, interpersonal and certain psychological and personality characteristics (NAMI, 2012). Women also may face additional stresses of work and home responsibilities, caring for children, abuse, poverty, and relationship strains (NIMH, 2012).

Depression is the result of much more than the biological factors it is commonly associated with. Although prescription drugs work for some depressed people, many do not get better with medication alone (National Institute of Mental Health, 2012).
Divergent interventions are needed to address some of the psychosocial components associated with depression.

Adventure-based therapy has recently emerged as an adjunct to more traditional approaches to therapy. It has been found useful in various therapeutic contexts to address a wide range of issues, including depression (Sheldon, & Arthur, 2001). Adventure therapy is an experiential approach to counseling or psychotherapy that integrates adventure-based activities and experiences with more traditional forms of psychotherapy (Durr, 2009). One of the more attractive features of adventure-based therapy is its adaptability to various populations and therapeutic goals. Positive change has been reported in areas associated with depression such as self-concept, self-actualization, personality factors, locus of control, behavior, self-efficacy, and self-confidence (Sheldon, 2001). In one study with women, a majority reported that the simple act of hiking gave them a major sense of accomplishment, increased their perceptions of their own competence, and increased awareness of oneself and others (Russell, 2006).

The purpose of this project was to address some of the psychosocial components of depression by connecting participants with a challenging adventure experience and support group. By engaging participants in a challenging and socially engaging experience, the project hoped to provide clients with the opportunity to challenge their thoughts and beliefs about their own empowerment and self-efficacy.

This project hoped to answer the question, “Does an adventure experience combined with a support group help relieve depression?”
It was my prediction that the project would improve depressive symptoms by addressing issues associated with depression such as, isolation, self-efficacy, empowerment, and self-esteem. I anticipated that the adventure experience and group dynamic would create positive affirmations about participants’ abilities to connect to others and effect change within their own lives.
Depression is a widely studied condition. Over the years multiple theories have been constructed in regards to its etiology. Depression is the cumulative effect of having multiple internal and external risk factors (Norton, 2010). In order to create appropriate interventions for depression, it is important to acknowledge its complexity and multiple epigenetic pathways. Depression includes cognitive and affective, interpersonal, neurological and physical components (Norton, 2010). Twin studies have validated the genetic component of depression by revealing that when one twin is depressed, the other twin will have a 50% likelihood of also becoming depressed (Sapolsky, 2009).

Neuroscientists have also been able to connect depression to brain chemistry imbalances and hormones within the body. It has been shown that women have a stronger vulnerability to depression at certain points in their hormonal life histories, including post-childbirth and menopause (Sapolsky, 2009). Although biological components are readily identifiable, they exist within an environmental context. Sixty to 70% of people do not get better with prescription drugs alone (National Institute of Mental Health, 2012). Environmental factors and personal experience have a great impact on biological functioning and depressive symptoms.

From a cognitive psychological perspective, depression can partly be attributed to the concept of learned helplessness. This model of depression asserts that a major component of depression is a cognitive distortion of one's ability to control one’s own world (O'Leary, Donovan, Cysewski, & Chaney, 1977). In other words, the depressed
individual perceives themselves as relatively ineffective in exerting control over significant life events and their outcomes. Seligman (1967) demonstrated the concept of learned helplessness through experimentation with animals. In his initial experiment, Seligman repeatedly exposed an animal to an adverse stimulus which it could not escape. Eventually the animal stopped trying to avoid the pain and behaved as if it was helpless to change the situation. Finally, when opportunities to escape were presented, this learned helplessness prevented any action.

According to O’Leary (1977), this type of helplessness may be acquired by individuals through the course of their developmental learning history. If a person has had a learning history characterized by an inability to control life events and their consequences, they may develop a relatively pervasive, trait-like sense of helplessness that may generalize to a number of situations (O’Leary, 1977). According to Sapolsky (2009), this type of learned helplessness can be seen in the correlation between depression and those who have experienced the loss of a parent at a young age. When a child loses a parent, they are learning about their personal level of control and self-efficacy. Children are in a phase of development where they are acquiring information about cause and effect; they are assessing the world around them and trying to determine if the world is a place where they have any sort of determination over the events in their lives. The loss of a parent may disaffirm the notion of self-control. The child may, in turn, generalize helpless feelings to future events (Sapolsky, 2009). In a 2001 survey of 70 undergraduates, researchers were able to show a positive correlation between the undergraduate’s level of depression and their perceived helplessness (Ozment, 2001).
In another study, 58 participants were surveyed to investigate the relationship between perceived locus of control, experienced control, and depression. Participants were given an Experienced Control Scale (Tiffany, 1967) to determine the degree of control experienced in stressful settings. Depression was measured by the Beck Depression Inventory. Results indicated that those in the sample who reported that they experienced a relatively high level of control over both internal and external sources of stress demonstrated significantly lower levels of depression on the Beck Depression Inventory (O’Leary, 1977). These results are consistent with the construct of learned helplessness and self-efficacy.

Self-efficacy is a term that has been associated with depression. It refers to the perceived ability to produce a desired action. Self-efficacy plays a role in determining the beliefs a person holds regarding his or her power to affect situations, therefore strongly influencing both the power a person actually has to face challenges competently and the choices a person is most likely to make (Bandura, 1997). Psychologists have studied self-efficacy from several perspectives, noting various paths to its development. According to Bandura (1997), “When one perceives an inability to influence events and social conditions that significantly affect one's life, it can give rise to feelings of futility and despondency as well as depression” (p. 153).

In one study of a large sample of adolescents, the connections between self-efficacy, anxiety, and depression were investigated. Results showed that low levels of self-efficacy were generally accompanied by high levels of trait anxiety/neuroticism, anxiety disorders symptoms, and depressive symptoms. It was also found that when
children and adolescents were confronted with threatening or negative life events, a high sense of self-efficacy helped to manage such events and protect them from becoming anxious and depressed. Otherwise, a low sense of self-efficacy hindered effective coping and put children and adolescents at risk of developing symptoms of anxiety and depression. This study suggested that diminished control over one’s environment is highly influential in the likelihood of depression (Muris, 2002).

Women experience twice the rate of depression as men (NIMH, 2012). Several studies have been conducted to give some possible explanations for this disproportion. In a study investigating gender personality differences and how they relate to depression, results showed a correlation between depression and the fact that women are said to become more likely than men to lack in self-confidence and to have low expectation for their ability to control important events (Nolen & Girgus, 1994). This correlates with the behavioral and cognitive theories of depression which hold that people who tend to have low expectations for their ability to control important events, and who blame themselves for the negative events in their lives are at increased risk for depression. Females with a more passive, internalizing style of coping are more vulnerable to depression. The article gives some possible explanations for these inherent differences. For instance, females are more likely to be confronted with abuse or harassment, experience verbal and physical threats, have restrictions on their choices, and experience devaluation because of their gender (Nolen & Girgus, 1994).

Adventure therapy has evolved into three distinct areas—wilderness therapy, long-term residential camping, and adventure-based therapy. Adventure-based therapy,
which is the focus of this paper, places individuals in situations in which prescribed physical and social tasks provide opportunities for personal growth (Sheldon, 2001). Gass states that activities involved with adventure therapy are designed to challenge behaviors and thinking (1993). Examples of activities can include initiative and problem-solving tasks, indoor wall climbing, ropes courses, and overnight trips. Adventure therapy provides a plateau where one can confront challenges that are specifically designed to develop capability and success while counteracting low self-worth, learned helplessness, and dependency (Sheldon, 2001). Luckner asserts that challenges of adventure therapy provide opportunities for participants to discover that many of their perceived limitations are self-imposed (as cited in Sheldon, 2001).

According to Gass, many of the principles and philosophies of adventure therapy are founded in the area of experiential learning. Experiential learning is based on the belief that behavioral change is a function of one's direct experience. Rather than being passive observers, participants involved in experiential learning processes need to be actively involved to facilitate change (Gass, 1993).

Adventure activities often possess the construct of challenge by incorporating new or difficult tasks. Recognizing that it is easy to maintain old and familiar ways of doing things within one's comfort zone, experiential learning encourages participants to move beyond their usual comfort zones (Sheldon, 2001). According to Wolf & Mehl (2011), individuals who find themselves beyond their comfort zones in a novel setting are likely to experience an increase in emotional arousal; a state that heightens the ability to learn
Adventure therapy is based on the principles of experiential learning but adds a specific clinical focus. The therapeutic use of adventure involves the treatment of a long-standing problem or behavioral pattern. Rather than focusing on pathology, adventure therapy focuses on clients' strengths and abilities, while providing opportunities for success. Correspondingly, rather than focusing on obstacles, the approach and resolution of the adventure initiatives encourage clients to focus on solutions and personal capabilities. Clients are given the opportunity to do things in a different way, thus breaking established patterns of behavior and thinking (Sheldon, 2001).

Adventure therapy provides what Erikson (1959) referred to as real accomplishments. As humans confront opportunities in the face of uncertain outcomes they build a sense of mastery which helps them reconstruct the narrative they hold about themselves. The challenges they overcome during an adventure experience provide them with new evidence about themselves. Delayed, incomplete or unmastered developmental tasks can be addressed by tangible corrective experiences. Trying something, regardless of the outcome, convinces the person of their own active participation, agency, and movement towards the future (Norton, 2010).

An investigation of the effects of a ropes course on adults diagnosed with major depression demonstrated decreased transient depressed mood following participation in the ropes course initiatives (Sheldon, 2001). In another controlled study, researchers investigated the effectiveness of high-ropes exposures as an add-on to inpatient treatment
in a naturalistic setting. In a sample of 247 patients, depressive symptoms, trait anxiety, locus of control and self-efficacy were assessed at admission and discharge of treatment. High-rope participants showed better follow-up outcomes than controls in trait anxiety and self-efficacy. Beneficial therapeutic effects were reported for clinical and non-clinical samples on outcome variables such as group performance, social skills, self-esteem, internal locus of control, self-efficacy and psychological symptoms, such as depression and anxiety (Wolf, 2011).

Clem, Smith, & Richards (2012) explained that therapeutic group process is another crucial part of the adventure experience. Social support, the development of interpersonal skills, cohesion and a trusting relationship with the group are important elements in creating a successful experience for clients. During group adventure activities, clients are challenged to adopt a cooperative approach where interpersonal support is accepted and encouraged. Collaboration may enhance the problem-solving process and lead to feelings of success (Clem et al., 2012). In one study, substance abuse researchers investigated the therapeutic value of a challenge course intervention on the self-efficacy and group cohesion of nine chemically dependent, adult females. Results indicated statistically significant improvements on both self-efficacy and group cohesion. Several themes were identified including group unity, trust, interpersonal growth, and self-confidence (Clem et al., 2012).
METHOD

Participants were provided by referral from Eureka Community Clinic staff. The sample included two females between the ages of 18-30 years who experienced depression at the onset of the project. After signing the informed consent, participants attended a weekly group at the Eureka clinic. Groups were designed to provide a safe and confidential space for participants to discuss their depression and connect with others. The curriculum was based off of the *Group Therapy Manual for Cognitive Behavioral Treatment of Depression* (Munoz & Miranda, 2000). Cognitive behavioral therapy is a form of treatment that focuses on examining the relationships between thoughts, feelings and behaviors. By exploring patterns of thinking that lead to self-destructive actions, people with depression can help to modify their patterns of thinking to improve coping (NAMI, 2012).

The adventure component, hiking Trinidad Head, was determined based on participant capabilities and comfort levels. Neither of the participants had experienced hiking Trinidad Head and both agreed that completing it would be new and physical challenge for them. Adventure activities often possess the construct of challenge by incorporating new or difficult tasks. Recognizing that it is easy to maintain old and familiar ways of doing things within one's comfort zone, participants are encouraged to move beyond their usual comfort zones (Sheldon, 2001). If the activity is too much of a challenge the client could potentially be traumatized by the experience. Zip-lining, the
original concept for the adventure, was too far beyond the comfort of the participants and could potentially have set them up for a failed experience. The group portion allowed time to discuss these options and ensure that the adventure activity was appropriate for those involved.

The hike took place on the last week of the project and incorporated elements of silence and check-in. We met at the bottom of Trinidad Head and checked-in about feelings and concerns for the hike. We then proceeded to hike the first leg of the trail in silence with the intent to notice our automatic thoughts. Paying attention to automatic thoughts was a component of the CBT manual that was practiced during group meetings.

Once we reached the first resting point we did a second check-in and spent approximately 10-15 minutes reflecting on thoughts that came up during the silence. Both participants noted some automatic negative self-talk during the first leg of the hike. We discussed some different thought-stopping techniques and talked about the ways in which our thoughts tend to direct our feelings and behaviors, which were more themes from the group. We continued to hike in silence and stop for check-in regularly. Each check-in included a reflection of automatic thoughts and a scale of 1-10 on how the girls were feeling. The last 10 minutes of the hike was free-flow discussion. At the end of the hike, we closed with overall thoughts and feelings about the experience.

Data for the project was collected through pre and post PHQ9 depression assessment surveys, focus groups, and participant observation. The PHQ9 is a tool that assesses for common signs and symptoms of depression (Spitzer, Kroenke, & Williams, 1999). The focus group took place after the hike and provided a qualitative element to the
project by allowing participants to reflect on their experience and identify which aspects of the project may have been beneficial for them. Observation occurred throughout group meetings and during the course of the hike. I took notes on participant behaviors, group connectivity, and group discussions as the project evolved. All materials regarding the project were stored in a locked filing cabinet and shredded upon project termination. Participants were provided with a resource list of counselors in Humboldt County where they could continue to get support for their depression after the project was over.
PHQ9 results showed an improvement for both participants following the completion of the study. According to the guidelines from the PHQ9, both participants went down in a category of depression. Participant 1 went from moderately severely depressed to moderately depressed. Participant 2 went from moderately depressed to mildly depressed. Participant 2’s score dropped by half. This participant went from a score of 14 to a score of 7. There were three categories of the survey in which both participants had an improved result. The first was the category of “little interest or pleasure in doing things.” The second category was “trouble concentrating on things,” and the third category was “having thoughts that you would be better off dead, or of hurting yourself.” In this final category, both participants went from experiencing these thoughts several days in two weeks, to no suicidal/hurtful thoughts.

These results are consistent with the focus group feedback. Both participants verbalized that the group was helpful because it allowed for a safe space to connect with others and vent to a neutral party. Participant 1 said that, “It takes the -I am alone in this-out of things.” Participant 2 said, “It gave me different ways of thinking and looking at things.” Both participants said that it helped to have somewhere to go to get out of their comfort zones and routines. They both discussed how it created motivation and accountability. In regards to the hike, participant 1 said that, “It felt good to get outside of my normal bubble.” This participant also said that, “The hike strengthened our group bond.” Participant 2 said that, “The hike was like a catalyst for us to get talking and it
was nice to have the fresh air and be outside.” She continued to say that, “The group and hike provided an outlet to express things and get out of the vortex of my depression.”

Both participants expressed plans to incorporate the hike into their lives in the future.

I was able to observe the participants evolving as the group progressed. By the third meeting I noticed that the participants started to relate to each other’s experiences and to give each other feedback and suggestions. I also noticed that the participants were finding common themes in their depression and connecting these themes to themes in their relationships, coping strategies, and self-talk. By the fourth group, the participants started to get excited about the hike and collaborate on exchanging numbers and getting transportation. During the hike the participants were enthusiastic. Without prodding, they were able to reiterate themes from the group and how they related to the hike. I also observed a deeper level of connectivity and trust on the hike as evidenced by participants sharing something more personal than they had shared in the indoor group context.

Toward the end of the hike the discussions became more optimistic and forward-thinking and there was a shift from rumination on frustrations, to more solution-focused thinking.
DISCUSSION

Due to the small sample size, survey results cannot be used to make any
generalized conclusions about this project. Although there was a large initial interest, the
final sample consisted of only two females. This could have been the result of many
factors such as limited transportation, lack of childcare, or concern for privacy.
Depression can also be associated with a state of apathy which can influence motivation.
This project may have yielded more conclusive results had the methods been tailored to a
smaller population. Focus group feedback and observation were used as the primary
methods upon which to base discussion.

One theme from the focus group feedback was that of social support. Both
participants stated that the social aspect was a major component in the quality of their
experience. Social support, the development of interpersonal skills, cohesion and a
trusting relationship with the group have been shown to be important elements in creating
a successful adventure experience (Clem et al., 2012).

During the hike, both clients shared something more personal than they had in the
group context. A possible explanation for this could be the connectivity experienced
while conquering a challenge as a team. During group adventure activities, clients are
encouraged to adopt a cooperative approach where interpersonal support is accepted and
encouraged (Clem et al., 2012). Although both girls were experiencing something new
and challenging, they were able to support each other through the experience. This may have created a more trustful bond.

Another theme from the focus group was the theme of getting out of one’s comfort zone. Both participants said that the support group and the adventure experience were new for them and pulled them out of their everyday routines. During adventure activities, participants are faced with new situations and knowledge that must be integrated with the old to reshape perceptions (Sheldon, 2001). It is possible that the simple act of trying something new could have given the girls a different perspective on their depression.

During the last portion of the hike I observed the girls helping each other talk through solutions to their personal challenges. Research suggests that collaboration may enhance the problem-solving process and lead to feelings of success (Clem et al., 2012). Towards the end of the hike, the girls seemed less focused on their actual problems, and more on the ways in which those problems could potentially be solved. This may have partially been related to the success they felt as they were completing the hike. Adventure therapy focuses on clients' strengths and abilities, while providing opportunities for success. Rather than focusing on obstacles, the adventure experience encourages clients to focus on solutions and personal capabilities (Sheldon, 2001).

Themes from the feedback discussion were that of social support, connectivity, and moving out of one’s comfort zone. These themes were consistent with themes from other adventure therapy results found in the literature. It is my conclusion that participants gained a benefit from the project because it gave them a sense of
accomplishment and connectivity in a novel setting, which may have increased their perceptions of their own competence and problem-solving abilities. It is also my conclusion that neither the hike nor the group would have been as effective as isolated experiences. The group played a large role in preparing the participants for the adventure activity by allowing bonding time, recognition of comfort levels, and a discussion of concerns. The group focused on a specific CBT curriculum that encouraged participants to be cognizant of their thinking and behaving patterns. These concepts were incorporated into the hike agenda and helped to create therapeutic structure for the experience. While the group focused on recognizing thought patterns and creating mental silence, the hike was an experiential activity where participants could practice these techniques in a real life situation.
PHQ9 results showed overall improvement, but results were insignificant due to the size of the sample. Had the sample size been known during project planning, a qualitative case study would have been used as a more appropriate method. Surveys are also subject to many variables. Improvement in any survey category may have been the result of factors unrelated to the project.

Additionally, the methods used were unable to differentiate between the results from the support group and adventure component. This project investigated the combined effect of the group and the hike. Although participants expressed a benefit from the overall project, there was no specification about which components of the project were responsible for that benefit. There was also no investigation of the importance of the support group curriculum.

Another limitation was that the project implementer was the same person to conduct surveys and focus group feedback. This may have created participant bias which could have affected the results of the study.

Lastly, the project was limited by the lack of diversity available in the rural setting. Both participants were white females in the 18-30yr age range. It is unknown how this project may have affected participants from other various age groups or ethnicities.
RECOMMENDATIONS

Further research is recommended with a larger and more diverse sample. A larger sample may yield more conclusive and generalizable results. There is also a need for a differentiation between support group and adventure components. This would help to pinpoint which specific elements of the project were correlated with which results. It would also be helpful to learn more about the importance of the support group curriculum as a preparation tool for the adventure.

It is recommended that the future project implementer be a separate person from the project researcher. This may help to avoid unnecessary participant bias.

Lastly, this project did not take into account the implications of the naturalistic setting. It is unknown if project results were contingent upon the adventure component being outdoors. The environmental element may have had an impact on the connectivity and positivity experienced during the hike. Further research would be needed to investigate this possibility.


