Chapter 9
Walking off the Mountain: Planning Aftercare Support for Adolescents in Wilderness Therapy and Their Families

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Chapter Highlights

- Additional treatment is necessary after adolescents complete wilderness therapy programs.
- Though counterintuitive, a continued separation of parents and their adolescent children post-wilderness therapy often provides the most benefit for families.
- The post-wilderness aftercare plan is individually crafted with the support of the wilderness therapist and considers many factors.
- Home treatment providers can support families making aftercare decisions post-wilderness therapy.
- Even when longer term treatment is indicated post-discharge, wilderness therapy is often a necessary step to lay the foundation for therapeutic growth and healing within the family system.

There is a common expression among mountain climbers that most accidents occur on the descent. The American Alpine Club (1953) explains that phenomenon as, "Once the summit has been reached, the stimulus for attentiveness becomes less and there is likely to be a relaxation of concentration" (p. 1). That sentiment can be applied to adolescent clients nearing the end of their wilderness therapy journey. After two to three months of exploring one's identity, developing emotional resiliency, and healing fractured family relationships (Russell and Hendee 1999; Russell 2001, 2003), these adolescents frequently describe their pride and sense of accomplishment as though standing atop a mountain peak. They have clarity, wisdom, confidence, and vision. However, they have not yet internalized that vision into reliable action (Russell 2005, 2007). In starting the descent, it becomes more

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challenging to maintain that vision and confidence, and adolescent clients are at risk of relapse (Russell 2005, 2007), as are their families. An intentional and comprehensive aftercare plan is paramount for clients transitioning out of residential treatment programs and the need for this plan is well documented (Nickerson et al. 2007; Russell 2005).

This chapter describes the process of developing an appropriate aftercare plan for discharge from a wilderness therapy program by answering the following questions: (1) Why is additional treatment necessary after wilderness therapy? (2) How is the aftercare plan determined and what factors are considered? (3) How can treatment providers support families making aftercare decisions? And, (4) Why is wilderness therapy necessary if longer term treatment is indicated? Throughout this chapter, the term *parents* will be used for ease of reading. However, it is more appropriate to recognize the many people responsible for parenting children, such as grandparents, aunts and uncles, guardians, foster parents, same-sex partners, stepparents, etc.

Why More Treatment? Isn't Wilderness Therapy Enough?

One would not expect a person who experienced a heart attack to leave the Intensive Care Unit and head straight home, returning immediately to the former lifestyle. The American Heart Association (2015) describes the process of preparing patients to return to home life as including treatment, monitoring, rehabilitation, and lifestyle changes, which might include separation from unhealthy triggers (e.g., fatty foods or physical inactivity). Perhaps a parallel can be drawn to wilderness therapy clients post-discharge. Due to the challenging life circumstances or diagnostic complexity they experience prior to enrollment, many adolescents arrive in crisis and as a last resort after many treatment failures (Russell and Hendee 1999; Russell 2000). We cannot expect adolescents leaving a wilderness therapy program, which essentially operates as a therapeutic intensive care unit, to discharge without a solid plan that supports internalization of gains made in the wilderness environment, and changes to unhealthy lifestyles (Nickerson et al. 2007, 2014). Nickerson et al. (2007) indicate that problematic triggers at home are many and include unhealthy family dynamics, negative peerinfluences, accessibility of substances, and academic stressors, among others.

Strengths and Limitations of Wilderness Therapy

In order to understand why more treatment is needed beyond wilderness therapy, it is necessary to explore the basic strengths and limitations of that setting. For the purposes of this chapter, it is assumed that the reader has at least a cursory understanding of the field of wilderness therapy, sometimes also referred to as Outdoor Behavioral Healthcare (see Chap. 15). Wilderness therapy is designed to

be a powerful, intensive, and short-term intervention for adolescents who are struggling in the home environment, and for whom traditional outpatient or other inpatient therapeutic services have proven ineffective (Russell 2000; Russell and Hendee 1999; Bettmann and Jasperson 2009; Ferguson 2009). Typically, these adolescents struggle with issues related to depression, anxiety, disruptive behavior, family relational problems, substance misuse, and other clinical disorders (Behrens et al. 2010; Bettmann and Tucker 2011). Fundamental goals in wilderness therapy include client stabilization, thorough assessment, initial treatment and intervention, and long-term treatment planning (Russell et al. 2000).

Wilderness therapy is designed to be most effective in supporting adolescents working through earlier stages of change (Bettmann et al. 2012; Prochaska and DiClemente 1983). From Prochaska and DiClemente's (1983) writing, one can infer that wilderness therapy will be less effective in supporting growth in the later stages of change that are dependent upon time and proximity to triggering situations, such as unhealthy family dynamics, substances, or unsupportive peer environments. And while there is tremendous benefit to adolescents being separated from their parents during wilderness therapy (see Chap. 8; Bettmann and Tucker 2011; Harper and Russell 2008), families do not have the opportunity to practice new skills together daily.

Taylor (2004) highlights the ethical importance of treating clients within the least-restrictive environment. Perhaps counterintuitive, many parents who choose to send their adolescent child to a residential therapeutic program, at times thousands of miles from home, *are* providing the least-restrictive setting to support change and growth (Bettmann and Tucker 2011; Harper and Russell 2008; Russell 2005). Parents frequently report believing that removing their child from the unhealthy environment was the only way to gain the clarity necessary to create change (Harper and Russell 2008).

According to Prochaska and Velicer (1997), approximately 20% of people in at-risk populations at any given time are preparing to take action to create change. This leaves approximately 80% of these at-risk people needing specialized support to be ready for action. That translates to approximately 80% of at-risk adolescents needing support to accurately identify their problems and work through their ambivalence about change (Prochaska and Velicer 1997; Miller and Rollnick 2002). Miller and Rollnick (2002) highlight the use of motivational interviewing to work with this population. However, for many adolescents, traditional outpatient, and inpatient therapeutic settings have proven ineffective in working through those initial stages of change (Russell 2000; Harper and Russell 2008) and they need a unique approach.

Trans-Theoretical Model: Stages of Change

Prochaska and Velicer (1997) describe the trans-theoretical model (TTM) of health behavior change as consisting of six basic stages: *pre-contemplation*,

contemplation, *preparation*, *action*, *maintenance*, *and termination*. Chapter 14 of this volume discusses the stages of change as they relate to the adolescent and the parents in detail; therefore, only a cursory overview is provided here. It is important to note that rarely are the adolescent's issues unrelated to the family system. It is essential that parents engage in their own change process alongside their child in order to shift the family homeostasis and allow the adolescent to decrease symptoms (see Chap. 7; Jackson 1957; Brinkmeyer et al. 2004; Harper and Russell 2008). Accordingly, the next several paragraphs offer interventions specific to each stage of change for both adolescents and parents in wilderness therapy.

For many adolescents in the pre-contemplation stage of change, though not all, just being sent to a wilderness therapy program enables them to recognize that a problem exists. Reading impact letters (see Chap. 2) from family members deepens awareness and understanding of the problem. And regular feedback from peers and the treatment team ensures awareness. For parents, the pre-contemplation stage is addressed via the family therapy they are expected to do at home; problem identification during weekly phone calls with the wilderness therapist; completing weekly homework assignments, such as reading specific books, journaling, or watching webinars; attending parent workshops; and reading letters written by their child addressing problematic family dynamics (see Chaps. 8 and 15).

Wilderness therapy interventions for adolescents in the contemplation stage might highlight how they are living incongruently with their personal core values, thereby self-perpetuating a shame cycle. They also explore the pros and cons of changing and not changing. In so doing, motivation to change is fostered. For parents, the same processes occur, though less intensely, as parents are still engaged in their normal daily routines. But parents have many opportunities to explore and potentially resolve their ambivalence about change via intentional letter writing with their child in wilderness (see Chap. 2), family therapy at home, practice of new skills directly with the adolescent via family phone calls or in-person therapeutic experiences, practice of new skills at home, both individually and with others, and other interventions previously described.

Interventions for adolescents in the preparation stage include making a relapse prevention plan, taking full accountability for past actions, and practicing necessary skills amid increased emotional pressure (i.e., using skills *when they count*, such as during the first in-person family interaction). Parents actively develop aftercare plans for their child as well as their own relapse prevention plans. Also, they typically participate in a reunion process that occurs just prior to discharge, helping further develop skills as a family (Ferguson 2009).

These first three stages are what wilderness therapy does best. In fact, Bettmann et al. (2012) state, "…that clients in wilderness therapy do not necessarily need to want to change in order to do so" (p. 1039). In other words, success in wilderness therapy does not mandate being in the action stage of change; rather wilderness therapy often helps clients *prepare for* the action stage of change. Wilderness therapy provides a powerful environment to challenge one's denial that a problem exists because the problems manifest in the wilderness just as they do at home (Russell 2000, 2005). An expression commonly heard in wilderness therapy is, "wherever you go, there you

are." As such, clients are able to weigh the pros and cons of change amid daily peer interactions, structured family therapy interventions (e.g., letters or phone calls), frequent and uncomfortable experiences that call for greater emotional resiliency (e.g., living outdoors, being self-reliant, making bow-drill fires), and introspective and reflective time alone such as occurs during solo experiences (Russell 2000). With the support of the treatment team, clients are able to create plans for how to *do* the therapeutic work they have spent the majority of their time in wilderness *discovering* (Russell and Hendee 1999; Russell 2002, 2005, 2007).

Additionally, these first three stages of change are further reinforced in wilderness therapy by the opportunities for safe relapses (Bettmann and Jasperson 2009). An important part of any change process is *relapse*, as relapses help clients resolve ambivalence about changing (Miller and Rollnick 2002). Having opportunities to make safe mistakes in wilderness therapy enables clients to practice new behaviors with minimal to no risk of harm as a result of those mistakes (e.g., as in the cases of substance use, self-harm, disordered eating, sexual promiscuity, or suicide). Adolescents can use their peers, treatment team staff, and parents (from afar) to practice new emotional resiliency and communication skills, and they receive feedback and coaching as they relapse into old patterns (Russell 2002; Bettmann and Jasperson 2009). However, the influence of wilderness therapy typically does not extend far into the fourth, fifth, and sixth stages of change, if at all: *action*, *maintenance*, and *termination* (Prochaska and Velicer 1997).

Reasonable Expectations for Wilderness Therapy Outcomes

Wilderness therapy helps families lay the foundation for long-term growth by directly interrupting unhealthy patterns in relationships, coping strategies, or identity formation. Adolescent clients, also called *students*, typically leave wilderness therapy with awareness of their struggles and the underlying reasons for them, motivation to change, and the skills necessary to support their goals (Russell and Hendee 1999; Bettmann et al. 2012). However, wilderness therapy is designed to be a short-term, intensive intervention, not a long-term solution.

Results from outcome studies demonstrate that adolescents are typically unable to sustain the significant gains made in wilderness therapy without more continued, intensive treatment (Russell 2005, 2007; Becker 2010). Russell (2002) found a few predictable themes from adolescents at the time of discharge from wilderness therapy: "a desire to 'change behavior', a desire to discontinue drugs and alcohol, and a desire to be a 'better person'" (p. 428). These *desires* reflect the first three stages of change (Prochaska and DiClemente 1983): awareness of the problems, motivation to address them, and perhaps even a commitment and plan for how to change. However, *desiring* change does not necessarily lead to *creating* change. The gains made in wilderness therapy programs must be supported by specific and intentional aftercare support, which frequently takes the form of residential therapeutic programs. These schools and programs typically last between one to two

years and involve a continued separation of adolescents and their families (Norton et al. 2014).

The notion of continued family separation post-wilderness therapy raises an interesting and frequently asked question about how family engagement, a clear predictor of success (Brinkmeyer et al. 2004; Bandoroff and Scherer 1994; Harper and Russell 2008), can occur when families are far apart. This topic is addressed at length in another chapter within this book (see Chap. 8). To summarize briefly, Kerr and Bowen (1988) indicate that a fundamental goal to create lasting family change is to decrease chronic anxiety within the family system while supporting each family member to further differentiate (Kerr and Bowen 1988). At times, the family system is unable to support these goals while living together due to dangerous behaviors by the adolescent or entrenched dysfunctional family system patterns (McGoldrick and Carter 2001; Norton et al. 2014). Without intentional separation and intervention, families usually revert to unhealthy homeostatic tendencies (Jackson 1957). In Chap. 8, the case is made for intentionally separating a particular population of families, and that chapter is a good resource for those who contest the above made assertions. Simply separating families is not the solution either; rather, therapeutic engagement of the entire family system *amid* physical separation and therefore decreased anxiety can actuate change. And because of the adolescent brain's adaptability, these changes can lead to long-term change as they are reinforced over time (Siegel 2013).

Navigating Aftercare Planning

Aftercare simply refers to whatever type of care comes after the current treatment. Given the typical complexity of issues facing adolescents and their families preceding wilderness therapy (Russell 2002; Bettmann and Tucker 2011), every adolescent and family will need to develop an aftercare plan (i.e., a plan for how to support continued growth post-discharge). Interestingly, only about 80% of wilderness therapy clients report believing that they were adequately prepared for aftercare (Russell 2007). Aftercare planning is fundamental to allow time for the seeds that have sprouted in wilderness to develop and blossom. From the earlier discussion about predictable stages of change as they relate to the wilderness therapy environment, a new question emerges: How do we best support families during the *action* stage of change? Although much of what is discussed below is considered within the context of wilderness therapy, many of the concepts are applicable in any residential setting.

Continuum of Care in Residential Treatment

Continuum of care refers to a multi-level system of delivering health care services of varying degrees of intensity (Evashwick 1989). Evashwick (1989) asserts that

ideally, one needing mental health treatment seeks out the least-restrictive setting necessary and then *steps down* in the intensity of support until additional care is no longer needed. As previously described, many families seek help from traditional outpatient therapy, family therapy, skills-focused group therapy, hospitalization, and other inpatient treatment before enrolling their child in a wilderness therapy program (Russell 2000), which frequently is the least-restrictive environment at that time.

Given the intensity of the wilderness therapy treatment approach and the stages of change it is designed to address, stepping down in the level of care is necessary to access the latter stages of change. Post-wilderness therapy, many adolescents continue the treatment process in a residential therapeutic program, such as a therapeutic boarding school or residential treatment center (Norton et al. 2014; Russell 2005; 2007). That treatment is typically followed by a return to the family system (whether in the home, a traditional boarding school, or an independent living option). Upon returning to the family system, it is necessary to incorporate various outpatient treatment services (Nickerson et al. 2007). Due to the tremendous gap in therapeutic support between a wilderness therapy program (i.e., the *therapeutic intensive care unit*) and the home environment (even with outpatient services), long-term residential treatment can be crucial.

Residential, Therapeutic Schools, and Programs

A variety of residential, therapeutic schools exist to fill this need. These schools range from *residential treatment centers*, which serve a population needing more acute clinical focus; to *therapeutic boarding schools* or *emotional growth schools*, which provide clinical intensity more balanced with academic focus (Norton et al. 2014; National Association of Therapeutic Schools and Programs, n.d.). For ease, these environments collectively will be referred to as *residential aftercare*, and more specifically as residential treatment centers (RTC's) or therapeutic boarding schools (TBS's). Chapter 20 of this volume provides an overview of the different types of programs that fall under the title of residential treatment, and it is important to note that most adolescents who leave wilderness programs transfer to client-funded (i.e., private) RTC's and TBS's.

Some essential components of these residential aftercare options are highlighted across the following literature. Norton et al. (2014) describe the intentions for these programs as: (a) developing adolescent emotional growth; (b) strengthening family relationships; (c) supporting academic achievement; (d) improving emotional resiliency; (e) fostering healthy relationships with peers and adults; and, (f) providing structure and positive activities to decrease problematic behaviors. In Russell (2005), the following themes emerged among parents regarding how they believed residential aftercare was effective: (a) family focus; (b) adolescent identity and confidence development; (c) care of treatment staff; (d) addressing deeper therapeutic issues; (e) structure, discipline, personal responsibility; and, (f) a safe, sober

environment. Duerden et al. (2010) argue that a strong residential program should incorporate a *positive youth development philosophy*, including these concepts outlined by Eccles and Gootman (2002): (a) physical and psychological safety; (b) appropriate structure; (c) supportive relationships; (d) opportunities to belong; (e) positive social norms; (f) support for efficacy and mattering; (g) opportunities for skill building; and, (h) integration of family, school, and community efforts.

One wilderness therapy program, Open Sky Wilderness Therapy, has unpublished data (2015) indicating that their wilderness therapists recommend 95% of their adolescent clients transition to RTC's or TBS's immediately upon discharge from Open Sky to continue the individual and family growth in the above domains. However, the percentage of families that *choose* residential aftercare programs is only 80%. What accounts for the 15% of families not following aftercare recommendations?

Grief and Emotional Resiliency in Parents

The conversation of aftercare planning tends to be particularly difficult for parents, as most parents *want* their child home with them. However, in many instances, togetherness is not what the child or family *needs.* In addition, there are also significant financial implications in aftercare planning. And because it is counter-intuitive to believe that better family therapy and healing can occur amid physical separation of a family, one can understand why many parents struggle emotionally to choose continued separation from their child.

Frequently, parents worry about placing their child in a residential aftercare program because they expect their child will be sad or angry about the decision and respond in a way that triggers parents' emotional responses, which is due to lower differentiation levels and higher emotional reactivity amid family system anxiety (Bowen 1978; Kerr and Bowen 1988). Parents might fear rejection or angry outbursts from their child or fear their child will feel abandoned by them. Sometimes parents are just starting to feel grief related their child being in wilderness therapy abating when they need to make this difficult aftercare decision, so they have a resurgence of present grief, as well as anticipatory grief. This grief can be compounded in families where the adolescent in treatment is their last child at home and they experience empty-nest grief earlier than expected. Parents who have a pattern of enabling or rescuing their child when both of them feel uncomfortable emotions might respond by not making this hard decision, further perpetuating the enmeshed pattern.

Parents have a unique and powerful opportunity to role model the very things they are asking their child to develop, which are emotional resiliency and differentiation. When a parent makes aftercare decisions from a place of heightened anxiety, rather than a differentiated and grounded balance of rational thought and emotion, they unintentionally reinforce this pattern of responding reactively when emotions are overwhelming. For most adolescents in treatment, that is exactly the

underlying problem that brought them to treatment. When parents demonstrate making decisions based on what their child *needs*, as opposed to what they or the child *wants*, parents role model making rational, balanced decisions. It is important for parents to be engaged in their own therapeutic process to increase their levels of differentiation and emotional resiliency, the antidote to emotional reactivity.

When Is Going Home Recommended?

Despite Open Sky Wilderness Therapy's (2015) data that indicates approximately 95% of adolescents are recommended to continue their treatment in a long-term residential setting, this is not an absolute recommendation for every family. Wilderness therapists assess each adolescent and family to determine aftercare recommendations based on the likelihood of relapse if the adolescent returns home (related to the student's progress and predicted stage of change at the time of discharge), the parents' stages of change, the differentiation levels of family members, and the risk to the adolescent and family if relapse occurs at home (e.g., suicide, accidental injury or death, substance use, promiscuity, disordered eating, academic failure, disrupted family relationships, etc.).

In considering whether a student might be successful upon returning home post-discharge, there are a few patterns this author expects to see. First, a student should have no significant risk factors for personal safety (e.g., substantial suicide ideation, self-injury, promiscuity, disordered eating, or substance use). In addition, there should be clear progress in addressing the treatment issues that brought the adolescent to wilderness, evidenced by a decrease in symptoms and a noticeable increase in differentiation and emotional resiliency. Ideally, the student is at least in the preparation stage of change and consistently demonstrating commitment to change. More important than commitment, which is easier to state than create, clear behavioral changes (i.e., action) must be evident to show that the student is actualizing intentions. And the student should be able to demonstrate these actions when under stress (e.g., particularly inclement weather, challenging interpersonal dynamics, difficult family interactions, etc.).

The family's readiness for change is also a significant contributing factor to a student's readiness to return home. Parents should at least be in the *action* stage of change, as they will be setting the tone and structure to support their children upon returning home. Unlike adolescents in wilderness therapy programs, parents are still engaged in their lives at home, with jobs, partners, and other children. Therefore, they have opportunities to practice change in everyday settings and actually engage the action stage of change, thereby demonstrating behaviors that support their stated intentions and commitments. When parents fail to show action in the home environment, it does not bode well for adolescents to implement action upon returning home. Parents should be able to role model emotional resiliency under stress, and they should have a high enough level of differentiation to be able to provide their child appropriate supervision and structure, while balancing that structure with

nurturance and autonomy (Siegel 2013). It is not uncommon for parents and children to be at different stages of change at the time of discharge, indicating the importance of family engagement in the treatment process (Brinkmeyer et al. 2004; Harper and Russell 2008). The relationship between parents and children is another factor; if there is substantial relational distress that has not improved or been addressed successfully in wilderness therapy, the likelihood of being successful at home under more relational stress is minimal. We cannot expect families to be more skillful when reunited at home, where more stress exists, than they have been during the wilderness process with less stress.

For families who do bring their child home in conjunction with treatment recommendations, many layers of support should be considered to promote the action stage of change. Nickerson et al. (2007) highlight important considerations in planning residential discharge: (a) outpatient individual, family, and group therapies; (b) couple or co-parenting therapy for parents; (c) intensive outpatient programming for substance abuse support, possibly including 12-step meetings and drug testing; (d) school changes to support academic success, and collaboration with the school; (e) psychiatric support; (f) positive, pro-social activities; (g) service projects and/or employment opportunities; and, (h) peer restrictions; and daily structure and routine. Other considerations for transition planning include: (a) a strong home contract clearly outlining the expectations for the adolescent's behavior at home, and the predicted consequences of meeting or not meeting those expectations; (b) dietary, exercise, and wellness plans; and, (c) a home transition program that can offer coaching, mentoring, and therapy. These recommendations will be individualized to support the adolescent's and family's unique needs.

Another important consideration is the likelihood of the adolescent and family to experience a perceived sense of failure if the adolescent returns home and either the adolescent and/or the family system are unable to sustain the gains made in wilderness. Often, families consider bringing their child home and having a residential aftercare placement as a backup plan in case home proves ineffective. However, if the adolescent is not successful at home, a return to wilderness therapy for a few weeks is often required to restabilize before transitioning to the residential therapeutic school placement, costing the family more money, emotional stress, and prolonging the grieving process. In addition, depending on the reasons for the wilderness placement, relapse at home can be dangerous or even life threatening. And ultimately, the adolescent will then transition to residential aftercare under the (self-imposed) perception of failure, rather than the momentum and pride of completing wilderness therapy and starting the descent from the mountain peak while maintaining clarity, vision, and confidence.

Parents should address the aftercare decision-making process in their weekly appointments with their home therapists. According to Nickerson et al. (2007), it is crucial for the wilderness therapist to collaborate with the home therapist to ensure solidarity in aftercare recommendations and planning for the family. Not all therapists understand the benefit of intentional family separation in supporting long-term change and often struggle with the same counterintuitive process as parents.

Educational Consultant

Many families enter wilderness therapy programs upon the recommendation of an *educational consultant* (see Chap. 6; Wilder 2011; Open Sky Wilderness Therapy 2015) or a *therapeutic placement consultant* (for ease, the former term will be used throughout this section). Other families find wilderness therapy via another healthcare professional, word-of-mouth, or online searches. For these families, a wilderness therapist who is recommending residential placement post-wilderness will usually also recommend that the family hire an educational consultant to make specific recommendations for the schools and programs that will best support the adolescent's and family's needs.

Whereas the wilderness therapist's role is relatively brief in a family's therapeutic journey, the educational consultant (EC) typically works with the family long-term. As such, the EC maintains a broader sense of the adolescent's and family's progress and needs over time. Not only does the EC help a family find residential and wilderness programs, but they also advocate for the family during such placements. The website for the Independent Educational Consultants Association (IECA 2015) indicates, "In times of crisis, parents are often overwhelmed by a barrage of emotions. The confusion and desperation associated with having a troubled teenager or child can be extremely trying. Parents may not be aware of the options available, or may not be able to decide on their own which alternative best meets their situation and the needs of their child" (para. 1).

Although wilderness therapists tend to know various residential, therapeutic programs, it is not within their scope of practice to make recommendations for specific aftercare programs. In contrast, a significant portion of the educational consultant's time is devoted to visiting residential programs across the country (see Chap. 6). Their research informs them of the many programs that exist, which are reputable and accredited, the various treatment approaches of each, the peer milieu at any given time, and the treatment team members (Sklarow 2011). These are components that the wilderness therapist cannot adequately address, and that are even more difficult for parents to discern.

Because of their different skill sets, the wilderness therapist works alongside the educational consultant and provides general recommendations for the type of treatment the adolescent and family will need moving forward. The therapist has comprehensive, daily observations of the adolescent and is therefore able to compile a list of the adolescent's aftercare needs, such as: (a) level of therapeutic care; (b) degree of family engagement; (c) clinical specialization (e.g., trauma or substance recovery); (d) therapeutic modalities (e.g., equine or art therapy); (e) school size; (f) single- or mixed-gender; and, (g) duration. The educational consultant then filters those recommendations through the programs they have critically appraised to generate a list of a few specific programs for the family to then research (Wilder 2011). The EC will help parents narrow their list and explore these options, along with why each was selected.

Getting Safely to Residential Aftercare

Once the decision has been made for an adolescent in wilderness therapy to attend a residential therapeutic school for aftercare, and the program has been chosen, it is important to create an intentional and thorough *transition plan* to get the child safely to the next program. While many metaphors can be drawn to reflect this transitional time, the simple concept of a seedling illustrates the importance of *going slowly* during the transition. While in wilderness, seeds are planted and students and families begin to sprout. They need time, nurture, and structure to blossom. When planting a seedling in the ground, one must be slow, intentional, and gentle. If moving too quickly, the roots become exposed or damaged. For adolescents leaving the wilderness environment that has been their home for two or three months, where they have moved every day at a walking pace, everything tends to be over-stimulating, in a way that people without that experience do not understand.

Probably the most important thing to consider is whether the family should transport the adolescent themselves or hire a transport company that specializes in safely delivering people to their destinations. Although many families do transport their child themselves, at times, it is contraindicated. Situations that warrant the outside help of a transport company might include: (a) when the child has not progressed far enough into the contemplation stage of change and is resisting aftercare placement; (b) when parent-child dynamics are emotionally unsafe; (c) when parents are susceptible to manipulation by their resistant child; or, (d) when physical safety of the adolescent is a concern (e.g., self-harm, running away, and accessing drugs). While many parents struggle with the thought of someone else transporting their child for financial or emotional reasons, sometimes even the adolescent can acknowledge this is the safest plan. A recent study by Tucker et al. (2015) found that students who were transported to a wilderness therapy program via a transport company improved similarly to those whose parents delivered the student themselves, and even showed a greater decrease in symptoms. If emotional or physical safety is a concern, parents should hire outside help.

In the majority of other instances where the family and wilderness therapist believe the family can safely deliver the student themselves, a number of factors are important to consider. First, the time should be kept short (typically two days maximum, and without a visit home during the transition) to prevent increased emotional stress and, in turn, emotional reactivity. Parents need to consider how much, if any, access their child should have to the Internet, electronic devices, phones, television, social media, music, friends and extended family members, different foods, and other types of stimulation. These are things the student typically has missed and will want to access, but each can be problematic in exacerbating grief about the aftercare plan, resentment toward parents, and shame about not being ready to return home, which can trigger emotional overload and reactivity. Despite progress made, under emotional stress people tend not to cope as well as

they do under ideal circumstances (Bowen 1978; Kerr and Bowen 1988). The wilderness therapist will guide these discussions with each family and make clear, specific, and individualized recommendations based on the family's particular needs.

One final consideration for this transition period is preparing parents to expect the somewhat predictable pressure from their child to engage old interactional patterns. Upon initially reuniting with each other, parents and adolescents frequently are uncertain about how to relate and interact after so long apart. They each tend to remember their pre-wilderness experiences of each other, which frequently were not positive. As such, they tend to regress quickly into old behaviors and beliefs about each other's intentions. Very quickly, adolescents can start pushing their parents and trying to manipulate regarding situations in which parents have already identified boundaries and the child has agreed (e.g., more time for the transition, use of electronics, calling friends, or even getting a tattoo). Having witnessed these occurrences on many occasions, it seems like adolescents almost cannot help but try old tactics with their parents to get what they want. They might try to make parents feel guilty about their time in wilderness or future aftercare placements; they will pull on parents' heartstrings and parents' grief, and they will test boundaries overtly to see if parents will actually do what they have said they will do. Parents should be prepared ahead of time with a plan of action so they do not buckle under this pressure. It is significantly easier to hold boundaries from afar than to maintain them once in-person with their child.

Aftercare for Aftercare?

Another conversation families will eventually have, when they choose residential aftercare following wilderness, is regarding the transition out of the aftercare placement. One might ask, "Will my child ever be ready to go home?" The process of deciding next steps after residential aftercare will be similar to the aftercare planning done during wilderness therapy. The treatment team will provide recommendations based on assessment of the student and family's levels of differentiation, emotional resiliency, and readiness for change. Then, families will again navigate the aftercare planning process and make the next set of aftercare decisions. Renewed and new issues might arise for parents, such as financial impact, parental grief, fear about transitioning their child home, etc. Aftercare options might include students returning home, stepping down further to a lower level of residential care (e.g., to a therapeutic boarding school after a residential treatment center), or remaining at residential placements until they graduate high school and are ready to transition to college or independent living (Nickerson et al. 2007). The goal is typically to reunify families, and students do often return home with outpatient aftercare support following the initial residential aftercare placement.

Supporting Families Making Aftercare Decisions

Despite a logical presentation by a wilderness therapist or educational consultant outlining how residential placement will best serve the needs of an adolescent and family, it is not often a simple or rational decision for parents, but rather a complicated, confusing, and emotional process. Parents usually need guidance to sort through logical, emotional, financial, logistical, and other aspects of aftercare planning.

Sometimes, parents expect their child's wilderness success to generalize into success at home. These parents often benefit from education. When a child is experiencing success in wilderness, the success needs to be contextualized as occurring in a highly structured and therapeutically supportive environment—significantly more so than what can be achieved at home. With the help of the wilderness and home therapists, parents should answer these questions: (a) Are my child's actions and intentions congruent under stress? (b) Has my child demonstrated repeated successes in difficult conditions? (c) How transferrable will those experiences be to the home environment? (d) How ready am *I* to support my child returning home?

In some instances, parents need to explore multiple aftercare options (e.g., bringing their child home, or selecting a residential therapeutic placement). Considering multiple options can help parents predict the likely outcomes for each setting. Realizing how difficult it will be to continue progress and success if their child returns home post-discharge can help parents make difficult decisions from an informed, rational perspective.

Sometimes highlighting the emotional aspects of the aftercare planning process for parents and validating and empathizing with their emotions is what they need. When they understand the uncomfortable emotions they feel in the context of grief, many parents are able to work through the grief, accept their emotions, and make a decision that is in the best interest of their child and the whole family. These parents tend to have a higher level of differentiation and are able to balance the emotional and rational aspects in order to make a decision that feels painful immediately, but ultimately one they believe will best serve their child and the family in the long-run (Bowen 1978).

In other cases, some parents struggle to stay present with their emotions, looking to decrease their perceived level of anxiety related to the aftercare decision. It is common to hear parents struggling to tolerate emotions related to the grief of not having their child at home, losing their child's senior year of activities they had planned, empty-nesting earlier than anticipated, or feeling unable to manage the anticipatory grief when they have not yet resolved the current grief of having their child in wilderness. At times, families fight logically something that is experienced emotionally. Various therapeutic practices can support these families, such as mindfulness and emotional regulation (Kim-Appel and Appel 2013; Linehan 1993).

It can also be hard to differentiate between the child's wants and needs, or between the parents' wants and the child's needs. Sometimes, parents relapse into

denial about the severity of their child's problems pre-wilderness therapy. In other situations, parents' own mental health challenges or low differentiation interferes with the aftercare process. In these situations, the decision can become a means to attack the co-parent, or to make oneself the hero. Sometimes, parents too easily accept aftercare recommendations and do not work through the emotional or logical aspects of the decision, instead following recommendations, but later blaming others for struggles during the treatment process. In some cases, parents make the decision not to bring their child home because they do not want to manage the child at home. While the previous situations might produce the desired outcome for the child, the process of arriving there is flawed. Parents need support making the most appropriate aftercare decision, but they also need to understand, align with, and commit to their decision. That way, families are much better prepared for long-term success and parents are ready to support their child in committing to change.

In the above instances where parents struggle with some aspect(s) of making aftercare plans, the wilderness therapist, educational consultant, and home professionals play a key role in helping parents make decisions that are in the best interest of the child and family by supporting parents' own differentiation processes and helping them progress through stages of change. Ideally, the wilderness therapy program has strong family therapy programming so that parents are a part of the solution and engaged in their own therapeutic growth (Brinkmeyer et al. 2004; Bandoroff and Scherer 1994; Harper and Russell 2008). Through that process, parents' own challenges can be highlighted and then addressed in home therapy. The wilderness and home therapists can support parents to be mindful of their emotions, differentiate the emotions from irrational beliefs, and practice the same skills their child is developing. In doing so, parents demonstrate that they are invested in their own growth and aware that they play a part in the child's problems, and therefore in the solution, which validates their child and expedites the therapy process.

When the therapist sees a clear need for a residential aftercare placement, but parents want to bring the child home, another approach that can help families is *motivational interviewing* (Miller and Rollnick 2002). This intervention helps assess parents' motivation to change, highlight discrepancies between what they state as their intentions and what they demonstrate in their actions, and support self-efficacy in helping them make decisions based on their values, just as their children are learning to do. In other cases, challenging parents to role model the things they are asking their child to do can help them make balanced decisions.

Finally, in some instances, a family is not willing or ready to follow treatment recommendations. In these cases, the therapeutic team can highlight their perceptions of the family's decision-making process and make predictions for what to expect when they bring their child home. Families should also be helped to identify clear behavioral markers that will indicate their home plan is proving ineffective. These markers might include sneaking out, reconnecting with unhealthy peers, violating the behavioral home contract, communicating aggressively, isolating, or many other early warning signs of relapse. Parents should be prepared to engage their backup plan (usually a residential placement, with a possible return to the

wilderness therapy program first to restabilize). In predicting the ways parents can expect to see relapse in their child—and in themselves—parents are better prepared to identify those markers and to respond quickly.

If Residential Aftercare Is Necessary, Why Do Wilderness Therapy?

This chapter has examined the importance of ongoing, long-term treatment in the form of residential therapeutic programming. If this level of care post-wilderness therapy is a necessary part of the continuum of care, why participate in wilderness therapy at all? This question warrants an entire book devoted to it, so the answer will remain concise. Wilderness therapy is an intense, short-term, powerful intervention designed to support adolescents and parents to move quickly through the pre-contemplation and contemplation stages of change and enter the preparation stage, in some cases even beginning the action stage. As such, adolescents and families in wilderness therapy have the opportunity to confront and address unhealthy family dynamics, coping mechanisms, and identity. Russell (2005) cites over 80% of parents and at least 90% of adolescents reported positive outcomes when residential treatment was combined with wilderness therapy. The majority of these families indicated two years post-wilderness therapy that they believed they would not have been successful without their wilderness intervention due to the therapeutic intensity of wilderness therapy. No other setting can provide this level of therapeutic intensity because adolescents are not participating in traditional school and are therefore strictly focused on the therapy process, and every component of the program is designed to be therapeutically intense, containing, powerful, and to hasten change. Norton et al. (2014) describe the significance of wilderness therapy in the continuum of care. They say, "Youth need a bridge between these two worlds in order to feel safe and fully engage in a residential, therapeutic educational milieu" (p. 479). They suggest wilderness therapy provides a *transitional space* to help adolescents transition from childhood to adulthood, start a healthy differentiation process, develop identity strength, and prepare for long-term support.

Conclusion

Wilderness therapy is a powerful therapeutic modality for at-risk adolescents and their families that, appropriately, is receiving increased clinical focus and study. A growing body of research has attempted to understand and describe the therapeutic process and benefits of this modality. However, it is difficult to capture in numbers and words the essence of this unique intervention. One must experience

wilderness therapy in order to truly understand its power, in order to understand why families express profound gratitude and amazement at the growth they and their child experienced, in order to understand the tenderness families feel in finding connection again, and in order to understand why wilderness professionals can be moved to tears observing these monumental shifts.

Yet, it is important not to lose sight of the mountain climber standing proudly atop the apex, feeling strong and capable, connected to self and others, and to something greater than both. Adolescents and parents frequently feel a sense of completion in the therapy process, which can be a dangerous place to find oneself. Professionals should challenge families with interventions at the end of one's wilderness therapy experience to highlight the ongoing process and to help students and their families start walking off the mountain more grounded and realistic about the work yet to come. As the field of wilderness therapy is still relatively new, it will be interesting to see how future research supports or shifts the current aftercare trends described in this chapter. As new programs emerge that are designed to support the transition of adolescents from wilderness therapy to home environments, new research will need to direct best practices for this industry. Much is yet to be revealed.

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