Attachment Processes in Wilderness Therapy

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Attachment is an integral part of human nature. Attachment theory presumes we are biologically predisposed to connect to others. Founder of attachment theory, Bowlby (1988) noted that attachment behavior "is seen in virtually all human beings (though in varying patterns)" (p. 27). Attachment theory describes the various ways in which we relate to each other based on our perceptions of human relationships. These perceptions we hold result from experiences gained earlier in life (Bowlby 1980, 1988). In formulating attachment theory, John Bowlby called attention to its biological base, noting that attachment

> ... emphasizes the primary status and biological function of intimate emotional bonds between individuals, the making and maintaining of which are postulated to be controlled by a cybernetic system situated within the central nervous system utilizing working models of self and attachment figure in relationship with each other. (Bowlby 1988, p. 120)

Attachment patterns begin in childhood but manifest throughout our lives. The manifestations of attachment behavior occur in different ways. In children, four attachment styles exist: secure, anxious-resistant, avoidant, and disorganized. Secure attachment is promoted by the ready availability and responsiveness of the caregiver to the child's needs. This serves as a guarantee of the caregiver's protection and support, and contributes in building the child's confidence and boldness in facing the world and adverse situations. In anxious resistant attachment, the caregiver's response to the child is characterized by inconsistencies. The caregiver is not always available. There is thus a lack of surety regarding the caregiver's availability. This breeds anxiety and makes the child fearful about exploring its environment. With anxious avoidant attachment the negative responses that often accompany the individual's care seeking behavior stirs up a desire to be emotionally self sufficient. This often becomes the case after repeated negative responses (Bowlby 1988).

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J. E. Bettmann, D. D. Friedman (eds.), *Attachment-Based Clinical Work with Children and Adolescents,* Essential Clinical Social Work Series,
DOI 10.1007/978-1-4614-4848-8_10, © Springer Science+Business Media New York 2013

In adolescence, attachment patterns typically reflect the relational patterns developed with one's earliest caregivers. This is due, in part, to self-perpetuating patterns of relating to others, introduced in the initial primary caregiving relationship (Bowlby 1988). While Bowlby claimed that initial attachment representations and subsequent relational and behavioral interactions are not part of what he defined as the "inborn temperament" (Bowlby 1969, p 127), attachment representations and relational constructs become more rigid and defined as a person ages. Thus, the likelihood internal working models will change after early childhood decreases (Bowlby 1973). Resulting cognitive, emotional, social and developmental manifestations from initial attachment schemas also become more rigid and less susceptible to external influence (Benoit and Parker 1994; Sroufe 2005; Main et al. 1985).

Attachment theory speaks specifically to the impact of separations on children. Attachment theory proposes that separations from one's attachment figures have a profound impact on young children. John Bowlby and his colleagues James and Joyce Robertson demonstrated this vividly in the 1969 film "John, aged 17 months, for 9 days in a residential nursery" (Robertson and Robertson 1969). The film tracks the institutional stay of a young British boy in an orphanage while his mother was in the hospital delivering a baby. The video clearly shows John's enormous distress at the separation from his parents, his resulting protests, and eventually despair and withdrawal. While the film tracks a toddler responding to separation from attachment figures, older children and adults can respond similarly to separations. Kobak and Madsen (2008) note that separations at any age constitute a threat to the caregiver's availability. They assert,

> Older children and adults are likely to perceive threats to a caregiver's availability when lines of communication are disrupted by prolonged absence, emotional disengagement, or signals of rejection or abandonment. As a result, disrupted lines of communication produce feelings of anxiety, anger, and sadness similar to those that have been documented in young children's reactions to physical separations (Kobak and Madsen, p. 24).

Such dynamics are relevant to wilderness therapy settings, which consist of adolescents' prolonged absences from their caregivers, emotional disengagement due to their isolation in wilderness environment, and potential signals of abandonment by being sent away to treatment.

Changes in Attachment

Attachment patterns developed during childhood can be modified significantly based on later experiences and encounters a person has in life (Bartholomew and Horowitz 1991; Bettmann 2007; Qi-Wu et al. 2010). While the majority of populations will remain relatively stable in regards to attachment classification, a minority experience life events which may change attachment security. Waters et al. (2000) demonstrated this phenomenon in a longitudinal study investigating the relationship between negative life events and changes in attachment classifications. They assessed the attachment styles of 50 adults between the ages of 20 and 22 years old. A previous

attachment study assessed these adults at 12 and 18 months of age (Waters 1978). Waters et al. (2000) found that change from secure to insecure attachment classification occurred with loss of a parent, life-threatening illness of parent or child, parental divorce, parental psychiatric disorder, and physical or sexual abuse by a family member.

In another study, Iwaniec and Sneddon (2001) measured attachment in infants who experienced failure to thrive symptoms and measured the same participants at 20 years of age. They found that attachment classification changed from insecure to secure in participants who experienced positive changes in environmental circumstances: Six were removed from home environments and placed into stable foster care homes, one was adopted, and one child remained in the home environment, but the mother left the child's father and established a positive relationship with a new partner. Furthermore, in a review of findings from the Minnesota Longitudinal Study on risk and adaptation from birth through adulthood, Sroufe (2005) explored implications of negative and positive life events on attachment representations. He concluded that attachment representations may shift from secure to insecure and from insecure to secure, depending on life events. He asserted that attachment representations in infancy only probabilistically predict attachment representations in later life and that many layered complexities play a role in forming relational development.

Changes in Attachment Due to Clinical Intervention

Some research has explored shifts in attachment classification due to psychotherapeutic intervention (Fonagy et al. 1995; Korfmacher et al. 1997; Levy et al. 2006). Levy et al. (2006) evaluated changes in attachment representations among 90 people with bipolar disorder receiving 1 of 3 year-long group therapy interventions: transference focused psychotherapy (TFP), dialectical behavior therapy (DBT), and modified psychodynamic supportive therapy (SPT). Using the Adult Attachment Interview (George et al. 1996), results indicated a three-fold increase of participants classified as securely attached from pre to post in the TFP group (from 5 to 15 %). Researchers found no differences in attachment classification from pre to post in the DBT or SPT groups. Such findings indicate that attachment representations may indeed shift as a result of clinical intervention. Similar to attachment theory, TFP is rooted in psychodynamic theory. Both trace problems to internally held beliefs and cognitions and thus focus on positively altering negative or dysfunctional internal working models to enable clients improve conceptions of their relationships and interactions (Levy et al. 2006).

In a similar study using different measures, Travis et al. (2001) analyzed intake and discharge interviews in a clinical population with significant interpersonal problems. The authors rated interviews based on Bartholomew and Horowitz's (1991) rating system, using four attachment prototypes: secure, fearful, preoccupied, or dismissing. Participants in the study received a 25-session, time-limited dynamic psychotherapy group intervention. Of the 29 participants receiving treatment, none

were classified as secure at intake. However, at discharge, seven participants were classified as secure (24 %). Notably, prior to treatment, 11 participants were classified as preoccupied, 16 as fearful, and 2 as dismissive. At post-treatment, 10 were classified as preoccupied, 8 as fearful, and 4 as dismissive. Overall, 19 (66 %) participants changed attachment classification from pre- to post-intervention. While, the small sample size of this study limits the generalizability of its findings, its results suggest the attachment classification can shift as a result of psychotherapeutic intervention. Similar to attachment theoretical approaches, the dynamic psychotherapy used in this study focuses on clients' relational patterns which manifest in sessions with the therapist. The therapist's relationship with the client is considered a key factor in effecting change. In this model, the therapeutic relationship serves as positive model in helping rectify the client's maladaptive schemas of relationships (Travis et al. 2001).

While wilderness therapy programs do not explicitly aim to change adolescents' attachment classifications, some such programs work on the familial attachment relationships of their clients (Bettmann 2007). Using intensive family therapy interventions, wilderness therapy programs aim to improve adolescents' familial relationships. Such improvement seems likely to impact those attachment relationships. Using an in-depth case example, this chapter will explore how attachment processes emerge and are worked through in the context of wilderness therapy settings. First, however, we must explore what wilderness therapy is. What is this treatment type which thousands of adolescents attend each year (Russell and Hendee 2000)?

History of Wilderness Therapy

We will begin by exploring its origins. The precursors of wilderness therapy include "tent therapy," a term coined in reference to the use of tents for housing patients outdoors (Williams 2000, p. 48). This approach was used by some mental hospitals in the United States in the early 1900s. The effects were favorable, and its proponents attributed its beneficial effects to the outdoor setting as well as the group interactions that occurred there (Williams 2000). In 1929, Campbell Loughmiller founded the first outdoor camping program; this program utilized adventure therapy and was aimed at underprivileged children in Texas. Loughmiller focused on socialization of clients through the use of small group cooperation (Russell and Hendee 2000).

Another historical contributor to wilderness therapy was the Outward Bound program, a pioneering effort in outdoor/adventure programs which held education as an integral component (Bandoroff and Scherer 1994; Gillis et al. 2008). Founder of Outward Bound, Kurt Hahn understood the wilderness experience as a catalyst for self-discovery, growth, and development (Kimball and Bacon 1993; Bandoroff and Scherer 1994). Kurt Hahn, to whom most authors link the beginning of contemporary outdoor and adventure education programs, created the first Outward Bound program for Blue Funnel Shipping line, a Britain-based company, in 1942. The month-long program had as its primary goal the fostering of participants' independence and resilience, as well as creativity and ingenuity (Russell 2006). The program

was reestablished in the United States in 1962, and became incredibly popular over the decades that followed (Kimball and Bacon 1993).

The incorporation of wilderness survival skills in wilderness therapy can be traced back to the Department of Youth Leadership at Brigham Young University (BYU) in the 1960s. Desert survival classes developed by BYU instructors became quite popular with students. The creators noticed that students appeared to have improved levels of self-esteem, which led to the development of a program for struggling freshman students. Soon after, the curriculum was adapted for troubled adolescents, eventually leading to programs such as Aspen Achievement Academy and the Anasazi Foundation (Russell and Hendee 2000).

A national survey conducted in 2000 revealed that 116 wilderness therapy programs existed in the United States, of which 86 participated in the survey (Russell and Hendee 2000). The majority of the programs that participated in the survey identified as private pay programs for which parents pay out of pocket or utilize their own insurance (81 %), while programs for adjudicated youth constituted a smaller percentage (19 %). Approximately 9,100 clients attended the programs in 1999, with an average of a little over 100 clients in each program. The authors estimate that with the inclusion of non-participating programs, wilderness programs serve approximately 11,000 clients a year (Russell and Hendee 2000).

These days, wilderness therapy treatment is commonly used as treatment for a variety of individual and family issues. Adolescents ' presenting problems typically include oppositional defiant disorder, substance abuse, depression, anxiety, trauma, and varied behavioral and emotional disorders and issues (Russell and Hendee 2000). Wilderness therapy programs typically do not treat acute psychosis, sexual deviance, extreme suicidal behavior, severe forms of behavioral and conduct disorders, and certain medical complications (Clark et al. 2004; Somervell and Lambie 2009).

Definition of Wilderness Therapy

Wilderness therapy is a behavioral healthcare model and a distinctive approach to adolescent mental health treatment (Becker 2010; Russell 2003). Wilderness therapy falls under the general framework of wilderness experience programs, which are programs that are operated in outdoor locations with the goal of client improvement through therapy, recreation, leadership formation, and/or instruction (Friese et al 1998; Russell 2001; Russell and Hendee 2000). Wilderness therapy, however, has specific characteristics that set it apart from other wilderness experience programs (Russell 2001; Russell et al. 1999). First, wilderness therapy is generally conducted in isolated wilderness environments, separating the client from settings they are accustomed to (Bettmann and Jasperson 2008; Kimball and Bacon 1993; Powch 1994; Russell et al. 1999). Program sites do not have amenities like indoor plumbing or electricity, and clients do not have access to computers or cell phones (unless used for family therapy interventions). Programs typically last between 3 and 8 weeks, providing a lengthy experience of living in a wilderness environment. Length of treatment is determined either by program model or clients' progress on treatment goals.

Living in a wilderness environment allows participants to focus more completely on the experience at hand (Bettmann and Jasperson 2008). In wilderness therapy, clients learn and use primitive outdoor survival skills (Bettmann and Jasperson 2008; Kimball and Bacon 1993; Russell et al. 1999). For example, clients are often expected to make fire without matches or lighters, prepare meals over a campfire, prepare their own shelters using tarp and rope, etc. (Kimball and Bacon 1993). Many programs also include outdoor challenges, such as difficult hikes, rock climbing, river rafting, rappelling, etc. (Kimball and Bacon 1993; Crisp 1996). The length of wilderness therapy programs varies greatly (Kimball and Bacon 1993), but normally ranges from 3 to 8 weeks (Newes and Doherty 2007).

These programs are most often created for adolescent clients (Becker 2010; Williams 2000), although adult programming is also available (Bettmann and Jasperson 2008). Wilderness therapy programs are typically not used as the first-line treatment for adolescent mental health issues (Clark et al. 2004; Russell 2007). However, for adolescents who appear less receptive to traditional forms of therapy, wilderness therapy programs present one viable option (Clark et al. 2004; Russell and Phillips-Miller 2002). Russell and Phillips-Miller (2002) found that clients voiced various reasons for attendance at a wilderness therapy program, including: school difficulties, abuse of drugs and/or alcohol, lack of success in other treatment modalities, emotional issues, and the client feeling as though they "needed help" (p. 422).

Therapy in this unique setting is carefully structured and includes "a process of assessment, treatment planning, the strategic use of counseling techniques (including group dynamics which are often a component of outdoor education programs), and the documentation of change" (Berman and Davis Berman 2000, p. 1). Russell (2001) asserts that wilderness therapy programs employ licensed therapists who are trained in the program's specialties, can create and tailor treatment plans, and help to manage aftercare services for clients. Romi and Kohan (2004) make the assertion that wilderness programs are:

> . . . a complex of components that impact on the participant and create a synergism that is greater than the sum of all separate influences. People and nature combine so that each pre-structured program becomes a unique creation, influenced by the personalities of the individuals involved—participant or professional—and by the terrain and the vicissitudes of natural phenomena (p. 133).

In its particular therapeutic approach, wilderness therapy does not attempt to force change. Rather, through its skilled personnel, it uses interventions such as psycho-educational lessons, outdoor activities, and group psychotherapy in a bid to help change identified behavior (Russell 2001).

What about wilderness therapy is particularly helpful to clients? Russell and Hendee (2000) studied this, exploring the variables that clients found most helpful in this treatment type. First, the adolescent participants cited solo time, which is a scheduled time designated for clients to be alone to reflect upon their lives. Solos typically last 2 to 3 days, where clients set up their own campsites within hearing, but out of sight of staff. Adolescents are expected to take care of themselves in their

campsites: building their own shelters, cooking their own meals, and completing therapeutic assignments designed by the treatment team. The clients also described the importance of relationships with program staff and therapists. Specifically, clients cited "non-confrontive and caring" (Russell and Hendee 2000, p. 172) relationship styles as helpful in engaging them in working through personal issues. Although the adolescents noted the difficulty of living in wilderness environments, they also indicated that it was empowering to master skills like hiking, reflection, and observation of the natural beauty around them (Russell and Hendee 2000). Other researchers examining the positive effects of wilderness therapy cite similar critical factors, noting the centrality of the wilderness environment, positive group dynamics, challenging and engaging activities, and therapist–client relationships (Becker 2010; Russell and Phillips-Miller 2002; Somervell and Lambie 2009).

Families play a critical role in adolescents' wilderness treatment. The family is sometimes regarded as a contributing factor in the problems adolescents face and thus intervention with the family system is important (Bandoroff and Scherer 1994). Some programs integrate elements of family therapy with wilderness programs (Bandoroff and Scherer 1994), which is an element Russell (2001) cites as a core feature of wilderness therapy. Such interventions may include mailed written assignments for clients and their families, family therapy via phone calls, and weekly phone contact between the program therapist and clients' families (Bettmann and Jasperson 2008). Some programs incorporate family seminars that include family therapy, groups, learning and usage of primitive skills, and trekking at the end of the client's stay (Bandoroff and Scherer 1994). Including families in the wilderness therapy process also aids in prospects for aftercare, as families can incorporate the skills they learned in their homes, creating an environment that sustains improved family relationships (Bandoroff and Scherer 1994).

Theoretical Foundations of Wilderness Therapy

Russell (2001) posits that, although wilderness therapy programs stem from various theoretical perspectives, several prevalent themes exist. First, wilderness therapy seems to be a blend of the Outward Bound, cognitive behavioral, and family systems models. Clients are exposed to challenging wilderness environments and then process the experience through these therapeutic modalities. Natural consequences are another important theoretical concept. Staff members are encouraged to let adolescents learn lessons on their own through experiences with the environment. Thus, staff members are able to take a caring, compassionate, and calm approach with clients, as natural consequences take the place of punishments. For example, an adolescent who rushes to build his primitive backpack quickly may end up with his backpack falling apart later in the day, a natural consequence to his rushing the task. Similarly, an adolescent who builds a poorly constructed shelter may find that he gets wet one night when it rains. Staff permits such natural consequences to occur, while also stepping in to support students in building new skill sets when needed.

Finally, metaphors, rites of passage, and times for reflection are also incorporated into most programs, mimicking traditional cultural practices (Russell 2001).

Hill (2007) also notes a collection of concepts which form the philosophical foundations undergirding wilderness therapy. These concepts include "full value contract," which refers to a group's agreement to maintain positive regard for its members and their contributions (Schoel et al. 1988, p. 33). This mindset becomes evident in the interactions that take place within the wilderness therapy group. Notably, the contract happens in the form of encouragement, the setting of goals or targets, and the way in which confrontations take place. Wilderness therapy also incorporates concepts from diverse models of therapy such as Adlerian therapy, behavioral therapy and reality therapy. For instance modeling, behavioral reinforcement, behavioral rehearsal, and behavioral contracts are typical wilderness therapy interventions which derive from behavioral therapy. Wilderness therapy's strength-based and egalitarian interactions between counselors and clients have links with Adlerian therapy (Hill 2007).

Attachment Processes in Wilderness Therapy Settings

Wilderness therapy and adventure-based therapeutic programs offer participants opportunities to gain new perspectives (Kluge 2007) and develop positive relationships that help mitigate negative behavioral patterns (Black et al. 2010). As a mental health treatment modality (Russell 2001), wilderness therapy can address attachment-related issues (Bettmann et al. 2008). Yet the study of attachment processes within the context of wilderness therapy is a relatively unexplored terrain (Bettmann 2007; Bettmann et al. 2008; Bettmann and Jasperson 2008).

Notably, out-of-home treatments for adolescents present a distinct challenge for attachment-based clinical work. How can treatment enhance the attachment bonds between family members when the treatment is residential, by definition keeping the adolescent and his parent apart? Further, in wilderness therapy programs, adolescents are far from their familiar family and friends, evoking strong attachment needs and the need for new relationships within the treatment setting. The wilderness setting and its therapeutic community of strangers activates the attachment system. Bowlby noted that the attachment system is activated by "strangeness, fatigue, anything frightening and unavailability or unresponsiveness by attachment figure" (Bowlby 1980, p. 40). Wilderness therapy incorporates such elements (Berman and Davis-Berman 2000; Romi and Kohan 2004).

In wilderness therapy settings, adolescents enter an environment of strangers: typically joining a group of eight other same-sex peers and three staff in the wilderness. This will be the adolescent client's group for the next month or 2 and strong relationships will form between them. But at the start, the adolescent joins a group of strangers in the middle of nowhere. Thus, their attachment system is strongly activated by the strangeness of the wilderness setting and the unavailability of their usual attachment figures. For the next month or 2, adolescents will be able to write their

parents, but will have no contact with peers from home. They won't be able to make phone calls, send emails, or text attachment figures. Separated from all attachment figures in their home lives, adolescents' attachment systems are strongly activated at the beginning of treatment.

Such activation leads to a range of adolescent behaviors, from withdrawal to acting out. Adolescents sometimes withdraw, speaking little and refusing to participate in daily activities. Others act out, by yelling, name-calling, becoming physically aggressive, running away, or exhibiting other behaviors. While most programs attempt to manage these varied behaviors with purely behavioral responses, we suggest that programs understand such adolescent conduct as reactions to the activation of their attachment systems. Reconceptualized, adolescents are simply responding to the threat that they perceive in the strangeness of the wilderness environment.

In the context of such activation, program staff needs to work hard to engage new adolescent clients in empathic, nurturing relationships. For the month or 2 that adolescents are in the wilderness, they will need new attachment relationships. They will need relationships which fulfill attachment functions, such as secure base and safe haven (Cassidy 2008). Staff or peers in wilderness therapy settings can fulfill such roles, but likely only if they are primed to do so. In-the-field training provided by such programs should coach staff to do this. Regular staff training should focus on alerting staff on how to attend to the critically important therapeutic relationships which evolve between staff and adolescent clients. Programs should provide mentoring for staff in order to develop these skills, encourage staff to observe therapy sessions at times, and encourage frequent debriefing of cases with program therapists. All of these approaches are likely help staff to recognize their critical positions as attachment figures. Staff who conceptualize their roles as attachment figures are likely to provide the attuned, attentive emotional responses to adolescent acting out which adolescents need.

Bowlby noted that it takes "a familiar environment and the ready availability and responsiveness of an attachment figure . . . touching or clinging, or the actively reassuring behavior of the attachment figure" to deactivate the attachment system (p. 40). Staff and therapists in wilderness therapy programs can provide such availability and responsiveness if alerted to the primacy of their clients' attachment needs. The case study below illuminates such relational dynamics between a client and her therapist in a wilderness therapy program.

Case Study

Amy[1] was a 15-year old Caucasian female who presented to treatment at a wilderness therapy program where I [JB] was the therapist. Raised in an upper middle class home in a suburban East Coast city, Amy was the 3rd of 4 children raised by her parents, who were now married for 21 years. In many ways, she was similar to her peers in the program: acting out at home, substance abusing, oppositional at home and sometimes at school.

[1] A pseudonym

However, my initial session with her was significantly irregular. Most of my clients in the wilderness therapy program were angry to be there, having been sent to treatment by their parents for problems that the adolescents themselves didn't see as problems. In our initial sessions, I was used to their angry narratives, long-winded diatribes against the stupidity of parents and adults in general. However, my initial session with Amy was absent of any dialogue.

When I was introduced to Amy, she was on her third day in the program. The three staff in her group of eight girls informed me that she had not yet spoken to anyone in the program. This was striking. I had not yet encountered such a client. I thought, "well, I'm the therapist. She'll definitely talk to me." After the introductions by staff, I invited Amy to an individual psychotherapy session with me. We sat about 150 feet from the staff and girls group, and I began the session as I generally did with other students by asking Amy how things were going and other opening questions. She was silent. I explained to her my role and who I was as a field therapist. She was silent. I explained to her how eager I was to get to know her and hear what she had to say. She was still silent.

I experienced strong countertransference in her silence. At first, I felt rejected, hurt by her unwillingness to open up to me at all. I felt inadequate as a therapist, assuming that my techniques were poor, my interventions inappropriate. However, I began thinking about what would make Amy silent. Using an understanding of attachment theory, I hypothesized that Amy was deeply wounded by her relationships with primary caregivers. I assumed that such wounds, if they existed, made it difficult or impossible for her to trust other adults. I conceptualized Amy as avoidantly attached, one whose style was to avoid close relationships. I considered the strategies of avoidantly attached individuals: the emotional withdrawal, the unease with intimacy, the over-regulation of emotion.

Using this knowledge, I approached our relationship cautiously, but with warmth. As the therapist and thus the treatment team leader, I encouraged the staff to respond to Amy with availability, empathy, and emotional responsivity. In short, I encouraged them to act as available attachment figures so that Amy might begin to engage and eventually to trust. On her fifth morning in the program, the previously silent Amy asked staff to pass her a piece of her clothing as she was packing up. The staff responded warmly and excitedly, pleased to begin engaging with Amy.

The therapists' schedule at this program placed therapists in the wilderness with the group of nine clients and three staff for two consecutive days each week. When I returned to the group the following week, I found Amy significantly changed. While she was still angry, her anger was directed at her family. She spoke eagerly with me, wanting to share her displeasure with her parents and to strategize how to leave the wilderness program early. I empathized with Amy's situation—being sent to treatment she believed she didn't need—and encouraged her to share her feelings with her family in letters. She was resistant to writing her family, but did so: long, angry letters filled with epithets, blaming, and threats. The Amy I had experienced in session, the Amy who was eager to share, was nowhere evident in her letters. I was enormously encouraged by her willingness to engage in a therapeutic relationship, but perplexed by the vitriolic language in her communication with her family.

In subsequent weeks, Amy continued to engage eagerly in a relationship with me and with the staff. She formed friendships with some of the girls in her group and made progress in moving through the level system of the program. However, her letters to her family continued to blame them and to threaten. Unusually, her anger was not limited to her parents, but spread equally on her three siblings as well. Adolescents in wilderness therapy programs are often angry at parents at the beginning of treatment, but tend to become less angry as treatment progresses and they see positive changes in themselves. I was concerned about the continued high level of Amy's anger at her family which seemed unusually long-lasting.

As per the program's protocol, I spoke weekly with Amy's family, giving them updates on her progress and encouraging them to be warm and responsive to her concerns in their letters back to her. I encouraged them not to respond to her anger with their own, but to allow her reflect her upset, and they were able to do this. However, I was troubled by Amy's inability to work through conflict with parents. She seemed able to work through conflict with peers in the program, for example, giving "I feel" statements to her peers when coached by staff when her peers did not do the dishes as assigned.

The program lasted 7 weeks; at the end of it, all families came to the wilderness site for 2 days of family therapy. Unlike all of her peers graduating that week, Amy refused to hug her parents when she first saw them after 7 weeks away. They were hurt by this and turned to me, asking for answers. I continued to be baffled by Amy's fierce anger and rejection of them, but conceptualized her anger as hurt. I understood her to be suffering from deep wounds with her primary attachment figures, her parents. What I didn't understand was what hurt her. I encouraged her parents to remain open and warm with her; this was difficult for them to do. Her parents tended to talk to each other, rather than risk her anger and disdain.

After they had spent 24 h together doing family therapy activities and some unstructured time, I met Amy and her parents for our first and last hour-long family therapy session in person. She was due to graduate the next day and to go home with her family. I resolved to spend the session helping Amy to amplify some of her wounds with her attachment figures. In this session, Amy began with her anger and blaming, but through my gentle questioning, quickly devolved into tears. I had seen her cry in sessions previously, but her parents hadn't seen her cry in years and they were shocked. I encouraged them to respond to her with empathy and warmth, even if they didn't understand the source of her distress. With encouragement, Amy spoke about her feelings of rejection by her whole family. In one critical moment, Amy spoke about an incident in which her parents and siblings went out for ice cream, but didn't invite her. She spoke about how isolated and lonely this made her feel. Her mother responded with surprise, explaining, "we didn't think you'd want to go. You never acted like you wanted to be with us." Amy described that similar incidents happened numerous times, resulting in her feeling of isolation and loneliness.

It appeared that Amy's hurt in her most important attachment relationships resulted in her complete withdrawal, until even those closest to her perceived that she didn't want to be with them. Amy's avoidant attachment strategies served to protect her from some hurt, but isolated her to an extreme extent. Her anger towards her family

was apparently a cover for the hurt she felt. Amy's ability to explain her hurt feelings to her family was the beginning of a rebuilding relationship between them.

Amy left the wilderness program the next day, headed to a therapeutic boarding school for the next year. In this environment, she would receive therapeutic and academic support. Her family headed to their home some states away. Six months later, I received a letter from Amy describing her appreciation for being seen and heard clearly while in wilderness. She expressed pride in her progress and pleasure at her achievements. Her letter brought me into tears. In wilderness therapy, Amy experienced being heard and understood, her hurt feelings were identified and amplified. This experience helped her to reconnect with her family and begin to modify her expectations of relationships.

Conclusion

This article presented a reconceptualization of adolescent dynamics in wilderness therapy settings, exploring how acting-out adolescent behaviors can be best understood in the context of powerful attachment dynamics. Adolescents entering wilderness therapy programs or other out-of-home care settings encounter strangeness, separation, loss, and change. All these activate the attachment system, but in an environment where there are no familiar attachment figures. In the case of wilderness treatment, clients have little access to their primary attachment figures: only through letters can they connect. In such an environment, adolescents' behaviors should be reconceptualized as attachment-seeking behaviors, even when they look angry, rejecting, withdrawn or avoidant.

But can brief treatment—such as a 7-week wilderness therapy program—change our clients' attachment relationships? While brief treatment seems unlikely to change attachment classification, it may shift adolescents' expectations of what their attachment figures can provide.

In the case of Amy, it seemed likely that her experience of open, warm, empathic, and attuned staff in the wilderness therapy program had enabled her to believe that her relationships with others could be so. Program staff met her avoidant withdrawal, anger, and blaming with warmth and acceptance. It seemed that perhaps Amy's new relational experience with program staff and therapists enabled her unconsciously to hope for more in her primary attachment relationships. Such hope may have led to her sharing of her hurt with her family, a critical first step in rebuilding their attachment relationship.

Wilderness therapy programs are uniquely positioned to work with adolescents' attachment behaviors because the treatment environment itself is likely to activate the attachment system. In the context of such activation, programs need to understand adolescents' aggressive acting or withdrawn behaviors as deriving from unmet attachment needs. Programs should train their staff and therapists to recognize adolescents' attachment bids, hidden though they may be. This training may enable programs to make significant gains with their clients.

Social workers wishing to learn more about such programs can do so through the National Association of Therapeutic Schools and Programs (www. natsap.com) or the Association of Experiential Education (www.aee.org). Both of these trade groups gather together programs doing similar work. By attending conferences put on by these groups or learning about their member programs on their websites, social workers can begin to get familiar with the work of these programs.

As psychotherapy is primarily a relational enterprise (Norcross 2002), psychotherapy in the wilderness is even more so. Wilderness therapy programs need to provide their adolescent clients with stable, responsive, and attuned figures who can meet attachment needs while adolescents' primary attachment figures are unavailable. Wilderness programs that serve troubled or vulnerable youth generally serve both corrective and preventive functions. This happens with the diversion of attention away from dysfunctional behavior and the instructing of youth in healthier responses and choices (Berman and Davis-Berman 2000) by equipping them with skills in handling difficult situations (Romi and Kohan 2004). These activities happen in the context of psychotherapeutic relationships. Understanding acting-out adolescent clients as displaying attachment needs, and in need of figures who can meet those needs, allows wilderness therapy programs to perceive the drives underneath the behaviors. Such understanding will both deepen and improve the treatment.

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