

Sara Smithson
The Theoretical Foundations
Of Wilderness Therapy

ABSTRACT

While an ever-growing number of studies have demonstrated that wilderness therapy can be very effective in facilitating emotional and behavioral change in at risk adolescents (Russell, 2003; 2005), a lack of understanding persists both within and outside of the wilderness therapy community regarding why and how wilderness therapy works. This study addresses these important questions by exploring the theoretical foundations of wilderness therapy and their relationship to practice.

Conceptualization of wilderness therapy practice, theory, and process is approached through consideration of existing definitions of the treatment model as well as the field's characteristics and demographics. An overview of ongoing program debates and discourse, outcome studies, and the present direction of research help to establish the current condition of the industry and its present successes and challenges.

The historical evolution of wilderness therapy's concepts and practice methods are explicated in order to contextualize and clarify the origins and evolution of the model's contemporary configuration and orientation. Further inquiry into the theoretical and functional components of how and why wilderness therapy works is undertaken through individual and integrative application of two postmodern psychosocial constructs: relational-cultural theory and narrative therapy. Application of these theories and principles to wilderness therapy processes yields suggestions for future research and industry practice.

THE THEORETICAL FOUNDATIONS OF WILDERNESS THERAPY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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Sara Smithson

Smith College School for Social Work
Northampton, Massachusetts 01063

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CHAPTER I

INTRODUCTION

Wilderness therapy is an experiential-based intervention that utilizes the natural, non-punitive reality of living in a wilderness environment along with therapeutic services to foster growth and change. It is most often utilized to treat the behavioral, mental health, and substance abuse concerns of at risk adolescents. Wilderness therapy combines more traditional mental health interventions with experiential education techniques and practice in a primitive, outdoor environment. Despite these simply-stated descriptions, the wilderness therapy field seems cloaked in bit of mysticism, both within its own literature and the public's perceptions of it. Imagery of clans of troubled teenagers backpacking for weeks across high deserts or through dark, deciduous forests evokes a strange exoticism juxtaposed to the routines of contemporary western society. This mystery is often reinforced by wilderness therapy staff and program graduates, many of whom express the feeling that one needs to have directly experienced the process of wilderness therapy in order to truly and fully *get* what it's all about.

This aura of inaccessibility and ambiguity has less to do with some inherent obscurity of wilderness therapy treatment and is more related to the nature of experience, whose transformative elements are irrevocably tied to singular and local people, places, and events. This does not negate the fact that there are archetypal, structural, and procedural aspects of wilderness therapy which can be exposed and described. Nevertheless, while the wilderness therapy field has a relatively good grasp on what it

seeks to achieve with clients, it has been less effective in explaining why the model is viable to address these goals and proving that it does so, to the detriment of clients who could potentially benefit from treatment.

Considering research results that indicate a significantly lower rate of recidivism for adolescents who received therapy in a wilderness program versus those treated in an institutional setting, Williams (2000) wonders “why we continue to provide treatment for adolescents that proves to be ineffective 65% of the time, when there is an available alternative [wilderness therapy] that repeatedly proves to be more effective” (p. 55). To answer this question, Williams speculates that the lack of existing literature explaining the connection between the field’s theory and practice techniques has resulted in lack of development and utilization of the treatment model. The efficacy of wilderness therapy’s components cannot be evaluated and improved without an initial understanding of what those mechanisms are and how they function.

Williams’ concerns are shared by other analysts examining the field (Russell, 2003; Russell & Phillips-Miller 2002; Romi & Kohan, 2004; Sibthorp, 2003; Harper et al., 2007). While research has established that wilderness therapy effectively produces positive emotional and behavior changes in *some* adolescents with *some* kinds of problems in *some* types of programs *some* of the time, much work remains in sorting out the interactions among all of those factors in order to develop a better understanding of which therapeutic goals wilderness therapy is proficient at addressing for which type of clients, as well as what best practices are indicated for programs. An ever-growing number of studies have demonstrated that wilderness therapy can be very effective (Russell, 2003; 2005), yet a lack of understanding persists both within and outside of the

wilderness therapy community regarding why and how wilderness therapy works. This lack of clarity about the critical link between theory and practice has perpetuated weak research design and implementation and has contributed to poor program evaluation and lack of practice standards within the field.

This study addresses questions fundamental and essential to the field: what are the theoretical foundations of wilderness therapy and how do they relate to wilderness therapy practices? Elucidating the nature and function of wilderness therapy's theoretical basis is the critical first step toward clarifying connections between treatment and outcomes. This is vital work toward improved organization and execution of program research and evaluation. The efficacy of wilderness therapy treatment practices for at risk adolescent clients cannot be fully described or improved upon until research begins with explication of the nature and relevance of its theoretical relationship to the process of therapeutic change.

CHAPTER II

CONCEPTUALIZATION & METHODOLOGY

One of the challenges the wilderness therapy field faces is ambiguity about which specific elements of treatment are required in order to constitute wilderness therapy. This study approaches conceptualization of wilderness therapy practice, theory, and process by first considering existing definitions of the treatment model as well as the field's characteristics and demographics. An overview of ongoing program debates and discourse, outcome studies, and the present direction of research help to establish the current condition of the wilderness therapy industry and its present successes and challenges.

In addition to definition confusion, diversity in program design and implementation combined with research limitations and a lack of cohesive treatment theory has resulted in diffuse and largely speculative explanations of why and how wilderness therapy works. This study addresses this concern by beginning with an examination of the historical evolution of wilderness therapy's ideas and practices in order to contextualize and clarify the origins and evolution of the model's contemporary configuration and orientation. Further inquiry into the theoretical and functional components of how and why wilderness therapy works is undertaken through individual and integrative application of two postmodern psychosocial constructs: relational-cultural theory and narrative therapy.

Relational-cultural theory and narrative therapy have been selected for this study due to their complimentary theoretical orientations and conceptual applicability to the experiential processes of wilderness therapy. Theories are situated in their historical and sociocultural contexts to allow deeper examination of the relationship between theory development and treatment practice. Specifically, relational-cultural theory's concepts of connection within responsive relational space; the roles of authority, transference, and empathy in relational work; and the functions of community and culture are considered along with narrative therapy's practice of externalizing problems, enabling of unique outcomes, and use of metaphors, including the rite of passage metaphor. Application of these theoretical ideas and principles to wilderness therapy processes yields considerations and suggestions for future research and industry practice.

Differentiation should be made, however, between the particular theories utilized in this study and the specific theoretical orientations of individual wilderness therapy clinicians. Like the eclectic origins of the treatment model itself, wilderness therapy clinicians have been trained in and practice from a wide variety of theoretical orientations. Rather than attempting to explore wilderness therapy theory deductively through a diverse range of individual clinical perspectives, this study attempts to approach treatment phenomenon inductively by analyzing patterns as they might be explained and understood by the selected theoretical orientations.

In the interest of contextualizing the perspectives and theories utilized in this study, it is noted that both of the theoretical orientations of relational-cultural theory and narrative therapy have been primarily developed by white, western practitioners who assert that they are unable to fully assess the validity of applying their theories to other

racial and cultural experiences (Fedele, 2004; White, 2004). Since the large majority of wilderness therapy program founders, staff, and clients match the cultural profiles from which these theories have been developed—and because this research study is also conducted by a white woman from the United States—many of the cultural and experiential assumptions made by relational-cultural theory and narrative therapy may remain relevant and applicable for the purposes of this study. Nevertheless, critical inquiry and input from the perspective of non-white theorists, practitioners, and clients is currently lacking and necessary to the further development of the wilderness therapy field if programs are to effectively and responsibly serve a diverse range of clients.

Another source of bias inherent in this study, present both in this researcher's perspective and much of existing research cited herein, is the leading assumption that wilderness therapy can be effective treatment for producing positive emotional and behavioral change in adolescents. While this supposition has been demonstrated in a variety of studies examining a range of programs, this researcher's interest in the intervention comes directly from personal experience with employment at a wilderness therapy program. This study will endeavor to document existing empirical support for wilderness therapy treatment and attempt to represent clearly and objectively the opinions and observations of sources cited.

CHAPTER III

WHAT IS WILDERNESS THERAPY?

Defining the Treatment Model

“Wilderness therapy” is a diffuse and evolving term used to describe multiple models and practices across the literature. This diversity of use has contributed to the field’s challenges in establishing theoretical and practical cohesion. In grounding a definition of the treatment model, it is important to first differentiate programs that conduct therapeutic experiences in a wilderness environment, sometimes termed “wilderness experience programs,” from wilderness therapy as a treatment modality. Wilderness experience programming encompasses a wide range of activities and objectives, including some types of outdoor, environmental, experiential, and adventure education, each of which may utilize aspects of wilderness activity and often also include therapeutic goals. One recent study identified over 700 potential wilderness experience programs in the United States, and this number is assumed to be expanding, making clarification of these terms even more critical (Friese, Hendee, & Kinziger, 2008).

Wilderness therapy, as defined by this study and others addressing clarification of the term, is a more individualized, clinical intervention which includes assessment and treatment planning by trained mental health practitioners (Hill, 2007; Russell, 2001). Other requisites for wilderness therapy are a therapeutic program model with expressed outcomes, selective admission based on assessment, individual and group psychotherapy by qualified professionals, evaluation, and aftercare planning for transition out of

program (Russell & Phillips-Miller, 2002). Wilderness therapy should also be differentiated from wilderness boot camps, which operate under an authoritarian, military-based model of treatment administered in a manner counter to the goal of individual empowerment within wilderness therapy (Conner, 2007).

In addition to individualized therapeutic services, the other critical, though less examined, element of wilderness therapy is the wilderness setting—the inclusion of significant outdoor experiences as an element of therapeutic change. Wilderness activity and characteristics are dependent on the geographical location of the program and can include primitive camping, backpacking, and other outdoor survival and recreational activities in undeveloped desert, field, forest, and mountain regions. Programs primarily operate wilderness expeditions on federal or state land and occasionally on private or tribal land (Russell, Gillis, & Lewis, 2008). The abundance of large, accessible tracts of public wilderness in western portions of the United States has made that region a popular location for programs, but wilderness therapy programs have been identified in at least 33 states (Kutz, 2008). Programs typically operate for at least two weeks within wilderness environments, with some remaining on expedition or in primitive camp environments for up to the full duration of the program. Despite the fact that wilderness setting is a fundamental aspect of wilderness therapy, little research has examined the role of the natural environment or considered the environmental impact of wilderness therapy practices (Beringer, 2004).

There are a variety of ways in which wilderness therapy programs combine psychotherapy and wilderness experience to produce therapeutic change, but many institutions share similarities in structure and practice. A typical wilderness therapy

program might offer residential treatment for at risk adolescents through simple, small group living in a primitive outdoor environment where clients work through therapeutic issues with clinical staff, skills-based curricula with field staff, and personal and interpersonal goals with their group. Most programs also conduct concurrent therapy with youths' families in order to facilitate change and support clients' successful transitions out of programs. Length of treatment is usually a minimum of 21 or 28 days, with many programs offering the option of longer terms. A 2006 survey identified at least 65 wilderness therapy programs operating in North America (Russell, Gillis, & Lewis, 2008). The broad scope of public opinion and press on the industry—from enthusiastic reports of impressive outcome studies, to angry allegations of maltreatment and mismanagement, to the television reality series “Brat Camp”—illustrates both existing variations in program intent and implementation as well as the fractured perceptions of the field's legitimacy and efficacy.

Characteristics of the Field

Many of the most recent and extensive research attempts toward clarifying the characteristics and trends of the wilderness therapy field have been led by Keith Russell, an associate professor at the University of Minnesota's School of Kinesiology and director of the Outdoor Behavioral Healthcare Industry Council's Research Cooperative. The Outdoor Behavioral Healthcare Industry Council is a coalition of outdoor programs formed in 1996 which describes its mission as to “unite its members and to promote the common good of our programs standards and our industry at large” by “developing and policing the standards of excellence for membership and to have effective means of operating a service business by sharing and discussing thoughts and processes” (Outdoor

Behavioral Healthcare Industry Council, n.d.). The Outdoor Behavioral Healthcare Industry Council currently claims seventeen member organizations, including many of the country's largest wilderness therapy programs.

One of the Outdoor Behavioral Healthcare Industry Council's functions has been propagation of the term "outdoor behavioral healthcare," which is not widely recognized or used beyond the agencies and activities affiliated with the Council. Russell, Gillis, and Lewis (2008) utilized the following definition of outdoor behavioral healthcare in their 2006 survey of the wilderness therapy field:

The term Outdoor Behavioral Healthcare...refers to programs that subscribe to a multimodal treatment model within the context of wilderness environments and backcountry travel to facilitate progress toward individualized treatment goals. The approach incorporates the use of evidenced-based clinical practices including client assessment, individual and group psychotherapy conducted by independently licensed clinicians, and the development of individual treatment and aftercare plans. (p. 55)

The creation of the term "outdoor behavioral healthcare" and organization of the Outdoor Behavioral Healthcare Industry Council are examples of the field's attempts to gain credibility with the clinical community, consumers, and funders such as state agencies and insurance companies. Russell has stated elsewhere, "We want to emphasize that wilderness therapy is not taking troubled adolescents into the woods so that they feel better. It involves the careful selection of potential candidates based on a clinical assessment and the creation of an individual treatment plan for each participant" (2001, p. 76). The industry continues to work toward building scientific rationale and a body of research evidence for wilderness therapy.

The degree and manner in which wilderness therapy programs meet the standards of the Council's outdoor behavioral healthcare definition vary. Some programs have

clinical staff accessible to clients at all times, while others check in with the clients to do individual and group work at regular intervals. The level of training and number of clinicians on staff differs significantly among programs, and 12 percent of programs identifying themselves as offering outdoor behavioral healthcare in the 2006 study did not have any licensed mental health professionals on staff at the time of survey (Russell, Gillis, & Lewis, 2008).

As level and type of clinical care are not consistent across programs, the nature of the wilderness component of wilderness therapy also varies in setting, activity, length, and intensity. First attempts at an industry-wide survey of outdoor behavioral healthcare programming Russell, Gillis, & Lewis (2008), conducted in 2001 and published in 2003, revealed a wide range of program models. At that time, 80 percent of the programs identified could be classified as base-camp expedition and residential expedition models in which wilderness expeditions were used to augment treatment administered at therapeutic schools, residential centers, or primitive, stationary base camps. The other program structure identified maintained 90 percent or more of program time on wilderness expedition, either in a contained program where groups of clients entered and completed treatment together according to a fixed treatment timeline or in a continuous-flow model where clients entered and left the program continuously based on individual admission and discharge criteria (Russell, Gillis, & Lewis, 2008). While a 2006 follow-up survey sustained the prominence of expedition and residential programming, it also described the emerging popularity of an “integrated expedition” model which offers wilderness expeditions of up to a week in rotation with two or three days of residential and educational curricula (Russell, Gillis, & Lewis, 2008).

It is not clear whether variations in the clinical and wilderness components of wilderness therapy are more reflective of differences in program intent and philosophy or program access to resources and funding. While the diversity in therapeutic design among wilderness therapy programs might represent a potential strength of the field by allowing for a wider range of specialized accommodations and treatments for clients, it also currently serves a confounding factor for researchers attempting to establish the strengths and weakness of program design and implementation as well as a source of confusion for clients searching for the most appropriate type of treatment.

Client Demographics

The factor which, in best practice, most greatly dictates the elements and structure of a wilderness therapy program is the needs of its target treatment population. Though programs focusing on treatment issues for younger adolescents, young adults, and adults exist, the majority of current wilderness therapy services are targeted toward older adolescents and teens. A 2006 survey of 65 wilderness therapy programs serving a total of 10,753 clients reported an average age range for treatment of 12 to 17, with more than half of programs also working with voluntarily-involved clients aged 18 and older (Russell, Gillis, & Lewis, 2008).

Youth referred to wilderness therapy programs have been identified by parents and guardians, school staff, or mental health professionals as “troubled” or “at risk” and failing to succeed in their home, community, and/or school settings. While the term “at risk” has also been used to describe extrinsic demographic characteristics such as low socioeconomic status or victimization of abuse, at risk youth referred to wilderness therapy usually have a prior of history of presenting with individual behaviors believed to

predict the likelihood of future adverse outcomes, such as substance use and emotional, academic, and behavioral problems (Dominitz, Fischhoff, & Manski, 2001; Hill, 2007). Berman and Davis-Berman (2002) define “troubled youth” as those with mental health concerns or juvenile court involvement. Many clients have also received earlier educational, healthcare, or social service interventions prior to their referral to wilderness therapy, and most clients have had prior involvement—often with limited success—with other mental health services. For many families, wilderness therapy is utilized as a last resort intervention when less intensive attempts to address concerns have not resulted in significant or long-term changes in adolescent behavior.

Wilderness therapy has been credited with success in addressing a variety of at risk behaviors and clinical issues, from treating the symptoms of reactive attachment disorder to addressing the mental health needs of victims of sexual assault (Kirby, 2006; Levine, 1994). Programs differ in the level of specificity of admission criteria and treatment foci. Adolescent clients are commonly referred for concerns such as oppositional behavior, depression, and anxiety. The prominence of substance use as a primary clinical focus also appears to be increasing significantly in recent years (Russell, Gillis, & Lewis, 2008). In addition, many clients struggle with attachment issues: although less than one half of one percent of U.S. population is adopted, one study found more than a third of children treated in wilderness therapy programs were adopted (Kirby, 2006). While positive findings continue to be forthcoming, there is not yet much established understanding of which aspects of programming are successful in addressing specific changes. This is an important area for further investigation if wilderness therapy wishes to support claims of individualized treatment, because certain aspects of

programming may prove appropriate or effective for some clinical concerns while contradicted by others (Russell, 2001).

With respect to gender, over two-thirds of wilderness therapy clients are male, and research indicates that male and female clients are referred to wilderness therapy for different reasons. Females present with greater mental health concerns, internalized emotional issues, and somaticized problems such as self-injury and eating disorders; males are more likely to be experiencing substance abuse, problems in school, and conduct disordered behavior (Harper & Cooley, 2007; Harper, Russell, Cooley, & Cupples, 2007; Russell, 2003). While age and gender have been identified as variables in treatment outcomes and significant to program components affecting those results in outdoor programming, little has been discovered about how these elements relate to program design and outcome in wilderness therapy (McKenzie, 2003).

The majority of wilderness therapy clients are of upper-middle socioeconomic status (Russell, Gillis, & Lewis, 2008). The resource-intensive demands of the treatment model, combined with limited empirical evidence of its efficacy, have caused funding for such programs to remain largely private, with existing state-run programs on the decline. The 2006 survey of the industry found 40 percent of wilderness therapy programs identified as private nonprofits, 34 percent were private corporations, and 8 percent were government-operated programs for adjudicated youth (Russell, Gillis, & Lewis, 2008). Wilderness therapy is an expensive intervention, with an average client cost of \$278 per day in 2006. Reimbursement by insurance companies for treatment was pioneered by an Arizona wilderness program in 1988 based on the requirement that the program met state requirements for adolescent residential treatment centers (Russell, 2001) and is

decreasing despite rising costs of care (Russell, Gillis, & Lewis, 2008). Two-thirds of programs accept third-party payment, which covers less than a third of treatment costs on average, helping to ensure that wilderness therapy remains economically unfeasible for many potential clients.

As might be expected given the correlation between socioeconomic status and race in the United States (Kennickell, 2003), the majority of clients served by wilderness therapy are Caucasian (Russell, Gillis, & Lewis, 2008). Orren and Werner (2007) reason that, because differences have been identified among racial and ethnic groups' responses to mental health interventions, wilderness therapy may also affect clients differently dependent on race or ethnicity. Despite the fact that socioeconomic status and race have been identified as important variables related to outcomes, little has been reported on these topics or discussed internally (Russell, 2001). Warren (2004) notes that race-sensitive literature in outdoor experiential education focuses more on creating employment opportunities for people of color than increasing race-awareness of white practitioners. Although a comprehensive survey of staff demographic data has not been published, it is likely that the majority of wilderness therapy staff are also Caucasian and of middle and upper-middle class socioeconomic class. Training is prohibitively expensive and field staff too poorly compensated to make outdoor leadership a viable career for people of low socioeconomic status.

Comprehensive research on the significance of demographic factors such as socioeconomic status, race, ethnicity, religion, and sexual orientation has not yet been published. Due to the physical demand, access limitations, and logistical challenges, accommodation for individuals with physical disabilities or extensive medical needs is

extremely limited. While a composite of program profiles identify adolescent, Caucasian males of upper-middle socioeconomic status with substance or behavior concerns as the most frequent recipients of wilderness therapy, this profile more accurately describes the type of client with the most access to the treatment model rather than the one most likely to benefit from such treatment. Clarification of the latter designation requires a careful attention to the relationship between treatment type, individual client characteristics, and outcomes not extensively considered in existing research.

Program Outcomes

Positive outcomes reported by wilderness therapy research are numerous and varied. The majority of existing studies examine small sections of wilderness therapy work and the narrow findings cannot be generalized. An example is Clark, Cooley, Gathercoal, and Marmol's (2004) evaluation of the effects of a 21-day wilderness therapy program which found that the program produced statistically significant decreases in maladaptive behavior, expressed concerns, dysfunctional personality patterns, and clinical syndromes. Of particular significance was the indication of characterological change in personality patterns, unusual in a 21-day intervention and of potential importance to the treatment of emerging personality disorders. Without the support of additional research, however, the results merely indicate positive short-term results for a particular set of clients in a particular program at one particular point in time.

Despite limitations to generalization, researchers have discovered a wide range of findings which suggest positive changes for clients across physical, mental, emotional, and behavioral domains. Groff and Werhan (2005) established that wilderness therapy resulted in improved physical health aspects such as increased strength, endurance and

cardiovascular output, and decreased weight, anxiety, stress and sleep disturbances as well as positive mental health developments such as improved social skills, decreased antisocial behavior, increased interpersonal adjustment, improved self-control and self-esteem, increased critical thinking. They also found that wilderness therapy aided in participants' development of an overall appreciation for the environment and an awareness of nature that encouraged personal reflection and the development of a connection with ecology and natural processes. Following discharge from wilderness therapy, clients participating in research studies have demonstrated improvements in areas including emotional problems, substance use, school performance, social relations, and suicidal ideation (Harper & Cooley, 2007).

Many youth treated in wilderness therapy require individual and family aftercare services, often in the form of outpatient therapy, residential treatment centers, or therapeutic boarding schools. Wilderness therapy programs usually work with families to develop individual aftercare plans to support clients' transitions from the program, and research has shown it possible for clients to sustain many changes or positive trends at 12 months following discharge (Harper & Cooley, 2007). In another post-treatment study, success in school and improved family communication were cited as positive outcomes and 85 percent of youth were utilizing some kind of aftercare counseling (Harper et al., 2007). Russell (2005) interviewed youth and families 24 months after treatment at a wilderness therapy program and found that 80 percent of parents and 95 percent of youth perceived their treatment in the program to have been effective, though many continued to struggle to some degree with substance use, behavioral issues, and social concerns. In general, research findings of individual programs and studies appear promising, yet more

extensive, comprehensive, and longitudinal studies are required to make a case for the success of the industry as a whole.

Safety and Regulatory Controversy

The aspects of wilderness therapy which complicate program analysis also present significant difficulties in program execution, particularly with respect to staffing and program logistics. Employment in wilderness therapy can be uniquely challenging, physically, mentally, and emotionally: direct care field staff in some programs live under the same conditions and demands as clients for a week or longer per shift or expedition with limited access to additional support. Because of this, Rosol (2000) stresses the importance of maintaining staff with strong training and demonstrated ability in technical skills including first-aid and survival, soft skills such as interpersonal communication, and advanced skills in psychotherapy and counseling. Despite the need for this complex skill set, staff training and level of experience in each of these areas is highly inconsistent.

The issue of baseline requirements for staff competencies is related to broader debate about an overall lack of standardization, regulation, and accreditation within the field which has resulted in poor policy, oversight, and implementation in some programs, and, in the most severe cases, injury and death of participants (generally due to environmentally-related conditions such as dehydration, heatstroke, and hypothermia). There is currently no federal regulation of residential treatment programs, including wilderness therapy, and, in 2007, the Government Accountability Office reviewed ten lawsuits involving deaths of youth participating in residential treatment centers such as wilderness therapy or wilderness boot camp programs (Kutz & O'Connell, 2007). Five

of the programs named in the dispute remained in operation at the time of the report, and the GAO released a follow-up report on the private residential program industry in 2008, finding, "...Ineffective management and operating practices, in addition to untrained staff, contributed to the death and abuse of youth enrolled in selected programs" (Kutz, 2008, p. 7). A bill has also been introduced to the U.S. House of Representatives which would encourage state licensing of residential treatment programs and establish federal penalties for abuse in such programs.

While industry-specific, federally mandated guidelines and penalties do not currently exist, some states do offer licensing or accreditation for wilderness therapy, and well-run programs take internal precautions to implement best-practice policies and procedures. Many also participate in industry coalitions in order to help prevent the types of accidents reviewed by the GAO. Organizations such as the Association of Experiential Education, the National Association of Therapeutic Schools and Programs, and National Association of Therapeutic Wilderness Camps have developed guidelines outlining industry standards and professional conduct. A limitation of these types of organizations is that most do not conduct inspections and audits nor investigate accidents and possible breaches of conduct, leaving programs responsible for self-policing.

One of the Outdoor Behavioral Healthcare Industry Council Research Cooperative's objectives is to establish a baseline description of safety issues in wilderness therapy such as frequency of implementation of safety restraints and critical incidents such as client runaways (Russell, 2001). This has been difficult to accomplish without uniform requirements for recording or reporting of these occurrences. Despite this, Russell, Gillis, and Lewis (2008) argue that most wilderness therapy programs have

sought licensing or accreditation in states where these recognitions are available to them in addition to maintaining the policies and procedures developed by professional organizations. They concluded that the residential treatment programs charged with abuse or neglect in the GAO's 2007 report either could not be characterized as wilderness therapy programs or were not representative of the industry's standards and practices. The fact remains, however, that some programs advertising wilderness therapy do not meet ethical and operating standards and continue to operate without a clear method for clients to differentiate them from safe and effective programs. Non-accredited programs are less likely to offer information to researchers, making the degree and scope of sub-standard programming difficult to gauge.

Research and Theory

A major factor in wilderness therapy's difficulty gaining public recognition and funding has been the field's inability to empirically demonstrate claims of positive effect in a comprehensive and coherent manner. The large number of variables and existing variations between programs has made broad study of the treatment model very challenging, and lack of internal and external validity has limited the contributions of existing research toward building evidence of wilderness therapy's effects. Serious limitations within existing research on wilderness therapy include small, non-random sampling; significant sample attrition; lack of control groups; and use of non-psychometrically assessed measures (Russell, 2003). While most programs utilize some sort of outcome evaluation, more than half use internally developed instruments conducted by program staff, resulting in reservations about researcher objectivity

(Newes, 2001). Very few programs engage in regular evaluation by an external organization (Russell, Gillis, & Lewis, 2008).

The industry has expressed an awareness of these weaknesses in evaluation procedures. In a 2003 address at the Symposium for Experiential Education Research, Henderson (2004) calls for a “research-friendly culture” with greater attention to theory-driven and evidence-based research (p. 184). In spite of these statements, comprehensive quantitative data has been slow in arriving. In a review of the types of research being published in the *Journal of Experiential Education* in the two years following Henderson’s statements, qualitative methods were found in 10 of the 14 research articles (Russell, 2006). Russell addresses these findings:

The reality of the demands by external constituencies that fund most of the programs is that they want to assess the value of the programs and they want to see quantitative information. This is nothing new to anyone in the field. I ask this question to engage dialogue on the subject: Are we as researchers doing practitioners and the field a disservice by focusing our efforts on qualitative inquiry and theoretical development through literature reviews, or is this information valuable to maintaining and improving practice? Are practitioners reading these theoretical pieces and practicing participatory/action research and implementing some of these ideas, or are researchers simply publishing to the choir? (p. 248)

Despite Russell’s implication that much of the field’s qualitative and theoretical research may have become superfluous or redundant, there is little cogency among descriptions of programs’ theoretical orientations. The most common theory-related themes in reviews of wilderness therapy literature include reflections of the methodological limitations of linking theory and practice (Williams, 2000), declarations of the current lack of theoretical understanding (Russell, 2003; Russell & Phillips-Miller 2002; Romi & Kohan, 2004; Sibthorp, 2003), and recommendations for further

investigation of theory (Harper et al., 2007). This lack of theoretical clarity is clearly at the heart of the current limitations of wilderness therapy research and practice.

Current State of the Field

The efficacy and viability of wilderness therapy remains under scrutiny and debate. The treatment model demonstrates potential for both substantial results and significant risks for adolescents in treatment. Further research is warranted to clarify the short and long term effects of treatment on subpopulations as well to analyze and address concerns regarding the risks posed by wilderness environments and wilderness therapy's practices. Continued interest in the model is likely to offer opportunity to further investigate these details. Russell, Gillis, & Lewis (2008) observe:

Given that [outdoor behavioral healthcare] is largely a demand-driven treatment alternative, it is critical to note that an estimated 20,000 clients and their families annually turn to OBH programs, despite the fact that they remain largely untested. Data from this survey shows that families who have tried other services that for the majority were ineffective, are willing to try OBH programs despite the relatively few studies that been conducted on their treatment effectiveness.
(p. 68)

While some of these client referrals may come from positive word-of-mouth recommendations, utilization of wilderness therapy despite lack of research support also suggests a level of desperation on the part of clients and families who have found traditional therapeutic interventions ineffective, placing weighty responsibility on programs to deliver consistent and quality care. Increased regulation of the field would likely increase the ability to cross-compare program effectiveness while decreasing incidents of program negligence. At the same time, program flexibility and individualized treatment remain important strengths of the approach.

Reviews of the literature reveal a lack of a well-explicated theoretical basis for wilderness therapy, severely limiting researchers' abilities to elucidate and demonstrate the efficacy of practice. This study addresses this deficiency by exploring the origins and evolution of wilderness therapy's use of theory and examining practices as they relate to contemporary psychosocial theory. Clarifying the theories behind wilderness therapy practices must precede assessment and refinement of treatment techniques: services cannot be improved if research does not address this step. As wilderness therapy programs seek greater recognition and legitimization as providers of intensive clinical services for adolescents, sound theoretical justification for such programs, supported by solid quantitative and qualitative research, becomes of even greater importance.

CHAPTER IV

WHERE DID WILDERNESS THERAPY COME FROM?

Introduction

If a prominent critique of wilderness therapy is its lack of an explicit theoretical basis, one fairly obvious reason for this confusion is the dual strategies it employs in appealing to public consumers and the professional community. In its online promotional literature, Arizona-based wilderness therapy program Anasazi Foundation (2009) describes its treatment philosophy as concrete, yet mysterious:

The Anasazi curriculum is a series of Makings that grow naturally out of the experience of living with one another on the land...Not: theories and models... The Anasazi Way recognizes the absolute, separate, and individualized rights and concerns of each YoungWalker...Not: a prescribed set of generic activities and interventions. (para. 5; para. 10)

Elsewhere on its website, Anasazi explains its non-clinical language choices: “Rather than using the traditional psychological terminology that many youth are resistant to and conditioned to reject, Anasazi has developed its own ‘language,’ drawn from aspects of the Native American culture and metaphors from nature, to engage the YoungWalker’s imagination and curiosity” (para. 5, quotation marks in text). SUWS wilderness program (n.d.), in Idaho, also chooses to avoid use of the word “therapy” in order to “differentiate SUWS from other, more familiar and predictable approaches to treatment” (para. 3). This is again a strategic semantic decision: “If the students think they will be ‘doing therapy’ when they start the program, they may be tempted to act or talk a certain way to meet perceived criteria” (para. 3, quotation marks in text). Both programs consciously

avoid professional jargon to avoid suggesting they offer more of the same type of programming that potential clients have already tried and found ineffective. In explaining this choice, Anasazi and SUWS remain conscious that they are circumnavigating preconceptions rather than proposing an entirely new approach.

Because of this strategy, Anasazi and SUWS refer to the youth they serve as “Walkers” and “students” rather than “clients,” but both programs are aware that their services constitute “therapy,” not just due to therapeutic intent, but because the programs borrow or emulate many aspects of mainstream treatment models and practices. Elsewhere on its site, Anasazi (2009) describes its “holistic, bio-psychosocial-spiritual approach to treatment” as incorporating positive psychology with a systems approach including Dialectical Behavior Therapy and Emotion-focused Family Therapy techniques (para. 3). And despite Anasazi’s disavowal of “theories and models,” their practice is, in fact, theoretically-informed and highly prescribed:

...Anasazi creates an environment that invites change. A successful milieu requires that all staff be trained in the intervention model and that every interaction between staff and program participants—both parents and children—be consistent with the milieu philosophy and intervention model. (para. 8)

SUWS (n.d.) is less transparent about its clinical interventions on its public website, but explains itself as a “comprehensive treatment program with an emphasis on combining the impact wilderness living with an emotional growth-oriented curriculum” (para. 1).

Though Anasazi and SUWS both currently offer what can be characterized as wilderness therapy, the programs have very different points of origin. Larry Olsen and Ezekiel Sanchez (1990) “pioneered the wilderness philosophy” at Brigham Young University in 1968 by developing a university-based wilderness program that became

Anasazi (para. 2). Anasazi's philosophical and theoretical orientations are grounded in the founders' Mormon faith: "We make no apologies for...our one choice—to follow principles given by the Creator" (para. 5). In its present form, Anasazi states that it encourages all religious beliefs in its programs and respects those who do not wish to include spirituality in treatment. Although SUWS is now known exclusively by its acronym, it was founded in 1981 as "The School of Urban and Wilderness Survival." SUWS has evolved beyond its original survivalist curriculum to treat clinical concerns and substance abuse issues. The differences in the original theoretical and practical intents of wilderness therapy programs such as Anasazi and SUWS suggest that the roots of modern wilderness therapy are diffuse and pluralistic, complicating efforts to define a common orientation.

To consumers failed by "generic" and "predictable" traditional therapeutic services, the wilderness therapy field describes itself in as a unique, alternative treatment option. In order to appeal to the professional community, referring agents, and third-party payers, wilderness therapy programs claim to offer "comprehensive" and "consistent" evidence-informed practice. Both of these campaigns describe a half-truth: wilderness therapy is neither a-theoretical nor a research-proven workbook model. The connotative difference between "generic" and "comprehensive," as well as "predictable" and "consistent," is one of efficacy, the very point the field struggles to establish. Wilderness therapy occupies a space which is beyond the territory of traditional therapy and informed by both current research in the sciences and ancient traditions which predate modern medicine and the advent of psychotherapy. An examination of the historical evolution of wilderness therapy's theories and practices may help to elucidate

this curious position and account for the particular challenges it faces in arguing its effectiveness.

Spirituality and Transcendentalism in the Wilderness

The concept of wilderness, the practice of therapeutic healing, and the characterization of the natural world as a therapeutic agent are not indigenous nor exclusive to United States history. Both Western and Eastern religious and spiritual traditions include stories of leaders, prophets, and mystics receiving visions and insight in the wilderness. Some traditions designate certain natural elements, places, or monuments as sacred; others worship the natural or experiential world directly. However, the U. S.'s historical relationship between its land, people, and ideas is unique. Although many wilderness therapy programs and related ideas and practices have been and are being developed elsewhere in the world, this narrative will limit its scope to events impacting the evolution of the field within the United States.

Native Americans are often characterized by dominant U. S. culture as practicing a nature-based religion. However, both “religion” and “nature” as implied in that description are Western socio-cultural concepts. Most indigenous American traditions do not subscribe to Euro-American conceptualizations of religious-societal and nature-cultural dualism, but rather understand spirituality as an inseparable aspect of cultural and social practice that “pervades even the habitual acts of sleeping and putting on shoes,” and which is given meaning by communal context “rooted in a profound notion of space and place” (Tinker, 2006, para. 3). Thus, while rituals such as the Plains Indians’ “vision quest” have been recast by Western culture as individualistic spiritual pursuits achieved through wilderness experience, the Plain Indians’ ceremony

understands the individual as acting “on behalf of and for the good of the whole community” with active participation of others in the experience (para. 6). Similarly, indigenous American society is not separable from nature, as explained by Chief Luther Standing Bear (1978), an Oglala Sioux: “We did not think of the great open plains, the beautiful rolling hills, and winding streams with tangled growth, as ‘wild.’ Only to the white man was nature a ‘wilderness and only to him was the land ‘infested’ with ‘wild animals’ and ‘savage’ people. To us it was tame” (p. 38, quotation marks in text).

For early European colonists in North America, the relationship between religion and society had been complicated by negative experiences of government-imposed religion or personal beliefs of evangelistic duty. Settlers also found themselves in a new and foreign physical environment which offered both the threat of failure and the possibility for survival. Davis-Berman and Berman (1994) characterize early European America colonists as believing the natural world was “dark and dangerous” (p. 21). This attitude cast the wilderness in opposition to human pursuits, something to be conquered and tamed by civilization.

This humanity-versus-nature conceptualization remained evident in the mid-nineteenth century discourse on “manifest destiny,” a term in a 1845 *New York Post* editorial asserting the U. S.’s sovereign obligation “to overspread and to possess the whole of the continent which Providence has given us for the development of the great experiment of liberty and federated self-government entrusted to us” (Axelrod & Phillips, 2003, p. 104). Away from the frontier line, though, some long-settled New England regions began to embrace European Romantic period beliefs including “the healing, restorative quality of nature” (Davis-Berman & Berman, 1994, p. 36).

This attitude was evident in the literature, religion, and philosophy of the U. S. transcendentalist movement spanning the late 1830s through the mid-century, most widely defined by the works of Ralph Waldo Emerson. Transcendentalists advocated individualistic, spiritual intuition in pursuit of understanding “which did not come by experience, but through which experience was acquired” (Emerson, 1842).

Transcendental philosophy holds that society’s predominant religious and cultural practices thwarted this type of experience, while nature facilitates enlightenment. Of his two-year experiment living rustically in a cabin in Walden, Massachusetts, American transcendentalist writer Henry David Thoreau (1904) wrote in 1854:

I went to the woods because I wished to live deliberately, to front only the essential facts of life, and see if I could not learn what it had to teach, and not, when I came to die, discover that I had not lived...I wanted to live deep and suck out all the marrow of life, to live so sturdily and Spartan-like as to put to rout all that was not life, to cut a broad swath and shave close, to drive life into a corner, and reduce it to its lowest terms... (p. 88-89)

As a movement, transcendentalism suffered from a confusion of jargon and esotericism, but it aroused a romanticized view of wilderness which was tapped by environmental conservation movements. Across the nineteenth century, the Hot Springs of Arkansas, California’s Yosemite Valley and Mariposa Grove, Yellowstone National Park, and the Adirondack Park were all established to protect these natural areas from the impact of human industrialization.

Recreational Youth Camping

The second half of the nineteenth century saw the United States through significant changes in national organization and climate, including the Civil War and Reconstruction. In 1890, the census declared the frontier line had ended, and Progressive

reformers focused efforts on addressing the social conditions created by urbanization. Restrictions on child labor created an “extended childhood” for youth which allowed the rise of American camping movement, beginning in the Northeastern U. S. (Paris, 2008, p. 5). Paris described this event as “adults’ anxious reaction to urbanization... a kind of nostalgic countermodern that conjoined traditional aesthetics and modern sensibilities” (p. 9). While early camping programs offered predominantly outdoor recreational opportunities, parents and reformers had reasons for sending urban children back into the wilderness: “Camps’ emphasis on productive, goal-oriented leisure reflected distinctly modern American sensibilities. Camp activities were designed to improve campers as well as to bring them more deeply into the group...” (p. 122).

This sentiment is evident in even the earliest camps, such as The North Mountain School of Physical Culture, which was founded by Pennsylvania physician Joseph Rothrock in 1876 on the premise that outdoor living improved the health of children (Davis-Berman & Berman, 1994). Burnt Island Camp, established in New Hampshire in 1881, is an early example of a program with an emphasis on developing responsibility and work ethic. Camps in the 1880s served a few thousand middle and upper-class Protestant boys, but the idea quickly spread at the turn of the century (Paris, 2008). Evidence of camps for girls emerged in the early 1890s with programs such as Camp Kehonka for Girls, established in New Hampshire in 1902, which emphasized the development of character and virtue (Davis-Berman & Berman, 1994).

Camping did not remain a class privilege. Along with the movement to create settlement houses to assist urban poor, Progressive reformers also began to develop opportunities for urban, working-class children to vacation in rural environments. Paris

(2008) notes: “Decades before extended vacations became standard among working-class parents, many social-service organizations expressly sought out some of the least fortunate urban children, providing weeks of camping to them free of charge” (p. 59). In 1877, the beginnings of the Fresh Air Fund were established when Reverend Willard Parsons moved from an urban New York parish to a more rural area of Pennsylvania and convinced church members to voluntarily host children from his former parish (Paris, 2008). This idea was appealing to upper and middle class philanthropists. In 1922, for example, The University of Michigan Fresh Air Camp ran three ten-day sessions managed by university student counselors for 143 “poor” and “underprivileged boys.” University literature describes the camp as:

...crammed full of happiness for these street urchins, who indulged in swimming hiking, baseball, nature study, campfire stunts, songs and talks... Most of the boys returned home heavier, and surely healthier and happier, because Michigan men and women proved themselves unselfish. (Reimann, 1921, p. 106)

These sorts of programs indicate some of the country’s first attempts to conceptualize and intervene in the lives of “at risk” youth populations.

Though certainly many were “underprivileged,” few minority children were included in early camping programs. Later programs were segregated in the same manner as other social institutes of the times. Despite their function as places of racial isolation, many camps appropriated Native American imagery, rituals, and handicrafts. This reflected an interesting reminiscence of frontier life and primitivism. Paris (2008) explains, “As many camp leaders saw the matter, Indian play was particularly suited to children’s culture because Native Americans represented a less advanced stage of civilization” (p. 208). Blackface minstrel shows were another popular camp activity:

“Cross-racial play at camps catering to white children taught campers their place in racial hierarchy while it initiated them into a specifically American brand of race nostalgia” (p. 191-192).

Psychiatric Tent Therapy

The late nineteenth century medical community eschewed psychotherapy in favor of a somatic-based, “scientific” perspective in order to maintain professional credibility and distinguish themselves from spiritual healers and lay practitioners (Caplan, 1998). Thus, psychiatric “tent therapy” is an early, anomalous, and accidental example of use of the outdoors as a therapeutic environment by the U. S. medical community. Tent therapy was inadvertently pioneered in the early 1900s when tuberculosis patients in New York had to be quarantined on the asylum lawn due to overcrowding and another group of psychiatric patients in California were displaced due to an earthquake (Williams, 2000). In both of these cases, patients living outdoors made a quicker and more dramatic recovery than those housed in the institutional asylums. The smaller groups, higher staff-to-patient ratio, and therapeutic influence of the outdoors were thought to have contributed to the success of the tent therapy. Tent therapy for inpatient psychiatric patients garnered some subjective positive reports in literature of the time and was experimented with in briefly, including a camp built on the Susquehanna River in Alabama for Binghamton State Hospital patients, but discourse on the subject disappeared from the literature by 1920 and practice died out accordingly (Davis-Berman & Berman, 2004).

Moral and Character Education

While tent therapy did not succeed in establishing an enduring link between outdoor experience and mental health, youth programming continued to become more explicit about its proposed behavioral outcomes and their theoretical contributing factors. A high-profile example is the scouting movement, begun in England by Robert Baden-Powell. When Baden-Powell published a scouting handbook for youth, *Scouting for Boys*, in 1908 following a highly-successful service in the British Army, the book enjoyed enormous popularity. Boy Scouts groups began to form immediately and internationally and were incorporated in United States for boys ages 11-18 in 1910. Baden-Powell postulated that outdoor activities, handicrafts, and community service would address perceived shortcomings in the youth of industrialized society:

Our aim was to improve the standard of our future citizenhood, especially in character and health. One had to think out the main weak points in our national character and make some effort to eradicate these by substituting equivalent virtues character and make some effort to eradicate these by substituting equivalent virtues, where the ordinary school curriculum was not in a position to supply them. (Baden-Powell, 1933, p. 141)

Girl Scouts groups were also started in the U. S. in 1912 by Juliette Gordon Low and incorporated in 1915. Girl Scouts maintained girls' "separate socialization" of the period with an emphasis on domestic pursuits, but it was also progressive in its emphasizes on outdoor recreation and the idea of "the gendering of adventure as constructed, no biological" (Paris, 2008, p. 52).

Private camps suffered during the economic collapse of the Great Depression. During this time, social service-oriented camps, which cost less and had connections to youth groups, actually had an easier time finding clients, with some children working in

settlement houses to earn camp vacation (Paris, 2008). While the camping industry continued to cater to “normal” children, there was a shift of program focus from individual moral or character correction to collective social adjustment as well as an increase in emphasis on observable, quantifiable outcomes (Paris, 2008). Davis-Berman & Berman (1994) name Camp Ahmek, a boy’s camp in Ontario, as the first program to attempt to support its stated goals with outcome data. A 1929 publication demonstrated the result of the programs’ goals of recreation and socialization, cooperation, citizenship, and role modeling through charts of behavioral observations. In the 1930s, some camps began to employ psychologists and psychiatrists to assess and treat participants. Paris (2008) describes “the growing clout of professional child-study experts, particularly in the fields of education, social work and psychology, and camp leaders’ eagerness to claim professional expertise in their own enterprises” (p. 240). As the attention shifted toward mental health issues, the importance of wilderness experience was deemphasized: camps moved from tents to cabins, with only 40% of programs still using tents by the 1940s (Paris, 2008).

Therapeutic Camping

While focused more directly on education reform, the progressive, child-centered movement of the late 1930s shifted the goals of many youth camping programs from fostering self-control in youth to supporting their self-actualization. The ideas of American psychologist, philosopher, and educator John Dewey were influential in creating this change. Dewey argued “the importance of the external environment to children’s socialization and, conversely, the ways in which children’s socialization could affect broader social change” (Paris, 2008, p. 236). Camping programs began to think

more critically of the ways that camp groups and environments could be used to encourage pro-social behavior in children.

The growing legitimization of psychotherapy, evident in the U. S. since the 1920s, had joined forces with the theoretical therapeutic intentions of youth camping by the late 1940s. Literature of this period documents camps using visiting social workers or psychiatrists to develop therapeutic goals related to “relaxation of the Superego” and “regression...to earlier levels of behavior” (Davis-Berman & Berman, 1994, p. 46). In Texas in 1948, Camp Woodland Springs, still in operation today as the Salesmanship Club of Dallas, began the first long-term, year-round camping program specifically serving boys with emotional and behavioral problems. The program was developed based upon its prior success working with underprivileged youth during a summer program started in 1946. Camp Woodland Springs’ therapeutic approach included “creative listening, non-judgmental attitudes, empathetic unearned love, strong emotional support, environmental modification, and responsibilities for the parents” (p. 49-50). The program’s founder, Campbell Loughmiller, believed that the perception of wilderness’s dangers and natural consequences fostered cooperation and self-esteem in youth, leading to the transference of an internalized locus of control and refined decision making (Davis-Berman and Berman, 1994).

Other camp literature from the late 1940s indicates an increasing utilization of systems theories. A 1947 author wrote, “Because children live together in camp in an extremely interdependent relationship, there is a unique opportunity for the growth of group feeling, and for each child to come to a greater awareness of the way in which what he does affects the group” (Backus, p. 131-132, qtd. in Davis-Berman & Berman, 1994,

p. 47). In 1947, Perlman became an early advocate for follow-up care to maintain therapeutic progress, warning that positive changes would not necessarily “follow the child home” (p. 158, qtd. in Davis-Berman & Berman, 1994, p. 48).

Experiential Education and Outward Bound

Developments in the social sciences continued to inform the way that camp leaders understood the purpose and function of youth camping. The work of Swiss biopsychologist Jean Piaget contributed heavily to the theory of constructivism, the idea that learning is a process by which experiences are systematically integrated and built upon. Though Piaget began his work in the 1920s, translations and receptive communities in the U. S were not observed until the 1960s (Seattler, 1990). In the interim 40s and 50s, however, American psychologist Carl Rogers began to support Dewey’s emphasis on the primacy of experience in learning, applying it to both the educational and therapeutic realms. Rogers (1980) distinguished experiential learning from cognitive learning and argued that it was experiential learning that led to positive change and personal growth. He placed emphasis on student’s control over the process of learning, directing learning toward problems with practical application to real life. Roger’s humanistic, person-centered perspective matched the constructivist view that a teacher’s role should be one of a mentor or guide, facilitating the learning process, rather than authoritarian and dogmatic figure. Rogers advocated a similar role for therapists.

One of the most prominent practice models of experiential education, and the one most literature considering the origins of experiential, adventure, or wilderness therapy cites as the primary precedent, is Outward Bound (Powch, 2004; Russell, 2001; Priest & Gass, 2007). The Outward Bound model was developed in Britain in the 1940s by Kurt

Hahn and Lawrence Holt and was originally created to train sailors during World War II by exposing them to challenging, skill-building experiences during sea and land expeditions. Hahn believed that powerful, genuine experiences would increase participants' perceived and real abilities to handle future challenges with competence (Wilson, 1981). The success of this approach led Outward Bound to create month-long programs for civilians that used physical fitness training, outdoor expeditions, skills training, and community service to foster character development. Like Boy Scouts, Outward Bound quickly became an international phenomenon and was introduced to the United States in 1962 in Colorado. Although Outward Bound promised character and skill-enhancing outcomes, it did not employ trained mental health staff or target at risk populations in its original form.

In response to the need for adolescent rehabilitation programs in the U. S. in 1950s and 1960s, more therapeutic camping programs were developed (Hill, 2007). These served juvenile delinquents and psychiatric day treatment or inpatient programs, though generally no formal psychotherapy was incorporated (Davis-Berman & Berman, 1994). Outward Bound also began to be offered as an alternative treatment for juvenile delinquents in the 1960s and 70s (Russell, 2001). During this period, increasing awareness of the detrimental effects of human activity on the natural environment led to the Wilderness Act in 1964 which established a government system to preserve and protect designated natural areas.

With the rise of therapeutic camping came the increased need for staff qualified to competently supervise and lead children in outdoor living environments. Concurrent to the development of therapeutic experiential programs, outdoor leadership programs

developed. In 1965, Paul Petzoldt, a chief instructor with the Colorado Outward Bound School, formed National Outdoor Leadership School to better prepare and train outdoor leaders (Priest & Gass, 1997). Petzoldt also created the Wilderness Education Association in 1976 to serve as an organization of U. S. university departments providing training in outdoor leadership.

Experiential education was also adapted for non-outdoor settings. In 1971, the learning principles of Outward Bound were applied to high school gym curricula in Massachusetts by non-profit organization Project Adventure (Neill, 2005). These same techniques were then utilized toward therapeutic goals in both traditional and outdoor settings, leading Project Adventure to introduce the genre of “adventure-based counseling” in 1979. The Association for Experiential Education (n.d.), a professional accreditation group for experiential educators and practitioners founded in 1977, defines experiential education as “a philosophy and methodology in which educators purposefully engage with learners in direct experience and focused reflection in order to increase knowledge, develop skills and clarify values” (para. 2). Many experiential education techniques developed in adventure programs such as Project Adventure were reincorporated for therapeutic use in outdoor wilderness programs.

Present-Day Programs and Ecopsychology

As suggested by the breadth and diversity of perspectives and practices contributing to this history, the development of the wilderness therapy field was not a linear, uni-disciplinary progression. Beginning in the 1970s and 80s, trained mental health workers and qualified outdoor leaders came together or became cross-educated to design and implement therapeutic, long-term, residential wilderness programs

specifically targeting at risk populations. Some of these prototypes for contemporary wilderness therapy were new adaptations of existing outdoor or therapeutic programs, others were add-ons, splinter organizations, or entirely new entities. As programs sought to meet residential treatment criteria in order to gain licensing, accreditation, and recognition by funding agencies, emphasis on the inclusion of current and evidence-based mental and behavioral health assessment and treatment techniques increased from the 1980s onward and continues in the present day.

The historical evolution of wilderness therapy might be described as arising from ancient assumptions about the curative properties of wilderness which were harnessed by recreational and character-building aspects of traditional camping, combined with the pro-social goals of therapeutic camping, adapted to experiential learning theory, and retro-fitted with contemporary psychotherapy. Davis-Berman and Berman (1994) found that certain themes have held over from early camping programs:

The recent decades have maintained many of the same basic philosophies about wilderness experiences... Predominant is the belief that the wilderness environment is curative and healthy, especially for urban youth. Additionally, it is felt that meaningful behavioral and cognitive change can occur using this environment as a vehicle for change. (p. 63)

Russell (2001) also notes a connection to earlier program theory and practice and observed the introduction of systems, cognitive, and behavioral perspectives:

Though each wilderness therapy program has a unique approach to wilderness therapy, there appears to be several common elements comprising their theoretical basis. Many of these common concepts are based on traditional wilderness programming ideas dating back to the 1960s in programs such as Outward Bound, but which are then integrated with an eclectic therapeutic model based on a family systems perspective with a cognitive behavioral treatment emphasis. This approach integrates the therapeutic factors of a wilderness experience with a nurturing and intense therapeutic process, which helps clients access feelings and emotions suppressed by anger, drugs, alcohol, and depression. (p. 79)

Modern psychosocial, behavioral, and systems theories as applied to wilderness therapy are not profoundly removed from the “goal-oriented recreation” of early youth camping programs. The techniques and targets, however, have been refined.

In an interesting completion of the experiential cycle, a recent critique of wilderness therapy theory refers back to the spiritual and transcendental qualities of the wilderness, charging current research with failure to consider “the therapeutic-curative potential of natural environments” (Beringer, 2004). Theodore Roszak (1992) has named this ecological-psychological focus “ecopsychology”:

The goal of ecopsychology is to awaken the inherent sense of environmental reciprocity that lies within the ecological unconscious. Other therapies seek to heal the alienation between person and person, person and family, and person and society. Ecopsychology seeks to heal the more fundamental alienation of person and environment. (p. 320)

This intention of restoring the relational rift between nature and civilization also implies a theoretical move closer toward Native American conceptualizations of planetary community:

The sense of the interrelationship of all of creation—of all two-legged, four-legged, winged, and other living, moving things (from fish and rivers to rocks, trees and mountains)—may be the most important contribution Indian peoples have made to the science and spirituality of the modern world. (Tinker, 1996)

Despite ecopsychology’s ambitions and the appropriation of Native American imagery by programs like Anasazi Foundation, it is unlikely that Western society stands collectively on the cusp of this paradigm shift. Instead, wilderness therapy finds itself caught in the cultural void between spirituality and empiricism. However, wilderness therapy’s characteristics also may place it in an ideal position to suggest possibility of surmounting that dilemma.

Hopkins (2004), in his critique of U. S. educational research, noted that “psychologistic social science conceives and studies fixed configurations; it does not deal well with problems of process. It stops phenomena in time and space” (p. 52). Hopkins proposed experiential learning and narrative as more productive forms of inquiry: “Because of its preoccupation with temporal factors in existence, phenomenology enables us to give more meaningful accounts of process” (p. 52). Dewey (1929) sought to make a similar case for the prioritization of process:

Since the root of the traditional conception of philosophy is the separation that has been made between knowledge and action, between theory and practice, it is to the problem of this separation that we are to give attention. Our main attempt will be to show how the actual procedures of knowledge interpreted after the pattern formed by experimental inquiry, cancel the isolation of knowledge from overt action.

Therefore, wilderness therapy may be more coherently explicated by an attention to the theoretical processes which produce its outcomes. Without accounting for these phenomenal procedures, it is not viable to imply that the relationship between program practices and outcomes is causal rather than incidental or coincidental. Wilderness therapy must facilitate something of significance—if the adolescent clients that programs like Anasazi and SUWS serve have been unsuccessful in traditional therapy, merely changing the name of their treatment would be unlikely to improve its efficacy significantly. Differentiating and legitimizing the field requires examination of the experiential processes which have allowed for its straddling of monist and dualist renderings of reality.

CHAPTER V

WHY AND HOW DOES WILDERNESS THERAPY WORK?

Understanding Wilderness Therapy

While historical consideration allows for a clearer account of the ambitious ideas, fortuitous accidents, and cross-discipline collaboration that had led to the establishment of the wilderness therapy field and assists in accounting for its simultaneous appeal to novelty and nostalgia, research struggles to establish coherent connections between theory and practice. It may also appear somewhat counterintuitive to propose an essentially premodern phenomenon—small group, primitive living in the wilderness—as treatment for the problems of adolescents in an increasingly postmodern society. From some perspectives, the model runs the risk of appearing an anachronism or an artifact of historical/cultural sentimentality. However, wilderness therapy’s focus on holistic, individualized treatment and concrete, contextual experience actually places it in an ideal position to appeal to postmodernity, which is less troubled by the wilderness therapy’s tenuous connection to empiricism. For this reason, a postmodern consideration of the field may yield more coherent explanations than rationalist attempts.

A fair amount has been written about the “what” of wilderness therapy: what goes into it, what comes out of it. The weakness in this research approach has been vague or nonexistent explication of the processes that are supposed to connect inputs and products, limiting the usefulness of outcome studies. Theoretical descriptions of the “why” and “how” of the of wilderness therapy phenomenology are needed in order to accurately

assess their efficacy. Examining the characteristics and practices of wilderness therapy from the perspectives of complimentary, contemporary theories of psychotherapeutic change may help to explain the processes that impact program outcomes and identify the aspects of wilderness therapy that currently facilitate or hinder therapeutic change.

Brief History of Psychotherapeutic Paradigms in the U. S.

While the advent of modern psychoanalysis was dominated by the work of Austrian neurologist Sigmund Freud in late nineteenth century Europe, Freud's theories and practices did not arrive in the U. S. until the early 1900s (along with Freud himself, who lectured at Clark University in 1909). Prior to bioscientific discoveries in the late 1800s, medical practice in the U. S. was fundamentally conceived as psychosomatic because physicians were unable to differentiate which aspects of the body and the mind contributed to illnesses (Caplan, 1998).

When new neurological and microbiological agents were discovered at the turn of the century, this had the effect of "jettisoning the mind from medicine" (Caplan, 1998, p. 7)." At that point, mental symptoms were assumed to have a not-yet-understood biological basis and treated with somatic cures. Physicians fiercely defended this model to differentiate themselves from spiritual healers and other "unscientific" practitioners who proposed alternate ways of understanding and treating mental illness. During the 1920s, due to psychoanalysis's psychological approach to mental problems, the work was limited to physicians trained in medical psychiatry (Caplan, 1998). In order to allow for standardization of data collection and communication among clinicians, mental illnesses were classified empirically according to the medical model and formally described in the

Diagnostic and Statistical Manual of Mental Disorders, first published by The American Psychiatric Association in 1952 (American Psychiatric Association, n.d.).

According to empirical orientation, the world was understood to consist of objective, outer reality and subjective, internal human experiences. Scientific, rational inquiry was championed as the most valid method for exposing and describing the nature of human experience. Prior to the 1960s, structural and drive theories were the primary modes for understanding psychoanalytic work (Coady & Lehmann, 2007). Mental health was understood and treated in terms of internal and intrapsychic motivations and desires. The American Psychoanalytic Association did not open membership to qualified non-physicians until 1964 (Lane & Meisels, 1994).

Amid the civil rights movement and other sociocultural transitions gaining visibility in the 1960s, humanist and feminist theorists began to question rationality's claim of objectivity and draw attention to the way that the modern era's assumptions had served to deny and silence the perspectives and experiences of groups and individuals outside of dominant culture (Coady & Lehmann, 2007). Systemic and ecological theorists expanded mental health practitioners' conceptualization of psychotherapeutic work to include consideration of social, political, and economic conditions, structures, and forces existing beyond the minds of individual clients (Ajaya, 1983).

Critical inquiry of modern empiricism continued through the late twentieth century. Postmodern theorists argued that reality should be understood as pluralistic, subjective, and contextual. Poststructuralists noted the dynamic relationship between concepts and their linguistic signifiers, also disputing the possibility of discovering a fixed reality or absolute truth. Subsequently, postmodern and poststructural inquiries

have influenced the way that many subdisciplines in psychotherapy understand the problems of clients and the role of practitioners in addressing those problems (Loewenthal & Snell, 2003). Some of these philosophical shifts, such as reduced emphasis on individual, psychological pathology and clinicians' presupposed authority to prescribe treatment, have required alteration of therapeutic modalities and practice. Two postmodern psychosocial perspectives, relational-cultural theory and narrative therapy, will be further considered with application to wilderness therapy.

Why Wilderness Therapy Works:

Relational-Cultural Theory

Introduction to Relational-Cultural Theory

Relational theory is a broad field of discourse with main ideas which include an emphasis on relationships, intersubjectivity, and social constructivism. Coady and Lehmann (2007) find the origins of relational theory in object relations, interpersonal theory, self psychology, and feminist psychotherapy. In the 1980s and 1990s, these ideas became more formally organized as relational theory and further influenced by constructivism, hermeneutics, and gender studies (Coady & Lehmann, 2007).

Relational-cultural theory began with the work of psychoanalyst Jean Baker Miller. In 1976, Miller proposed a reframe of the relational attributes of women traditionally viewed as weaknesses in *Toward a New Psychology of Women*. In the following years, Miller began meeting collaboratively with psychologists Alexandra Kaplan, Judith Jordan, Irene Stiver, and Janet Surrey to discuss feminist ideas and clinical practices. These discussions organically converged into the theoretical framework which became relational-cultural theory (Jordan & Hartling, 2002). Miller continued to develop

and expand relational-cultural theory with other practitioners and researchers when she became the first director of Wellesley College's Stone Center for Developmental Services and Studies in Massachusetts in 1981. The Stone Center currently continues to be a source of scholarship and training related to relational-cultural theory and practice.

Relational-cultural theory shifts the clinical focus from individuation and separation to relationship and connection. From this perspective, pathology is caused by chronic disconnection (Miller et al., 2004). The relational therapist works intentionally toward helping the client to move back into growth-fostering relationships. An open and genuine communication style is essential to this process:

Mutual empathy, an essential component of authenticity, is the core relational dynamic that leads to growth in therapy. It depends on the client seeing that she/he *has an impact* on the therapist. In order for the person to know that she/he matters, that she/he influences or moves us, she/he needs to see and feel the therapist's response. This clearly goes against rules about neutrality, nondisclosure, or non-responsiveness held by many traditional therapists. (Miller et al., 2004, p. 67, italics in text)

In this model, a neutral, nonresponsive therapist is not only unhelpful, but potentially damaging. A clinician's role is to be emotionally available, respectful, responsive, open to being moved, and empathetic, helping clients to experience new relational possibilities. Boundaries are described as "a place of meeting rather than an armored dividing line, protecting against an impinging outside world" (Miller et. al, 2004, p.70).

Drawing from feminist theory, relational theory also recognizes inequities of power and views them as political rather than natural (Robb, 2006). Relational-cultural theory does not insist that the capacity for empathy and relationship work is gender-dependent or biologically determined, but insists that gender roles are generally characteristic of the ways women and men are encouraged to behave in contemporary,

dominant white culture (Miller & Stiver, 1997). Although relational-cultural theory was developed to better explain women's experiences, it has been more recently conceived to describe all human experience, including men's (Fedele, 2004; Jordan & Hartling, 2002). Relational theorists note that cultural expectations about relationship preservation are usually gendered: boys create inauthenticity to avoid connections and girls become inauthentic to preserve connections (Robb, 2006).

Miller believes that growth-promoting relationships produce "five good things": "increased zest (vitality), increased ability to take action (empowerment), increased clarity (a clearer picture of one's self, the other, and the relationship), increased sense of worth, and a desire for relationships beyond that particular relationship" (Jordan & Hartling, 2002, p. 48). These "good things" very closely resemble Russell's (2001) claims of the positive outcomes for wilderness therapy, which include a "sense of accomplishment...combined with physical health and well-being," "empowerment," "enhanced sense of self," "increased self esteem," and "interpersonal skills" (p. 72). Considering the relational characteristics of clients and staff within the program culture and natural environment of the wilderness therapy model from the perspective of relational-cultural theory may help to explain the dynamics which produce these outcomes.

Small Group Living: Responsive Relational Space

The enduring consistency of the small group interaction in wilderness therapy allows for a level of sustained relational contact matched only by some other forms of long-term residential treatment. Wilderness therapy occurs in a small group context, typically in a configuration of 6-12 clients and 2-4 staff. Some programs utilize rolling

admission, so that groups are on-going and consist of clients in various stages of treatment, while others conduct treatment with a consistent client group for a predetermined duration. The specific training level of staff varies among programs: some have therapists remain with the group at all times, others have groups lead by field staff with regular visits from clinicians. Regardless of specific configuration, the intensive milieu, consistent peer culture and continuous staff contact in wilderness therapy increase the level to which clients genuinely impact others and, collectively, the group. Time and proximity allow clients both inevitable experiences of disconnection as well as the opportunity to negotiate reconnection within a variety of relationships. This facilitates many of Miller's "good things," most saliently relational clarity.

Clients' behavior affects others on a practical level not often present in traditional therapeutic contexts: if one client refuses to get up in the morning or proceed down the trail, other are not protected from the consequences of those choices—the entire group's functioning is affected until the situation is resolved. In wilderness therapy, conflict is a natural and anticipated event arising from individuals working to negotiate and achieve individual and group goals. Experiencing and resolving these difficult relational interactions is essential to client growth. Robb (2006) articulated the important role of conflict in relationships in relational-cultural theory:

The greatest risk of all to good relationships is the idea that they should be without conflict—that peace is a soporific, changeless hum of contentment and concord instead of a creative, agile, often infuriating, heartbreaking, and dumbfounding struggle to keep up with difference and change, to stay connected with actual growing people and not substitute an ideal or some other static idea about them. (p. 190)

There are rarely external punishments or reinforcements for clients' disruptive or accommodating behaviors—external consequences absent, positive relationships ultimately develop their own intrinsic value. Functional or cooperative behaviors of group members translate directly into smooth routines or obstacles overcome. A wilderness group that is not identifying and confronting relational conflicts is considered ineffective—either group members are actively avoiding the difficulty of interpersonal work or the group's leaders have allowed the format to become too undemanding, allowing clients to remain complacently disconnected.

In facilitating group process, relational-cultural theory distinguishes between relational responsiveness and reactivity. Reactivity is an impulsive response enacted solely on one individual's internal experience. In contrast, relational responsiveness involves “a consideration of context and concern about the possible impact of our actions or words on the other person and the relationship” (Miller et al., 2004, p. 68). Many adolescents referred to wilderness therapy struggle with reactive and impulsive behavior. While studying the effects of wilderness therapy on personality characteristics of adolescents, Clark, Marmol, Cooley, & Gathercoal (2004) expressed the importance of intervening in these types of interactional problems:

The authors believe that the maladaptive behaviors of these teens are often driven by difficulties with affect regulation and impulse control, and dysfunctional ways of perceiving, and relating to self and others. These problematic patterns of thinking, feeling, relating, and behaving may or may not develop into personality disorders, but clinically it makes sense to treat them during adolescence while the individual's characterological structure is still somewhat malleable. (p.230)

Since regulation, control, and relating are all negotiated within the social arena, they influence the creation and disruption of relational connections. As noted by the

researchers, persisting problematic relational patterns in adolescent clients may risk developing into entrenched behavior styles which can manifest as personality disorders and other clinical concerns in adulthood in addition to a wide range of other life problems if persistent and unaddressed.

The small group format in wilderness therapy allows relational processes and their products to be rendered visible to clients. Clark, Marmol, Cooley, & Gathercoal (2004) found that wilderness therapy was more successful than traditional treatment approaches in creating characterological change. The authors attributed this efficacy to clients' dependency on the leadership of "quasiparental" treatment providers within "small social groups" (p. 230). Since personality disorders are perceived as especially challenging to treat clinically, this connection between relational experience in wilderness therapy and characterological change appears particularly relevant to treatment with adolescent.

As noted by Clark, Marmol, Cooley, and Gathercoal (2004), the intensity of the small social group experience can be connected to clients' relational experiences prior to entering treatment via transference and are thus closely related to presenting problems. Relational-cultural theory expects this type of enactment in group work: "Because of the group format, the presence of so many memories in a room, and the similarity of a group to a family, many of the transferences evident in a group involve siblings issues in the family of origin, as well as issues with authority or getting enough from the family" (Fedele, 2004, p. 208). As relational-cultural theory seeks to increase clients' capacity for new ways of interacting, wilderness therapy allows clients the opportunity to practice new styles of relating and develop a greater insight into the positions of others through

intensive and sustained work with a contained group of clients and staff. One wilderness program graduate stated, “Everybody knew that I had more to offer and could do a lot better. All I was doing was setting myself up to fail. The best part of this whole experience is that I have a brand new start at everything” (Catherine Freer Wilderness Therapy Programs, n.d., para. 7). This client’s sense of clarity, self-worth, and empowerment have all been impacted by the group process in a way that is representative of many others’ experiences.

Wilderness Therapy Staff: Authority, Transference, and Empathy

When author Gary Ferguson (1999) asked a therapist for Utah wilderness program Aspen Achievement Academy to explain her understanding of why wilderness therapy works, she replied, “It’s about nature, and it’s about group dynamics—living together twenty-four hours a day. But if I had to narrow it down, pick one thing that’s really magic, it’s the relationship that happens between the students and the instructors” (p. 66). Relational theorists would agree that creating positive relational possibilities between at-risk adolescents and supportive adults is essential to therapeutic change. It is often these relationships that provide clients with the capacity and desire to expand and pursue more relationships.

Staff positions in wilderness therapy program are uniquely challenging—physically, mentally, and emotionally. Field staff work continuously with clients in the wilderness from one week up to a month at a time. During work periods, staff live and interact constantly with clients, experiencing the same conditions and demands. Staff usually do not utilize any special gear, food, or other privileges not available to clients. While working, staff contact with life outside the program is generally limited to brief

contact with support personnel. This willingness of wilderness therapy staff to fully immerse themselves in the therapeutic group process is generally recognized by clients and helps to alter the power dynamics which have often created relational disconnections with authority figures in their lives outside the program.

Relational-cultural theory is concerned with power and the way that control is used to disrupt and prevent relational connection. Miller & Stiver (1997) state, “We propose that psychological troubles follow from those situations in which one person or group has more power than another and can thereby create and enforce disconnections and violations” (p. 50). They also note that families are often highly influenced by the patriarchal model of power which provides a problematic context for the relational experiences of children. While wilderness therapy groups are often metaphorically described as families to explain the consequences of relational behavior, staff do not position themselves as traditional authoritarian figures, but as guides or mentors with specialized training in wilderness survival and relational work. Thus, clients come to respect staff authority for the value of the information and insight they possess rather than their ability to use patriarchal power to control clients’ behavior. This does not mean that staff do not have limits and expectations for client behavior. However, these expectations are framed in terms of safety—it is staffs’ responsibility to ensure the safety of the program participants and environment. It’s up to the clients to make the decisions that impact their level of success in the program.

This non-authoritarian relational dynamic between staff and clients provides an unusual opportunity to work with issues of transference. Freud believed a therapist needed to present as objective and neutral so that the client could transfer past

relationships upon the therapist for interpretation. Relational-cultural theory does not maintain that neutrality or interpretation are key parts of therapy. If the goal of therapy is to facilitate connections, neutrality creates distance and is counter-productive. This perspective fits well with the practice of wilderness therapy staff, particularly given that it is extremely difficult to affect a “neutral” stance while living with clients 24 hours a day for extended periods of time. Relational-cultural theory understands transference as an inescapable aspect of all relationships that occurs as people utilize past experiences to interpret current interactions. Instead of interpreting transference, relational therapists explain that they “try to create a new experience of relationship that will differentiate us from the harmful relational images our patients carry with them from the past” (Miller & Stiver, 1997, p. 141). Miller & Stiver theorize that people create “relational images” from experience which become “the framework by which we determine who we are, what we can do, and how worthwhile we are” (p. 75). Errors in these images and related meaning constructions are a source of problematic thoughts, feelings, and actions. Relational therapists seek to use a therapeutic relationship to create new relational images and shift client’s relational frameworks. In wilderness therapy, authentic relationships with staff help to enact this process.

Moving away from the power-over model of authority allows wilderness therapy staff to come into greater relational connection with clients. Relational-cultural theory describes empathy as the process that makes this relational connection possible. Miller et al. (2004) note that empathy does not connote simple or superficial niceness but involves the complex work of “trying to be in the truth of another person’s experience in all its many facets” (p. 182). This is the main interaction style of wilderness program staff: “In

wilderness therapy,” writes Russell (2001), “the primary care staff approach the therapeutic relationship in a nurturing, caring, and empathetic way” (p. 73). Since many client problems have been influenced by difficult relationships, this empathetic approach is recognized by clients. In a qualitative study of the factors facilitating change in adolescents in a wilderness therapy program, Russell (2000) referenced Roger’s core conditions of genuineness, unconditional positive regard, empathy, and concreteness in comparing statements about the importance of their relationships with therapeutic and field staff:

It is interesting to note the similarity in comments made by case studies with these four core conditions of change. All four clients similarly referenced the relationship that each had established with the therapist and staff while in the field, and how that relationship helped them speak openly of their issues. The relationship was established, they said, through a caring and non-confrontive approach by program staff. (p. 75)

Davis-Berman & Berman (2002) described similar findings, stating:

Properly developed and utilized, [the therapeutic relationship] can be a powerful, if not the most powerful therapeutic tool facilitating growth and change. This relationship takes time, effort, respect, and an attempt to develop empathy with participants. Empathy, or the ability to see the world through the perspective of the other, is critical to assessing emotional risk, and to designing programs that minimize perceived risk and cater the therapeutic program to the needs and capabilities of the participants. (p. 309)

While other high-level adolescent interventions such as residential, inpatient, and juvenile detention ramp up external control in order to provide containment and consequences for behavior seen as out-of-control or destructive, the empathetic approach of wilderness therapy staff, along with small group culture, help to shift the power dynamic and greatly increase possibilities for relational work. Wilderness therapy staff are in an ideal position

to assist with the restructuring of client's relational images by interacting with clients in an authentic and compassionate manner.

Wilderness Setting and Culture: A Place Where Things Matter

Ferguson (1999) asked a wilderness program participant if living in the wilderness was "kind of hiding out from your problems" (p. 243). The client disagreed, explaining, "Say you go into a psych ward... It's no big deal if you do anything or not. If you want to lay around, you lay around. If you want to watch television, you watch television. It doesn't matter. That wasn't true in the wilderness. Out there what you did mattered a lot" (p. 243). Relational-cultural theory understands the interpersonal transaction of individual experiences within group process as producing this feeling of mattering: "Connection is the experience while validation is the process" (Fedele, 2004, p. 199). The environmental context and sociocultural structure of wilderness therapy help to facilitate this process.

Wilderness setting is one of the most salient features differentiating wilderness therapy from other modalities, yet its influence is rarely considered in the literature, just as problems located within individuals and society are prioritized in mainstream psychotherapy scholarship with some disconnection from environmental considerations. While relational-cultural theory does not explicitly address the physical setting of therapeutic treatment, it does emphasize the importance of considering the cultural and societal contexts and associated meanings of all aspects of relational interaction (Fedele, 2004). Therefore, the meaning of the wilderness environment for clients, and the nature of the program culture constructed within this environment, are interactional components of relational relevance.

Beringer (2004) notes that adventure programming developed out of the social sciences rather than environmental science. Thus, wilderness therapy practitioners are trained in psychology or social work rather than disciplines which more carefully consider non-human life and the relationship between people and the natural environment. Beringer makes a case for further expanding contextualization to include people's relationship to their environment:

Whether or not it is cognitive, behavioral, experimental, or clinical psychology, environmental aspects have been regarded as complicating rather than illuminating human phenomena and the study of human beings. Rather than potentially improving understanding and prediction of human behavior and its underlying thought, feeling, and spiritual processes, analyzing situational and contextual elements to human activity have been seen to confound or "pollute" psychological investigations. In the individualistic paradigm championed by mainstream psychology, it is difficult to see that individual pathologies and social problems might not only be rooted in individual histories, but also in social relationships and concern over the state of the world. Just as psychotherapy has moved toward healing adolescent behaviors in a family context, so might it move next to contextualizing individual issues in larger social and environmental concerns. Outdoor adventure therapy, in particular, might be well placed to set directions, practicing as it does, in the larger ecological context, the outdoors. (p. 65, quotations in text)

Beringer's suggestion to expand research perspective to consider ecosystemic context as well as individual and social concerns is supported by relational-cultural theory's emphasis of contextualization of individuals in as movement away from individual pathology.

The social and physical environment of wilderness therapy are joined to enhance clients' experience of mattering and process of validation through the use or allowance of natural consequences for clients' actions and inactions. The combination of an extended small group experience led by empathetic, nondirective staff in a wilderness setting allows the use of natural consequences to alter the traditional power dynamics of

relationships while preventing clients from displacing responsibility (Long, 2001). The reality of living in a wilderness setting allows staff to step back from authoritarian positions: “The therapeutic approach in wilderness therapy does not appear to force change, but instead allows the environment to influence client response through natural consequences” (Russell, 2001, p. 78). Wilderness program Catherine Freer’s (n.d.) promotional literature describes the wilderness setting as enabling program culture as a key component of change:

Living in the wilderness helps your child slow down and provides them with solitude and time to reflect on the issues and behaviors that have led to their enrollment in a wilderness program and time to process the important therapeutic feedback they are receiving from staff. Wilderness living naturally presents challenges. Consequences are not distributed by an authority figure of questionable motives and fairness, but by nature in her simple, direct way. Your child is encouraged to face these obstacles and to push beyond his or her own self-imposed limits. (para. 2)

Because many adolescents referred to wilderness therapy have experienced conflict-laden relationships and exhibit related behaviors viewed as acting-out, conduct-disordered, or oppositional and defiant in other environments, altering program power dynamics is a key aspect of program culture necessary to facilitating changes in relational interaction. This allows clients to become empowered in experiential, relational terms which offer significant meaning and validation.

Conclusion

The social and environmental structure and culture of wilderness therapy work to enact relational-cultural theory’s matrix of “good things” provided by growth-oriented relationships. These components are interrelated, as clients’ relationships to their peer group, staff, and environment each produce experiences of vitality, empowerment,

clarity, self-worth, and wishes to further expand relational connections. These experiences, allowed by program structure and space, create opportunities for growth which continue to expand, as described by one staff at a wilderness program recounting the memory of a particular teenage client impacted by the program:

After climbing Mount Washington, one of my students declared that hiking and going after [mountain] peaks would be a new alternative to his drug use. He also decided that climbing would be a positive activity that he wanted his family to enjoy with him. He was very sincere about this, and after he graduated his family took a weeklong camping and hiking trip to celebrate with him. It was actually a very moving thing. (M. Dickson, personal communication, June 6, 2009)

The possibility and process of moving and being moved are at the heart of relational-cultural work as facilitated by wilderness therapy.

How Wilderness Therapy Works:

Narrative Therapy

Introduction to Narrative Therapy

Narrative theory is another multidisciplinary supposition with wide areas of influence, including philosophy and cognitive science. Broadly, narrative theory understands narrative—human descriptions of sequential procedure—to be the temporal or causal phenomenon linking events and human experience. Narrative therapy developed in the 1980s, chiefly through the practices, publications, and collaboration of Australian social worker and family therapist Michael White and New Zealand anthropologist and family therapist David Epston. White's work was influenced by British anthropologist and linguist Gary Bateson's work with cybernetics, Jerome Bruner's literary theory, and French post-structuralist philosophers Jacques Derrida and

Michel Foucault (White & Epston, 1990). White also co-founded the narrative counseling and training center the Dulwich Centre in South Australia in 1983.

Narrative therapy draws from postmodern and constructivist theories in order to understand people within their sociocultural contexts, moving away from the conceptualization of the individual or family unit as the pathologized entity. Sexton, Weeks, & Robbins (2003) note that White and Epston's collaboration emerged during a period when Australia and New Zealand were confronting the oppression of their indigenous populations. Accordingly, narrative therapy recognizes therapeutic actions as inherently political gestures directed by social forces. The use of narrative therapy in practice increased in popularity in the U. S. following the publication of *Narrative Means to Therapeutic Ends* by White and Epston in 1990.

Narrative therapy describes narrative as people's theories of existence. These theories dictate the ways in which people assign meaning to their experiences:

The idea that it is the meaning which persons attribute to their experience that is constitutive of those persons' lives has encouraged social scientists to explore the nature of the frames that facilitate the interpretation of experience. Many of these social scientists have proposed that it is the narrative or story that provides the primary frame for this interpretation, for the activity of meaning-making; that it is through the narratives or the stories that persons have about their own lives and the lives of others that they make sense of their experience. Not only do these stories determine the meaning that persons give experience, it is argued, but these stories also largely determine which aspects of experience persons select out for expression. And, as well, inasmuch as action is prefigured on meaning-making, these stories determine real effects in terms of the shaping of person' lives. (Epston & White, 1992, p. 123)

According to narrative therapy, meaning and interpretation are inseparable from experience itself: "All expressions of life are units of meaning and expression, and it is

these expressions of life that significantly constitute our lives—it is these expressions that actually make our lives up” (White, 2004, p. 48).

Narrative therapy uses narrative’s impact on people’s lives to re-author stories that are identified as oppressive or limited. This is done by deconstructing clients’ narratives about themselves and their experiences and externalizing the problems, allowing a reduced sense of entrenchment. Epigrammatically, narrative therapy states, “The person isn’t the problem; the problem is the problem” (Epston, 1989, p. 26).

Narrative therapists minimize their own authority in order to make the client the “expert” on their experiences. Narrative therapy also often makes use of small group work or audience reflection in order to facilitate additional perspective and “thick” or “rich” descriptions of clients’ experiences. It also utilizes writing and text to document the narrative process, often through journaling and writing letters.

Narrative therapy recognizes the transformative role of relational experience in the process of narrative creation and recreation. White (2004) references the experience of the “katharsis” of Greek tragedy, referring to an emotional experience which produces new perspectives, ideas, meanings, and understandings rather Freud’s cathartic release of libidinal energy:

...It becomes possible for us to identify the places that our therapeutic conversations have taken us to that we could not have predicted. And it becomes possible for us to acknowledge that, on account of these powerful expressions of life, we have become other than who we would have otherwise been if we had not been present to witness these expressions. (p. 50)

According to narrative therapy, meaning is derived according to options offered by people’s social environments: “...acts of interpretation are determined by the interpretive resources that are available to them... Meanings are negotiated in communities of people

and within the various terms and institutions of culture” (White, 2000, p. 9). Narrative therapy rejects a psychological conceptualization of pathology and argues that people’s problems are created by problematic narratives which have been influenced by social and cultural contexts.

According to White & Epston (1990), narrative therapy’s positive outcomes include decreased interpersonal conflict, increased sense of self-efficacy, cooperation, “new possibilities” for action, a “lighter, more effective” approach to problem-solving, and options for “dialogue, rather than monologue” (p. 40-41). Again, these results are very similar to client changes championed by wilderness therapy programs. Wilderness therapy attempts to create a culture and community which offer the opportunity to utilize resources and engage in experiences which allow clients to reconsider and alter problematic self-narratives. The unique composition of wilderness programs allows the narrative therapy processes of problem reconceptualization, metaphorical interpretation, and rites of passage. These mental actions are connected to concrete programs experiences which are influenced and validated by wilderness therapy staff and the client group.

Wilderness Therapy Narratives: Externalizing Problems and Enabling Unique Outcomes

Adolescents referred to wilderness therapy have been labeled “at risk” or “delinquent” by the authority figures in their lives. They often have a long history of externalized problem behaviors and harbor related internalized mental health concerns. Clients usually process their initial referral to wilderness therapy as punitive and carry the conception, reinforced by their primary social environments, that they are “problem children,” “troublemakers,” or “bad kids.” These negative self-labels, combined with

failed experiences with previous intervention methods, create the assumption, on behalf of clients and others in their lives, that their problems are inherent and enduring ways of being and behaving. One of the challenges of wilderness therapy is to assist clients in realigning these internalized self-conceptions and associated behaviors so that they will be able to experience greater levels of positive success.

Narrative therapy challenges the assumption that human behaviors are outer manifestations of inner forces and disorders that “reside at the center of the self” (White, 2000, p. 16). White notes that the pervasiveness of self and structuralist perspectives, as well as the concept of childhood itself, are relatively recent, western cultural constructions. He questions the belief that there is an authenticity to be uncovered that is the bedrock of identity, the discovery of which is essential to people becoming who they really are. He describes the conduct of children as indicative of this fact:

This challenge to structuralist or essentialist accounts of life is apparent in children’s readiness and capacity to be other than who they are, in their habit of bringing together things that are not usually brought together to produce yet something else, in their comfort with multi-voiced identities, and in the significance they accord their connections with other children in matters of self-definition. (p. 19)

According to narrative therapy, identity is instead formed and reformed within the social domain, developed through socially negotiated claims about identity that are confirmed and verified by others, creating a sense an authentic self-identity (White, 2000).

This perspective allows the possibility that problematic identity claims can be renegotiated and altered within a therapeutic social context: “delinquent youth” can conceive of themselves as something else and experience that identity verified by others. Narrative therapy considers the experience of “personal failure” to be a reflection of a

failed aspect of the modern power system which requires people's identity to conform to the system's norms (White, 2004). Failing could, in this way, be construed as "feats of opposition and acts of refusal" toward modern power (White, 2004, p. 175). Exploring this possibility does not lead to a more genuine or true understanding of self, but rather opens and explores other values, actions, and goals available for identity engagement. Wilderness therapy clients are asked to examine their existing understanding of their self-identity and consider whether it is helping them to support their values and pursue goals.

Narrative therapy acknowledges the experience of multiple authenticities across different social contexts. Within wilderness therapy, most adolescents' relationships prior to placement have been highly context-dependent and compartmentalized: while some interventions focus on systems communication and coordination, family, teachers, peers, and clinicians only interact with clients in one or two of the range of settings navigated. Wilderness therapy is unique insofar as all aspects of clients' daily living—domestic, educational, recreational, and therapeutic—occur within the same group of peers and adults. At the same time, this social and environmental milieu is fully new, with fewer preconceptions about clients' identity and expectations regarding performance. This "outside" environment and relational consistency allow for continuous feedback from the environment and social, whose perspectives are enhanced and clarified by their cross-contextual position.

The constant relational conciliation necessary for group functioning in wilderness therapy requires clients to explicate and examine their individual self-narratives in order to make meaning of their program experiences. As clients are able to recognize a greater correspondence between their actions and the subsequent reactions of others, their

problems are increasingly understood as contextualized instances of thinking, feeling, or acting in specific situations with specific people. From here, clients are able to organize these events into systemic patterns which are possible to be conceived of as narratives rather than essentialist descriptions of self. According to narrative therapy, externalizing problems in this manner frees clients to seek alternate ways of existing: “As persons become engaged in these externalizing conversations, their private stories cease to speak to them of their identity and of the truth of their relationships—these private stories are no longer transfixing of their lives” (Epston & White, 1992, p. 126).

While narrative therapy primarily engages clients through conversation, wilderness therapy also engages clients in actions which clarify the position of problems as outside the “self.” The experiential nature of wilderness therapy allows clients to augment dialogue about unique outcomes in their past with attention to present and future manifestations of these stories and possibilities. Unremitting, moment-to-moment opportunities exist to create events which draw attention to dysfunctional aspects of self-narrative or demonstrate concrete results of changes in meaning. While these experiences and conversations occur within the group, most programs also conduct concurrent and equally important work with clients’ families. Clients are often asked to communicate with their family through letters. In this manner, problems are identified and discussed in a structured fashion and plans for new courses of action are identified. In narrative language, wilderness therapy provides a responsive context in which to try out different self-characterizations and plotlines which lead to new places in narrative discourse. These experiences enhance clients’ sense of their efficacy and responsibility to thoughtfully participate in the process of change.

Wilderness Therapy Metaphors: Proposing New Perspectives and Possibilities

Metaphors are linguistic and conceptual devices that suggestion connections or parallels between two separate terms. Within wilderness therapy, a wide range of metaphors are employed to help deconstruct and clarify clients' past experiences, frame and process program experiences, and suggest new options for future outcomes both within and beyond the program. Conceptual metaphors require some familiarity with both terms utilized but are employed to clarify the understanding of one term via a greater comprehension of the other by transferring a more concrete understanding of one term toward the more abstract term. For example, metaphors incorporating representations of family are common in wilderness therapy (Russell, 2001). The skills and actions required to successfully complete a concrete physical task, or, alternately, the skills and actions required to successfully navigate group relationships, are identified and employed toward enhancing clients' understanding of their family functioning.

Narrative therapy is itself a metaphor—a construct which compares storytelling with the way that people organize and understand sequences of experience to make meaning. Narrative therapy's "interpretative method" is the study of meaning-making according to the stories of experiences "in order for persons to make sense of their lives—to provide them with a sense of coherence and continuity" (White, 1989, p. 6-7). In addition to the myriad of concrete and relational micro-metaphors employed in wilderness therapy, the program experience itself serves as a metaphorical experience intended to be transferred to clients' understanding of their lives beyond the program. Second Nature (n.d.), a multi-site wilderness program with facilities in Utah, Oregon, and Georgia, describes its understanding of this process:

Because wilderness is unrelenting and comprehensive, teens must proactively respond to this fresh, challenging environment. They must consciously make choices knowing that they are completely responsible for the outcomes. The wilderness provides an environment free of negative external stimuli and influences, yet offers a richness of inherent lessons found only in the natural setting. Second Nature provides a structured yet simple lifestyle with feedback and healthy relationships. Because of the abundance of real challenges in the wilderness and its clear metaphor, our program safely mirrors the family and social lifestyle with structure, boundaries, feedback, relationships and challenges. In these surroundings, a client is more capable of examining and changing their internal processes. (para. 2)

While Second Nature describes the wilderness therapy metaphor as “changing...internal processes,” narrative therapy questions the dualist differentiation between internal processes and external reality. Instead, it understands the characteristics of program environments and relationships as enabling an alternative narrative experience which allows critical examination of past stories.

Narrative therapy understands transference as a metaphorical, hypothetical construct to which the therapist has no privileged access. The hidden meanings and values of client stories reside within the clients’ experiences and are discovered through questioning and quests for thicker descriptions of events. The aspects of environmental, cultural, and social conditions which play into the creation of problems are also rendered visible and taken into consideration in the process of assigning meaning. Naming these forces does not reduce clients’ self-efficacy, however. They are still able to become “completely responsible for outcomes” due to an enhanced understanding of how problematic choices have previously dominated their experiences in unnecessary ways.

Many wilderness therapy clients have already had experiences with both behavioral and psychodynamic approaches to intervention and have found neither heavily external nor predominantly internal attention helpful in altering their understanding of

themselves or their experiences. Wilderness therapy employs both systematic external conditioning and internal reflection in developing metaphorical frameworks. Differences in the efficacy of facilitating change could be attributed to the power dynamics of wilderness therapy as well as the developmental appropriateness of teaching adolescents through concrete experience. Russell (2001) explains:

Self-care and personal responsibility are facilitated by natural consequences in wilderness, not by authority figures, which troubled adolescents are prone to resist. A goal is to help clients generalize metaphors of self-care and natural consequences to real life, often a difficult task for adolescents. Wilderness therapy takes place in very intense social units...with wilderness living conditions making cooperation and communication essential for safety and comfort. (p. 74)

The experiential element of wilderness therapy increases the likelihood that clients will be able to metaphorically apply insight from program experiences to more abstract understandings of how to successfully navigate the world.

Wilderness Therapy Experience: A Rite of Passage

A structural and procedural metaphor often used explicitly in wilderness therapy is the rite of passage, a symbolic, ritualistic transfer from one social status to another.

Aspen Achievement Academy (n.d.) describes its treatment in this manner:

The Academy creates a modern “rite of passage” designed to assist adolescents in making the transition to responsible young adulthood. It guides each participant through a series of powerful metaphors that symbolize stages of growth, provide deeper insight towards developing self-reliance, and generate a sense responsibility for self and community. (para. 2)

Clients in wilderness therapy have generally experienced one or more types of failure or limitation in role performance. The rite of passage metaphor essentially serves to prepare adolescents for more adeptly meeting societal norms regarding their behavior and success measures when they return to their home cultures and enter “adulthood.”

Narrative therapy also employs the rite of passage metaphor to describe the process of therapeutic change:

Our interpretation of this metaphor structures a therapy that encourages persons to negotiate the passage from novice to veteran, from client to consultant. Rather than instituting a dependency upon 'expert knowledges,' this therapy enables persons to arrive at a point where they can take recourse to certain alternative and special knowledges that they have resurrected and/or generated during the therapy. (Epston & White, 1992, p. 13, quotations in text)

Utilizing the work of anthropologist Arnold van Gennep, Epston and White explain a rite of passage as the progression through the stages of separation, transition, and reincorporation. They describe the separation phase as being followed by an experience of liminality which precedes and enables transformation: "It is in this liminal space that new possibilities emerge which can be explored" (p. 13). The rite of passage metaphor is essentially an alternate framing of the re-storying process. Perhaps due in part to cultural wilderness-as-transformative myths and familiarity with rite of passage narratives in film and literature, wilderness therapy as a self-transforming experience is a common description employed or embraced by adolescent clients. The characterization of the wilderness therapy context as a sort of *tabula rasa* provides a liminal space through which clients feel able to explore transformative narratives. Specific narrative practices, such as journaling and storytelling, are often used by wilderness programs to facilitate this process.

Both Aspen Achievement Academy and Epston and White speak of a rite of passage as moving clients toward managing greater amounts of power and responsibility. Wilderness therapy programs are characteristically structured to support these transitions,

often employing some sort of nature, journey, or transformation metaphor in their descriptions of this process. Russell (2001) describes the general flow of these phases:

The wilderness therapy process is typically guided by phases, stages, or levels which can be broadly grouped into the following phases: (a) a cleansing phase, which occurs early in the program, (b) a personal and social responsibility phase; a particular emphasis once the cleansing phase is well underway or complete, and (c) a transition and aftercare phase. (p. 71)

Aspen Achievement Academy's phases are called Mouse, Buffalo, Coyote, and Eagle. Second Nature's students move through Earth, Fire, Water, and Air. SUWS' stages are Orientation, Individual, Family, Venturer, Explorer, Navigator, Guide, and Search and Rescue. Regardless of the specific metaphor employed, each program's phase system seeks to move participants "from client to consultant" with the ultimate goal of reincorporating clients into their home environments within a different type of role and status than when they left for the program.

Conclusion

Wilderness therapy utilizes narrative therapy's understanding of the ways in which experience and meaning-making are connected. Wilderness therapy programs guide reflection and reconfiguration of existing narratives and provide additional experiences, in combination with therapeutic dialogue and reflection, which isolate and contextualize problems and expand clients' outcome possibilities and opportunities to employ new ways of understanding the past and acting in the future. These processes occur in a small group context which allows for the enrichment of individual narratives and reinforcement of identity transformation. Correspondence between clients and their families help to realign their understandings of existing family narratives and prepare new expectations for future interactions.

CHAPTER VI

WHERE IS WILDERNESS THERAPY HEADED?

Narrative Process in the Relational-Cultural Context

There are a number of points of intersection between the theoretical orientations of relational-cultural theory and narrative therapy. Both prioritize subjective experience and plurality while considering the influences of social construction, cultural context, and political power. Each deemphasizes individual pathology and minimizes the prescriptive authority of clinicians. The concepts of connection and disconnection are functionally analogous to thick and thin narratives, and each theory requires an aspect of the other to support its own claims: relational-cultural theory needs narrative to explain how relationships come to have meaning and narrative therapy needs relational connections to explain why narrative has meaning. Josselson, Lieblich, and McAdams (2007) offer an explanation for this point:

Relationships are central, from the very beginning of and throughout life, to the constitution and expression of the self. The enigmas of distinguishing self from other and understanding the ways in which the self creates the other and the other creates the self have challenged philosophers and social scientists. In general, psychology has attended more to the self and its development into separateness and autonomy than to the experience of relatedness to others. This has been, in part, because the agency and actions of the self are more visible and more accessible to language than is the interpenetrating flux of experience that is denoted linguistically as *relationship* between and among people. While we can witness the products of a person's doings in the world, we need narratives to access the relational meanings that may create, direct or sustain these activities (p. 3, italics in text).

While relational-cultural theory considers emotional and pre-linguistic experiences and narrative therapy appeals to processes of thought and language, both seek to increase connections and possibilities, largely in cooperation with each other.

One relational critique of narrative therapy is that the expert or rationalist stance that narrative therapists sometimes take in deciding which narratives are “good” or “bad” for clients reduces their agency (DeYoung, 2003). In return, narrative therapy questions the historical and social contexts of modern identity implied in the concepts of “relationship dynamics” and “psychological needs” (White, 2004, p. 133). Both of these challenges are fairly easily dismissed as mischaracterizations and/or unresolved arguments against both theories. Narrative therapists rely on deconstruction of client-driven descriptions to determine the value of narratives, and relational therapists recognize “selfhood” and related ideas as social constructions. At the same time, relational therapists also have some influence over clients’ understanding of what constitutes “growth-fostering” and “nonproductive” relationships, and narrative therapy is inherently unable to fully escape use of sociocultural assumptions.

While arriving from different philosophical angles, psychodynamic theory, relational-cultural theory, narrative therapy, and experiential learning theory are all fundamentally pointing to the same conceptual phenomenon with reference to transference: the application of experientially-derived knowledge to the understanding of subsequent experiences. Psychoanalysis focuses on bringing consciousness to the oft-unconscious and potentially distorting nature of meaning assigned to experience, relational-cultural theory draws attention to important differences in meaning between past and current experiences, narrative therapy emphasizes the social construction of

transferential assumption—there is no *a priori* guarantee that experientially-derived knowledge is helpful or relevant to future experience, and experiential learning argues the constructive aspect of experience. Despite differences in orientation, all of these perspectives advocate utilizing knowledge and experience in ways that expand the possibilities for inquiry, insight, and experience and lead to positive change.

While more has been written about the power of “novelty” or “the unknown” in the setting and activities of adventure education, it may be the novelty of relationships in wilderness therapy that most effectively allows clients to explore new self-narratives and ways of being. The level of characterological change effected by wilderness therapy is made possible by a series of concrete experiences and guided reflection upon those experiences. Pondering the difficulties of explaining why wilderness therapy works, Ferguson (1999) wrote:

A lot of the good that goes on in a program like this seems due less to the application of existing theory than to a mixed bag of tactics and intuitive strategies, hand-delivered by a slightly freaky bunch of mentors, in a place a thousand miles beyond the frenzy of the culture at large. (p. 91)

Small group work, empathetic relationships with non-authoritarian staff, a community culture made possible by the wilderness setting, external conceptualization of problems, metaphorical frameworks of reality, and rite of passage rituals all have individual therapeutic merit, but it is the holistic combination of these elements that constitutes the therapy of wilderness programs—a safe, consistent, and relatively impartial physical and relational space reduces clients’ need to maintain or resist particular ways of acting and relating. In this way, new experiences open up greater possibilities for relationships and self-narratives.

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Implications for Wilderness Therapy Practice

Target Populations and Differential Treatment

If wilderness therapy functions by offering clients opportunities for interrelated relational and narrative growth, it must be able to attend to both of these processes in order to be fully effective. This requires that the content and structure of programs support these types of development in ways which are accessible to clients. One area that relational-cultural theory and narrative therapy's prioritization of empathy and contextualization illuminate as important for program development is the consideration of target treatment populations and differential treatment of those populations. While wilderness therapy programs do conduct pre-assessment to determine the appropriateness of clients for their program, and some programs do offer specialized groups for particular treatment issues such as substance abuse, greater consideration of client treatment needs and clear demonstration of the ways that programs attempt to meet these needs is warranted.

This attention to differential treatment is one factor which can make the difference between a successful therapeutic experience and an ineffective or potentially harmful one. For example, a qualitative study by Russell (2000) assessing elements of wilderness therapy programs reports positive influences of the solo experience, an opportunity for individual client isolation intended to facilitate personal reflection, for clients with conduct and substance abuse issues. However, Russell simultaneously questions the therapeutic value of the solo for a depressed client. Russell also remains doubtful of the appropriateness of time-limited aspect of wilderness therapy for clients with very severe emotional or antisocial concerns. These recommendations make

practical sense from relational and narrative perspectives because the relational needs of a depressed, disconnected client will not be met by the further isolation of solo, while clients with very thin and problematic narrative histories may not find sufficient time and support within wilderness therapy groups to deconstruct and alter them.

While practitioners with relational-cultural and narrative therapy orientations both make concerted effort to address issues of difference in literature and in practice while noting the potentially limited applicability of their perspectives toward individuals from other social and cultural worldviews and experiential contexts (Fedele, 2004; White, 2004), it has been previously noted that wilderness therapy serves a fairly homogeneous demographic population. A second area in which a need for differential attention has been recognized but not yet translated into research evaluation is diversity in client identity. Harper and Cooley (2007) recognize the importance of considering gender in wilderness therapy in treatment, and Warren (2002) recommends that outdoor practitioners be trained in the areas of intention, self-awareness, intervention, and information regard issues of race, gender, and class. While sexual orientation or disability status may be key treatment issues for some adolescent clients, the wilderness therapy field has done little to consider how its model may address or neglect these kinds of identity-related topics. In general, there has been little research or training attention accounting for gender, race, or class factors specific to wilderness therapy.

Wilderness therapy must consider not only categorical variations in diagnosis and diversity but also individual client and group differences in order to create successfully therapeutic relational and narrative experiences for clients. That is, programs must not only cultivate awareness and accountability for difference at the treatment population

level, but wilderness therapy practitioners must also exercise this perspective within their individual and group work. Successful performance of therapeutic narrative work requires clinicians to exercise a level of relational empathy in order to understand individual clients well enough to assist them in transferring learning and meaning from one term to another. To this point, it is not coincidental that the term “metaphor” is derived from a Greek word meaning “transference.” In a discussion of the use of metaphors in experiential education, Gass (1995) notes that the efficacy of such exercises depends on clients’ ability to recognize parallel structures:

Presenting isomorphic frameworks also requires an ability on the part of the facilitator to match their introduction to the client’s reality. Knowledge of a client’s language and other symbols is important, but facilitator should not underestimate the importance of properly comprehending the client’s reality. Truly effective framing requires much more than merely placing labels or images from the client’s environment onto adventure experiences. (p. 8)

Gass discusses the need to account for individual differences by creating metaphorical frames that are “open” enough to allow clients to internalize their individual understandings (p. 8). In order for wilderness therapists to facilitate in this process with clients, wilderness therapy experiences must both successfully refer to past experiences and as well as connect to new experiences in order to propose new possibilities for interpretation. This also requires a type of transference learning such that clients must possess the capability to engage in order for wilderness therapy success to translate to behaviors and attitudes beyond program completion, and may mean that this time of treatment may not be as effective for clients with other learning styles.

Program Structure

In addition to the question differential treatment, wilderness therapy must also consider the ways that program structure supports or hinders client change and recidivism. One procedural and ethical question programs face is whether to accept clients for involuntary admission. Involuntary clients who are unable to be coerced into treatment by their parents are usually transported to programs using professional escort services who temporarily assume custody to relocate children to residential treatment programs. Although escorts are trained in nonphysical management techniques, they are authorized to use restraint procedures to transport noncompliant clients.

Russell, Gillis, and Lewis (2008) found 40% of program respondents stated that a large percentage of adolescent clients are voluntarily admitted. 30% of programs surveyed utilized private or legal escort services, with 20% of programs specifying that a “small” percentage of their clients were escorted. Thus, while a relatively small number of adolescents are involuntary admitted to wilderness therapy, the procedure is in clear violation of the empowerment and respect for client rights advocated by both relational-cultural theory and narrative therapy. Wilderness programs must consider the potential impact that escort practices have on treatment for adolescent clients.

Following consideration of transition into a wilderness therapy program, client transition out of the program is equally important. It is in the transition from program to aftercare environment that narrative therapy’s rite of passage metaphor encounters the most difficulty in implementation. Bell (2003) acknowledges the parallel between placing clients in a new environment lacking preconceptions or expectations within wilderness therapy and the loss of previous a role through a rite of passage but points out

serious limitations in the execution of the final stage of the rite of passage model, incorporation:

While the ROP [rite of passage] model has similarities to outdoor programs, the model is generally ineffective in most contemporary contexts because of three major challenges associated with the third stage: (a) outdoor educators tend to neglect the importance of the community in providing an elaborate incorporation ritual to support initiates after the transitional/liminal phase; (b) the people supporting a role-shift may not believe in a single, instant, powerful experience as the determinant for new responsibilities (for good reasons), but rather see growth as a slow process of accumulation; and (c) democratic post-industrial societies value role pluralism, where freedom from role definition is often valued more than defined role clarity. It is important for outdoor programs to understand these challenges prior to deciding if an ROP model is the best method for framing an experience, and certainly before investing effort into using a ROP model and expecting transformational change. (p. 41)

Bell further elaborates the challenges of securing role definition within contemporary American culture:

When a rite of passage occurs, its effectiveness is demonstrated by how well the initiate learns and takes on the intended role and responsibilities in the community. Within small, pre-industrial cultures, years of tradition and reinforcement can form a cultural consensus of role definition, but a cultural consensus is difficult to replicate in pluralistic communities valuing role-diversity and choice. A society promoting freedom from strict gender roles, as well as freedom from systematic racism, sexism, and homophobia is not a society that easily reverts to creating narrow and clearly recognized role definitions. In fact, contemporary North American society displays a history working to devalue rituals in an effort to provide freedom from role definition (Grimes, 2000). (p. 41)

In pointing out the culture value of overcoming oppressive forms of role performance, Bell makes a compelling argument for reconsidering the use of the rite of passage metaphor in wilderness therapy. Programs must consider whether it is possible to use the rite of passage model to promote reincorporation into position that resists repressive and limiting role definition.

This potential pitfall may be overcome by narrative therapy's conception of the rite of passage as moving clients into a position of personal authority, where self-determination remains an integral aspect of role definition. According to White (2000):

Narrative therapy, as I understand it, is not associated with some global proposal about how things should be. Rather, it is about local inquiry into what is happening, into how things are becoming other than what they were, or into the potential for things to become other than what they are. (p. 170-171)

White's localization of role definition and legitimization of multiple authenticities across settings and relationships may help to reduce Bell's concerns about the potential of rites of passage to reinforce narrow and oppressive role performances. However, the ability to advocate for self-definition of roles and navigate multiple authenticities requires a level of relational skill that programs must consciously work to develop in clients if they hope to administer a meaningful ritual experience.

Bell (2003) also notes that an excellent rite of passage ritual during a wilderness program may not translate into change due to lack of support and reinforcement for the role change following discharge. Wilderness therapy programs vary in their attention to aftercare services for discharged clients. Russell, Gillis, and Lewis (2008) reported that 51 of 65 programs reported that their programs developed individualized aftercare plans including behavioral and emotional components to support the client and family following transition from the program. An average of slightly more than half of clients returned home upon discharge from programs. It is very difficult for clients to transition from a program culture which has supported relational growth and validated new self-narratives back into a setting and social environment that expects clients to refer to and reenact their ways of being and behaving prior to the program experience.

Because clients need aftercare support in order to sustain the positive growth begun in treatment, the critical role of family work in wilderness therapy has been identified by researchers, but this point has yet to fully impact program practice (Harper & Cooley, 2007). When Russell, Gillis, and Lewis (2008) surveyed 66 wilderness programs regarding the amount of contact time they conducted with parents, 50% responded that they provided 15 hours or less of contact time per client. 30% of programs reported between 15 and 30 hours and 20% reported more than 30 hours. The primary forms of parent contact included individual parent sessions, family session, psychoeducation groups, support groups, seminars, and online support services as the primary types of family involvement offered by wilderness therapy programs. Because therapeutic changes enacted in wilderness therapy, as understood by relational-cultural theory and narrative therapy, occur within a social context, it is critical for clients' primary relationships outside of the program to recognize and support these shifts wherever possible if they are to be sustained. It is extremely important for programs to continue to consider and support the most effective ways of interfacing clients' program work with the transition into their succeeding social, educational, and therapeutic environments.

Conclusion

The wilderness therapy industry appears to be following a trend similar to that of the social work field in general in seeking greater external regulation, professional legitimization, and scientific recognition. While viability and accountability are crucial objectives toward ensuring that services are effective and efficient, it is important that wilderness therapy not lose the elements which have made it more effective for many

adolescent clients by preemptively assimilating with prevailing sociocultural theories and practices. This requires that wilderness therapy programs continue to improve their ability to understand, express, and assess the processes and practices which facilitate therapeutic change in clients.

Controversy and lack of a cohesive treatment model persist, yet the wilderness therapy industry continues to expand. The diversity in program origin, orientation, and practice which has impeded comprehensive research may, in many cases, be facilitating more effective and responsive treatment for individual clients. As increasingly multicultural and pluralistic communities develop across the U.S., wilderness therapy's simultaneous appeal to empiricism and spirituality places it in a prime position to address the therapeutic needs of clients by facilitating meaning-making and relationships. "Both empiricism and spirituality," notes Kellert (2007), "and, by extension, science and religion, thus, reflect a universal human tendency to seek meaningful connection with creation" (p. 27).

While much further research is warranted to demonstrate the ways and means by which wilderness therapy functions and facilitates positive changes, some of the most compelling reasons to view the work from relational-cultural and narrative perspectives come from program testimonials in which clients describe their experiences with these programs. A former Second Nature client attributes her therapeutic change to the support and clarity provided by a relational community:

At Second Nature I have had a life changing experience. I have learned more about myself and my interactions with others than I have in my entire life. Second Nature provided me with a safe and encouraging environment to grow and express myself. I am very thankful for having this opportunity and am thankful to

all the staff for helping me along the way. (Second Nature Wilderness Programs, n.d., para. 4)

A Catherine Freer client describes his wilderness therapy experience in self-narrative terms, naming the program as the liminal space which allowed new ways of acting and being:

At this point in time I have two episodes in my life. The troubled, scared, alcoholic, depressed and suicidal Thomas that only existed in life, and the happy, proud, active and smiling Thomas who is living his life and typing this letter right now. My turning point in between these two episodes was the Catherine Freer Wilderness Therapy expedition. (Catherine Freer Wilderness Therapy Programs, n.d., para. 10)

Both of these testimonials speak to the transformative power of phenomenological experience and wilderness therapy's ability to enact that process for some at risk adolescents. Early twentieth-century French writer René Daumal (2004) also expresses the narrative impact of experience in relational terms which resonate with the metaphors of wilderness therapy:

You cannot stay on the summit forever; you have to come down again. So why bother in the first place? Just this: What is above knows what is below, but what is below does not know what is above. One climbs, one sees. One descends, one sees no longer, but one has seen. There is an art of conducting oneself in the lower regions by the memory of what one saw higher up. When one can no longer see, one can at least still know. (p. 105)

Wilderness therapy suggests unique potential to create meaningful connections in clients' lives that endure long after treatment has ended.

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