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ORIGINAL PAPER

Family Therapy in Outdoor Behavioral Healthcare: Current Practices and Future Possibilities

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Abstract This paper highlights the role of the family in the treatment of youth who attend Outdoor Behavioral Healthcare (OBH) programs. It discusses the history of OBH, provides a critical overview of the research on the impact of OBH programs on family functioning, and discusses the importance of increased intentional integration of family therapy into OBH settings. To show this integration, this study presents a case study that highlights the role of the family, as well as the home family therapist throughout the phase of OBH treatment. Areas for future esearch are provided as well as suggestions for the increased utilization of adventure activities with families.

Keywords Outdoor behavioral healthcare · Wilderness therapy · Adventure therapy · Family therapy

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Approximately one out of five adolescents in the United States has a diagnosable mental health disorder (Schwartz 2009). These disorders impact youth functioning across all settings including the family, school, and peers. The disorders have significant impact on youth and their families. For example, the associated distress can lead to suicide, the third leading cause of adolescent deaths (Schwartz 2009). Despite the need for services, treatment of children and youth with significant mental health issues is often challenging in an outpatient setting, regardless of access to treatment (Harpaz-Rotem et al. 2004). Harpaz-Rotem et al. (2004) studied outpatient service utilization in children and youth with significant mental and behavioral health issues and found that 55 % of children and youth dropped out of treatment in <1 month. In adolescents, it has been argued that attitudes towards mental health treatment are a significant barrier to effective treatment in an outpatient setting (Harpaz-Rotem et al. 2004). Parents of struggling adolescents are then faced with the challenge of finding effective alternatives. In these instances, children are often placed in residential treatment centers (Frensch and Cameron 2002; Zelechoski et al. 2013); however, an increasing number of families are choosing to place their child into an Outdoor Behavioral Healthcare (OBH) program as an effective treatment option (Russell and Phillips-Miller 2002). The purpose of this paper is to provide a brief introduction to OBH, discuss the potential benefits of this unique intervention for individuals and more specifically to highlight the role OBH currently can play in supporting family therapy in building healthy families. Further, this paper seeks to address future possibilities for integrating the role of family therapy within OBH settings.

Outdoor Behavioral Healthcare

OBH, also referred to as wilderness therapy, is a type of adventure therapy. Adventure therapy as a larger field of treatment is defined as "the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective and behavioral levels" (Gass et al. 2012, p. 1). Adventure therapy interventions can be found in a variety of settings including community based mental health centers, residential treatment programs as well as in OBH programs (Norton et al. 2014). OBH programs are therapeutically based interventions in which clients are involved in outdoor adventure pursuits aimed at creating changes in targeted behaviors, directly focusing on a clear and distinct set of outcomes for each client (Russell 2001). Participants in OBH programs live in the wilderness in small groups and engage in individual, group and family therapy. Primitive living or survival skills are used in an effort to promote growth, rehabilitation or other therapeutic outcomes (Harper and Russell 2008; Russell 2001). In addition, some OBH programs engage in the intentional use of additional adventure experiences such as rock climbing, rappelling and mountain biking to augment their programs to meet similar goals (Magle-Haberek et al. 2012).

Overview of OBH

In most cases, adolescents are removed from the home and placed in an OBH program (Tucker et al. 2015a, b), essentially removing the individual from the family system (Olson and Gorall 2003). The roots of sending youth away to OBH programs can be traced as far back as the late 1800s; however the term OBH was not coined until the 1990s. Kurt Hahn's Outward Bound programs which operated in England in the 1940s and later (1962) in the United States are recognized as the original programs (Hattie et al. 1997; White 2012). In the 1960s and 1970s wilderness-based programs were developed to promote personal growth, support struggling students, and as a mental health intervention (Kelly and Baer 1968). The number of "therapeutic" wilderness-based programs in the western United States continued to grow throughout the 1980s and 1990s; however, until the early 1980s traditional clinical processes appear to have been absent from most programs (White 2012). Many of the primitive skills based OBH programs were influenced by the instructors and graduates of a 28-day survival class offered at Brigham Young University (White 2012). These early programs were founded on the premise that the primitive wilderness experience is a powerful mechanism for therapeutic change, that it is "curative and healthy" (Davis-Berman and Berman 1994, p. 63). Psychological assessment and individual therapy as part of the wilderness experience became more common in the late 1980s. Movement toward integrating more traditional clinical processes into wilderness treatment continues today (White 2012).

In its growth, OBH was marked by a few tragedies widely portrayed in the media. For example, Jon Krakauer's piece in *Outside* Magazine, "Loving Them to Death," brought public and governmental scrutiny to the industry (Krakauer 1995). In 1996, in an effort to address this scrutiny and promote accountability, a group of leaders from wilderness therapy programs formed the Outdoor Behavioral Healthcare Industry Council (Russell 2003a) and the term OBH was introduced. The OBH Industry Council initiated a systematic effort to create and promote safety standards, training, research, and stronger clinical models among wilderness programs (Harper and Russell 2008). The organization continues today under the name of the Outdoor Behavioral Healthcare Council with 22 active program members who are required to engage in accreditation, outcomes research and risk management reporting in an effort to promote the professionalism of the field (OBH Council 2015).

Most OBH participants spend 6 to 8 weeks in the wilderness living with limited equipment and supplies. For example, students may learn to build fires without matches, build shelters, learn to identify edible plants and navigate their way across the land. Although all OBH programs have a component of outdoor group living, not all programs focus solely on expedition and wilderness survival. Other programs use a base camp model from which participants engage in weekly trips that involve adventure activities including backpacking, rock climbing, canyoneering, and mountain biking (Magle-Haberek et al. 2012). In addition to the experiential and adventure components of each program, participants in all OBH programs engage in weekly individual and group therapy with licensed clinicians.

Recognizing the important role of the family, most OBH programs also include varying family components. Harper's (2005) survey of ten member programs of the OBH Council found the majority of programs intentionally involved families in the treatment process, including incorporating family goals within treatment plans and providing families with counseling and psycho-educational information. On average families had between 10–30 h of contact time with the individual in treatment. Also, the majority of programs utilized letter writing, therapist-parent phone calls and direct family participation to keep families involved in programming (Harper 2005). Similarly, Russell et al. (2008) in their survey of 65 wilderness therapy programs, found that 84.1 % of the programs

reported offering family sessions and 79.4 % reported offering parent sessions with an average of 27 h spent in contact with the family per youth. Additionally, 71.4 % offered psycho-educational family groups, 68.3 % offered parent/family support groups, 50.8 % offered parent seminars, and 38.1 % offered online support services (Russell et al. 2008). Clearly, clinicians have a variety of options in OBH settings to engage the family in treatment.

What Does the Research Say?

Research on the impact of OBH programs has been growing over the last 20 years. Similarly, OBH research and theory has identified a number of factors as agents promoting change in clients. These include rites of passage, self-efficacy, positive group living, positive role modeling, beauty and mystery, spirituality, nature as an educator/feedback loop, relationship trust, model fidelity, and solo time (Russell 2000, 2001; Russell and Phillips-Miller 2002). Overall, youth who participate in OBH programs have consistently shown clinical improvements after treatment as measured by both youth and their parents (Bettmann et al. 2013; Norton et al. 2014; Russell 2003; Tucker et al. 2011). Unlike the weaker methodologies of the past for which the field has been criticized (Hattie et al. 1997), this research tends to employ better measurement instruments like the use of the Youth Outcomes Questionnaires (Y-OQ), a well-established behavioral outcome instrument (Russell 2003a; Wells et al. 1996) and the collection of longitudinal data which supports lasting improvements in OBH clients (Bettmann et al. 2013; Lewis 2012; Zelov et al. 2013).

Research has been limited however by its larger focus on the adolescent client and not the family, despite OBH programs engagement with the family. Only a few studies have specifically looked at the impact of OBH on the family. Harper et al. (2007) evaluated the impact of an OBH program on family functioning, adolescent behavior and mental issues. At 2-months post treatment, families reported significant increases in family arguments but significant improvements in youth's communication with the parents as well as improvements in youth's success in school and decreases in problem behaviors. Similar to earlier research on client outcomes in OBH, however, the measurement tool was created specifically for the study hence limited the validity of these findings. More recently, Harper and Russell's (2008) mixed methods study aimed to evaluate the impact of OBH involvement on the family. Qualitative interviews with 14 families at intake, discharge and 2 months post discharge revealed several themes. Families felt that sending their youth to wilderness helped to abate a family crisis or even worse outcomes for their child. In addition, the OBH program provided a needed separation and distance from the youth in order to see the situation with better clarity even though there were mixed emotions about sending their children away. Finally, families saw the experience as providing an opportunity for a new start as a family. Despite these positive themes, quantitative findings suggested minimum impact on family functioning after participation (Harper and Russell 2008).

Due to the need to more effectively assess the impact of OBH on families, OBH Council member programs recently began to gather data using the Family Assessment Device General Functioning (GF) scale (Epstein et al. 1983) at intake, discharge and post-discharge in addition to the Y-OQ. Preliminary research shows significant improvements in family functioning after participation in OBH programs as reported by the youth; changes that were maintained 6 months post treatment (Paul et al. in press). This is the first study using normed measures in which the families reported significant improvements in family functioning after OBH participation; however, more research is needed to substantiate these findings.

An Integrated Model of OBH and Family Therapy

Family therapy's influence in the field of OBH has often gone unnoticed when compared to wilderness therapy programing as the industry has attempted to differentiate itself as a newly emerging profession. In the early 1980s primitive and survival models dominated the industry (White 2012). The 1990s brought more therapy integration and cognitive behavioral models as well as adventure, evidence-based, and client centered models based on autonomy-support and positive affect engagement. More recently as family therapy was influencing program development, OBH programs began to use techniques to address family communication and homeostatic patterns of interaction by integrating traditional family therapy techniques into practice (Faddis and Bettmann 2006). A focus on maladaptive patterns within the family was a cornerstone of treatment. For example, impact letters, gratitude letters, letters of accountability, group role-playing, family workshops and seminars, and other communication with parents became standard. Some programs have parents join their child in the wilderness for a number of days, allowing the therapist to help the family learn and practice new healthy behaviors.

Despite the increased efforts, for the field of OBH to grow, family therapy needs to be more effectively integrated into the individual and wilderness treatment process. Research consistently demonstrates the efficacy of family involvement in increasing positive long-term outcomes for youth discharged from residential care to stable family contexts (Nickerson et al. 2006; Robinson et al. 2005).

Diamond and Josephson's (2005) study on 10 years of family-based research stress how "engaging parents in the treatment process and reducing the toxicity of a negative family environment can contribute to better treatment engagement, retention, compliance, effectiveness, and maintenance of gains" (p. 872). Based on this research, family therapy integration in OBH may be critical to creating meaningful change for the youth and the family. Depending on the family structure and support systems in the home, this integration may include work with the primary therapist at the OBH program who can do family therapy, as well as clinicians at home working with the family. To highlight how family therapy can be integrated throughout OBH, each phase of treatment within a typical OBH program is illustrated in the following section.

Admission and Intervention

Parents often initiate the admissions phase. Psychological testing is usually completed for an individual client at intake (Bettmann et al. 2014). This may also include parent interviews and family assessment such as the Family Adaptability and Cohesion Scale (FACES) and the Dyadic Adjustment Scale (DAS). Family therapists may use these reports to help unify the family around common goals and treatment expectations. It can also be used to motivate clients and their families to engage in the process more fully. Family therapists working with a family at home may consider the unique opportunity of OBH and decide to refer a family member. Family therapists may then provide OBH therapists with direction and insight to help direct the treatment phases in an effort to target areas most critical to impacting positive changes in the family. For example, cognitive, academic, and personality testing may show a high mean scores on perceptual and verbal subscales and low mean scores on working memory and processing speed. Additionally, personality testing can highlight where low motivation and poor reasoning might be an unconscious personality mechanism. The information can be used to help clients see how sobriety can increase processing speeds and effective reasoning and how through deliberate practice clients can re-shape their reasoning and personality. These two outcomes may be necessary for life goals such as a university education or job training.

As the results are reviewed with a therapist in an effort to identify areas of concern and treatment goals, it provides parents an opportunity to consider their hopes and expectations for treatment. Parents then discuss treatment options with their child. Family therapists can effectively facilitate this discussion and help with goal identification and in setting appropriate expectations. The admissions process also allows the client to learn about treatment and make a choice with their family.

Often this choice has family leverage which also needs to be addressed in treatment. For example, some families may choose to transport their child to an OBH program without the child's knowledge or consent (Tucker et al. 2015a, b), which may impact the family attachment, communication and trust (Bettmann and Tucker 2011). Although some may view this as a potentially damaging step, experts agree,

> "Legal interventions and sanctions or family pressure may play an important role in getting adolescents to enter, stay in, and complete treatment. Adolescents with substance use disorders rarely feel they need treatment and almost never seek it on their own. Research shows that treatment can work even if it is mandated or entered into unwillingly" (NIH 2015)

An adolescent may initially view forcible admission to a treatment program as unfair. This is a typical adolescent response. Although children and young adults with depression or anxiety may feel their parents have violated their trust, children with addictions may respond with even greater resentment and anger, feeling betrayed. Despite this, research suggests that transport for some families is seen as a last resort option and youth transported to OBH programs improve equally as well as those who are not transported (Combs et al. 2015; Tucker et al. 2015a, b).

Pre-Contemplation/Problem Identification Phase

Although some clients are in contemplation stage when entering treatment, most clients are in a pre-contemplation stage of change, therefore they do not see the need to seek treatment, making out of home placement necessary (Bettmann et al. 2013). OBH programs provide novel environment posing a dramatic change in lifestyle and living conditions. This novel environment often serves as a catalyst to initiate processes leading to feelings of hope. The sense of hope creates beliefs and expectations that change is within reach (Miller and Flaherty 2000). Family therapists can capitalize on this hope and belief in change by helping parents move from blaming and justifying communication to supportive communication. In other words, the family therapist at home can use the new environment and sense of hope in the child, to move the family from maladaptive to adaptive interactions. Specifically, parents can be coached by the family therapist to write effective impact letters. This is a letter describing how the parent's life has been affected by the child's behavior, writing in direct frank language, but avoiding hostility and blaming. Family therapists may teach parents to repackage the message in a way that it is easier for their child to listen and understand their experience.

For example, parents may describe the impact of constant worry about the health and safety of their child on their lives. They then may describe the experience of seeing their child overdose, rushed to the emergency room, put on a ventilator, and have to be resuscitated. The child then reads the letter to his or her peers around a campfire at night. This process is a vital part of helping change an individual's story about themselves and their relationship with others. Honest and open feedback from peers may be more readily given and accepted in this context, promoting insight and self-awareness (Russell and Farnum 2004; Russell and Phillips-Miller 2002). The child hears her parents differently and is held accountable for her interpretation and response to the letter by peers. Further, this process is supported by the OBH therapist observing the child's response to the letter and to her peers' feedback, and can use techniques such as reframing and circular questioning to help her hear the message, clarify what is said and begin to see the parent's experience. Later, when the parents visit their child in the program, the child may be invited to share the experience of reading the impact letter and the feedback provided by peers. Ideally, the OBH therapist and family therapist at home work collaboratively so the family therapist is briefed on the process, and can then continue work with the parents to build on the experience when they return home.

Treatment Phase

The treatment phase may include a variety of interventions. Some family therapy techniques have effective application in OBH settings. For example, therapists may use genograms and family mapping to identify family goals for treatment. In addition, Faddis and Bettmann (2006) highlight the potential impact of family sculptures and reflecting teams. Frequently, a peer group will help another group member with a family sculpture. This peer group also reflects back their own reactions and insights often based in their own family experience, and their experience living in the wilderness with their peer. This non-threating insight from others helps OBH participants develop a better understanding of family interactions. Reflecting teams provide opportunities for peers to offer clear and honest feedback. In this process, the OBH therapist can help the child recognize how well they responded to the peer feedback and then have the student compare that response to their response to their parents (Gass et al. 2012). They can then discuss how they can respond more effectively in future conversations with their parents. During group sessions, field guides and peers can provide reflective feedback about their insight on interpersonal effectiveness, coping skills, strengths, and other relational patterns from their experience together in the wilderness. Additional sessions occur between clients, OBH therapists, and field guides, who then create a treatment plan with specific therapeutic goals to take in the field and address throughout the week. This expanding of the treatment team allows for practical application of relational skills in the client's operational world. The expanded team can provide broader support and accountability.

Adapted modes of additional family therapy practices may also occur in this phase when parents and siblings visit the program and spend time with their child. This includes, but is not limited to, family therapy sessions with a therapist, group therapy with other families, and family sculpture family therapy groups, as well as spending time in the wilderness or engaging in adventure activities as a family. One important approach is for the child to lead their parents in an adventure where the child demonstrates gains in self-efficacy as he or she uses skills learned in the program to lead and care for the family. Other opportunities include increased family efficacy, peer modeling of improved relational patterns, psycho-educational groups, and family ceremony and rite of passage. As children lead their parents in a wilderness context, parents may see their child as an independent and functional person, changing long held perspectives of their child as a "problem." The child can adopt the role of servant-caregiver as he or she takes responsibility for the parent's safety and well-being. These experiences and role reversals can provide a completely new narrative and impetus to change for the entire family system. Ideally the OBH therapist and parents would debrief the experience with the home family therapist. This collaborative relationship provides synergy for the home family therapist to build on these experiences using the new narrative and family efficacy story as they prepare the parents for the child to return home.

Another aspect of the OBH therapy process involves the intense shared wilderness experience of the group including the field guides, peers, and individuals. Wilderness experiences lead to a process of breaking down targeted and inappropriate barriers individuals create as protective devices in relationships and in society. The process has been called "fractional sublimation" or a peeling away the protective layers (Taniguchi et al. 2005). It is difficult to maintain facades or images when confronted with the challenges of wilderness living. A unique feature of OBH is peer milieu where the family and individual dynamics are discussed in the peer group and the group reflects these dynamics back to an individual, creating a new communication feedback loop (Harper et al. 2007; Russell and Phillips-Miller 2002). Through this process, OBH participants learn positive communication skills (Tucker 2009). Theory and research suggest open and positive communication is critical for families to overcome dysfunction in family processes (Olson and Gorall 2003). Under the

guidance of the OBH therapist, the group living context in the wilderness is a unique mechanism to help participants peel away their facades and approach their interactions and communication differently. As changes are seen in the child, and interpersonal skills are enhanced, these gains are communicated to the parents and home family therapist who discuss how they can support these changes and build a stronger relationship with their child.

The awareness of communication problems can also be brought to the forefront as peers role play family interactions. Peers are effective actors as they take on and play the role of different family members and reflect the communications patterns of their families. The OBH contexts of wilderness and group naturally lead to fractional sublimation and break down barriers, increasing vulnerability and humility, and leading to greater trust among group members (Taniguchi et al. 2005). It indeed can be a powerful context for the process of self-understanding and reflection to occur. The OBH therapist can use the dynamic interaction of wilderness and peer role playing as a foundation for continued reflection and self-understanding.

The distance from the family of the OBH group can provide a safe and effective practice space for changing the dynamics with actual family members (Harper and Russell 2008). The OBH therapist facilitates the process promoting growth for both the child and the parents. The OBH therapist communicates the child's progress to the parents and home family therapist. The home family therapist also communicates the parent's progress to the child, creating hope among family members for healthy interactions when they are reunited, which the home family therapist can foster the development.

In an ideal situation, the home family therapist and program therapist engage in co-therapy. For example, the home therapist may join in on phone calls where the parents are in their home office. In this scenario, updates are given and processed therapeutically based on the parents' reactions. The home family therapist is in a better position to see, interpret and respond to those reactions. With effective communication between the OBH therapist and home family therapist, the home family therapist may use experiences and interventions from the OBH program as a foundation to continue strengthening the family. The more familiar the home family therapist is with the OBH programs and processes, and the greater the communication between therapists, the more effective this collaboration will be in helping families.

Aftercare Planning Phase

Most OBH programs are designed to be an intermediate level of care. All clients will benefit from follow up services at some level. Aftercare planning is vital. Parents and clients often talk frequently in therapy sessions using a combination of face-to-face, phone or video conferencing. Effective aftercare planning should include the parents and the home family therapist, and where appropriate, it may involve an educational consultant. Along with discussions with the child, decisions regarding aftercare programs can be made together. This allows for information to be gathered but also gives an opportunity for the client and family to plan together using improved family interactions to create a shared map for the future (Gottman 2011). As Johnson (2012) describes in her Emotionally Focused Therapy model (EFT) attunement of family members creates trust and security in attachment styles. Attunement is a key social skill. It is a couple's, or parent and child's ability to understand and fully process interactions and move beyond negative emotional interactions and build stronger relationships. This attunement of a shared map in the aftercare process often has a repairing effect on the parent–child relationship. Here again, collaboration between OBH and family therapists may provide synergistic benefits, by guiding both client and parents to a plan that meets therapy needs as well as wants for the future direction in the client's life to build on the experience. For example, the OBH therapist may initiate aftercare discussions while supporting positive communication and attunement and outline aftercare options. Including the home family therapist in the discussions and gaining their input may serve to support the parents and the child and give them greater confidence to move forward.

In an effort to provide insight into the OBH experience, below we present a case representing a typical student.

Andrew: A Case Study

Andrew is a 16-year-old male diagnosed with a moderate substance use disorder. He regularly uses marijuana and alcohol. Andrew was arrested for driving under the influence, was detained at school while drunk, and marijuana was found in his possession. He was suspended from school and referred to juvenile court. In the year preceding his arrest, his school performance dropped from a B average to failing, he quit the tennis team, and was fired from his part-time job. These issues were accompanied by increased conflict with his parents and oppositional behavior at home and school. Andrew refused to follow the family rules. He began engaging in verbally abusive behavior towards his siblings and parents. His parents described him as "feeling entitled" and often angry when they would not provide him with the material possessions his friends had, such as a car, motorcycle, and money to attend concerts. Efforts by his parents to help Andrew produced heightened conflict in their marriage.

Consequently, his parents sought help from a marriage and family therapist.

As Andrew's issues intensified, and when he was arrested for driving under the influence, it became apparent the marital and family issues were systematically connected to Andrew's substance abuse. In particular, Andrew and his parents no longer engaged in open communication, and his parents' communication was also disrupted, undermining the family's ability to adapt and deal with Andrew's substance use and maintain cohesive family relationships (Olson and Gorall 2003). In consultation with the family therapist and after discussing different treatment options, Andrew's parents had him transported against his will and admitted to an 8–10 week OBH program in another state. The purpose of the admission was to help Andrew with his substance use and restore and enhance his communication skills. It was also to provide a respite for his parents from the stress and conflict at home in an effort to continue marital therapy. Part of the OBH program involved his parents attending seminars to help them become more effective parents which focused on managing conflict and strengthening relationships (Arbinger 2015). With the permission of the parents, the OBH therapist contacted the home family therapist to discuss Andrew's case and to better understand the family dynamics. This was followed by a conference call including both therapists and the parents to discuss key issues and their hopes for Andrew and their family as they began the process of participating in the OBH program. The OBH therapist and home family therapist committed Andrew's parents to engage in the weekly phone sessions with the OBH therapist, attend the parenting seminars and the parent wilderness experience. In addition, they agreed to include the home family therapist in these processes where appropriate.

Andrew was initially angry, resistant and in denial. His OBH program included living at a base camp and engaging in week-long trips including rock climbing, mountain biking, backpacking and other activities. He was in a group with seven other young men who had a variety of behavioral and emotional problems. He attended weekly individual and group therapy while at basecamp. He developed strong relationships with his field staff and therapist. Treatment goals were identified each week by his therapist. These goals were communicated to his parents and home family therapist. The home family therapist integrated Andrew's goals into the parent's therapy sessions, focusing specifically on how they can support Andrew in the program and during aftercare in achieving his goals. Then, under the direction of the therapist, the field staff implemented specific techniques focusing on his goals. Most goals focused on issues around substance use and anger management and the development of effective coping skills.

After 3 weeks in his OBH program and without marijuana and alcohol, his level of opposition decreased and he began to express some satisfaction with participation in the program and therapy. He particularly enjoyed mountain biking and was developing excellent mountain biking skills. He enjoyed the feelings of accomplishment and total engagement without being high, as he used his new found skills to take on more and more challenging trials (Csikszentmihalyi 1990). He realized he could find a natural "high" through his newfound skills without drugs and alcohol. He developed a genuine desire to gain knowledge and skills and to continue growing. He also began to miss his parents and siblings and to acknowledge the many comforts his parent provided him. These experiences and growth were shared with his parents and home family therapist. In their therapy at home the family therapist helped them develop strategies to encourage and support Andrew's desire to learn and grow and engage in challenging activities like mountain biking when he returned home.

This specific OBH program was founded on a strength-based approach from positive psychology and Self-Determination Theory (Deci and Flaste 1996; Peterson and Seligman 2004; Seligman 2011). For example, an emphasis was placed on choice and autonomy, experiencing engagement or FLOW (Csikszentmihalyi 1990), building healthy relationships, finding meaning through service, skill development and achievement. During week four of the program, Andrew's therapist directed the field guides to have him engage in a "gratitude letter" intervention. This intervention involves identifying a person who had a positive influence in your life and write a letter describing how he or she impacted you. In this letter, you describe how the person influenced you and express gratitude. Andrew agreed to write a gratitude letter to his parents and describe the important influence they had on his life. Research has shown this intervention increases happiness and life satisfaction, decreases depression, moderates materialism and entitlement, and positively impacts relationships (Lyubomirsky 2008; Emmons and Mishra 2012; Toepfer et al. 2012).

During Week seven Andrew's parents attended the parent seminar. The family was reunited for the first time since he was removed from the home. His parents had been in marriage therapy, and they had attended the parenting seminar. Andrew had been living drug free, and facing new and difficult challenges with each week and adventure in the program. In addition, the peer role playing process described in the treatment phase section provided him with insight about his own role in family conflict and with tools

to better engage in positive communication and healthy conflict. Consequently, Andrew's perspective of his parents had changed. His gratitude letter described how angry he was at them when he was sent to the OBH program and how he had vowed never to return home. He then described how over the weeks his world had changed as he read their weekly impact letters and participated in reflecting teams. He recognized his bad choices and how these choices had affected him and his family. He expressed sorrow and asked for forgiveness. He told his parents how grateful he was for them and for everything they had provided him. He specifically addressed how his mom had always been so caring toward him, and how he loved her cooking and how she decorated the house. He also wrote about how he admired how his father showed honesty, respect, and kindness towards everyone he met. He also expressed his gratitude for their continued concern and love for him. He expressed gratitude for many simple things of life at home, for a bed, for shelter from the weather, for a hot shower, and for his mom's enchiladas. Emotions were difficult to control as he read the letter. Both Andrew and his parent's hearts were touched. For the first time in over a year, they were able to talk without fighting. It was a powerful life changing moment for all of them. With Andrew's permission, his parents shared the gratitude letter with the family home therapist when they returned home. Their family therapist processed the experience with them, and invited them to write a gratitude letter to share with Andrew at their next visit. They then spent time talking about things they were grateful for about Andrew.

In the context of this family situation OBH provided a number of benefits. The building of self-efficacy around living in the wilderness, doing adventures, and building better interpersonal skills changed Andrew. He developed a love of learning new skills and realized he did not need drugs and alcohol to feel high. In addition, the collaborative work between the OBH therapist and home family therapist allowed the family therapist to process Andrew's experience and capitalize on key insights. It provided energy for marital therapy and strategies to manage conflict around Andrew in their marriage. The OBH context also provided an opportunity to change the parent–child relationship and to strengthen open and positive communication. This laid a foundation to help the family adapt and become more cohesive with the help of the family therapist at home (Olson and Gorall 2003). OBH provides a unique and potentially powerful venue for affecting individual family members in an effort to strengthen families. It provides a respite from the constant emotional flooding process associated with highly conflicted parent–child relationships. OBH programs also give emotional space to the family (Harper and Russell 2008). OBH as an intervention engages participants in wilderness where physical movement and a positive peer culture can facilitate decreases in depression, anxiety, and other symptoms while also increasing the physical health of participants (Tucker et al. 2015a, b). It allows the brain to clear as a client becomes sober (Russell 2001). Most OBH programs require parents to use this space to work with a therapist to heal, develop and grow. Making change without being in a constant flight or fight response and using letter writing to practice communication patterns is a healthy way to internalize a new homeostatic pattern that can help to strengthen the family. It may also allow the client and family to co-create a healthier narrative for themselves and their shared meaning as a family.

Future Directions and Implications for Family Therapy Within OBH Programs

The Need for More Research

Engagement of the family within OBH treatment presents a unique opportunity. When families are a part of the intervention, youth have better long-term outcomes (Diamond and Josephson 2005; Robinson et al. 2005). Hence, moving forward it is important for OBH programs to take time to reflect upon their use of family as well as their specific use of family therapy within the treatment setting. Although this article provides an overview of how families can be engaged in OBH programs, effective family engagement is inconsistent at best (Russell et al. 2008). A significant criticism of OBH has been the question of whether participants maintain gains after treatment (Paquette and Vitaro 2014). Programs that remove the adolescent from their family and community have been especially vulnerable to this attack (Harper et al. 2007). Research has indicated that youth treated separately from their families or home environment may lose gains made in treatment (Bettmann and Jasperson 2009; Frensch and Cameron 2002) or even show an increase in negative behaviors upon returning home (Dishion and Andrews 1995). It could be argued that the more effectively families are integrated into the treatment process when youth are separated from their family and home environment, the more this potential loss of progress in treatment can be mitigated when the youth returns home. Further research is needed, however, to understand the extent to which family engagement in treatment mediates successful transitions home and long term outcomes for youth.

OBH research has also received repeated criticism for the dearth of experimental designs in the literature (Paquette and Vitaro 2014). It is important to note the likely reasons these research designs, and even some quasi-experimental studies, are lacking. OBH programs are

logistically intensive and expensive. Most programs are operated by agencies where conducting experiments would be economically and ethically challenging at best. Ideally it would require random assignment to treatment and control groups (Rubin and Babbie 2014). Most parents seeking help are unlikely to agree to place their child on a wait list to serve as a control group. Even if feasible, placing participants on a wait list who are in need of treatment is a violation of treatment ethics (American Association for Marriage and Family Therapy 2015).

Moving forward research is first needed to gain a better clarity on the use of families within OBH programs. Once a more comprehensive understanding of the use of family in OBH programs is established, further investigation is needed into how family engagement impacts the outcomes of OBH participants and their families in the long term including what role the home family therapist may play in that change. In the future, home family therapists may need to enhance their role in OBH in promoting family growth and the long-term outcomes for youth transitioning home. An additional barrier in integrating home family therapists may be that they are unfamiliar with the OBH model and thus feel ill equipped to insert themselves in the treatment process while the youth is at an OBH program. Thus it may fall on the OBH program therapist to support the home family therapist in understanding both the model and the importance of their role in the treatment process. Future research should seek to identify best practices in a possible collaborative effort between OBH clinicians and home clinicians in an effort to meet this goal.

Engaging Families Through Activities

In addition to better integrating traditional family techniques into OBH treatment, it may benefit OBH program clinicians to intentionally engage in adventure activities with families as part of their treatment with more frequency. The use of adventure activities with families as a clinical intervention is not a novel idea (Gass 1993, 1995). Just as mental and behavioral health professionals brought processing and debriefing skills into adventure education, clinicians trained in family systems theories began to explore ways to incorporate family therapy concepts and techniques into adventure experiences (Gass 1993; Gillis and Gass 1993). Adventure therapy with families incorporates the techniques and beliefs of other family therapies but delivers these practices through the medium of adventure activities.

Lung et al. (2015) stress how adventure activities can be used as agents of change with families, whether this is in a clinical office, a family home, or in an OBH setting. Adventure activities that are chosen intentionally to match the current needs of the family can highlight in real time the current strengths and challenges of families. Families are not asked to role play but act as they are, "in the moment, and to display their typical way of dealing with experiences" (Lung et al. 2015, p. 9). In this model it is the family therapist's job to properly assess the family, choose activities that match the needs of the family based on their assessment, facilitate the activity, guide the learning by providing opportunities for family members to reflect upon their "interactions, thoughts, and behavior in the here and now" and help facilitate the application of their learning to their lives outside of the therapy setting (Lung et al. 2015, p. 10).

In OBH engaging families more often and intentionally in adventure activities together may provide the benefit of the parents participating in a parallel therapeutic experience to their children, who are engaged in adventure therapy throughout the duration of the program. This may possibly aid in transference in that the youth and the parents both have access to a similar language, created through shared therapeutic adventure activities; that they can together refer back to. Research has shown that living in a camp setting and engaging in activities together, which parents could have access to at OBH programs, can bring personal enlightenment to family members (Haber 2011), provide new opportunities in a technology free environment to build relationships (Hickmon et al. 1997) and improve family cohesion (McLendon et al. 2009). It may also give the parents better insight into the applicability of their child's experience in OBH.

In addition, utilizing adventure activities is not limited to the outdoors, hence using adventure activities with families provided at home or in an office setting could provide home clinicians with more active ways to engage families when the youth returns and build upon the foundations created while the youth was at their OBH program. For example, Swank and Daire (2010) describe a model of multiple family adventure therapy groups in which groups of several families meet weekly for 2 h to engage in a variety of adventure experiences over the course of several months. In this model, through the use of share adventure activities which challenged families to solve problems and take risks, families are able to find their commonalities in terms of their family challenges similar to tradition group therapy, support each other and give constructive feedback to help in the clinical growth of the families (Swank and Daire 2010). Utilizing adventure activities intentional with families regardless of the setting can provide new opportunities for learning and growth while engaging the families in shared experiences, which can also be fun (Lung et al. 2015).

Closing Remarks

The purpose of this paper was to provide a brief overview of how family can be more thoroughly integrated within OBH programs including the role of the home family therapist in that process. The current relationship between OBH and family therapy may not, in many instances, fully utilize the potential benefits to help heal individuals and families; hence more attention must be paid to the important role of treating the family as well as the youth. This includes an active role, if available, by the home clinician in treating both the youth and the family. Clearly, there are risks in separating family members from the system when conducting therapy. In certain situations, however, a need exists to remove a family member as part of the therapeutic process. In these instances, OBH can provide a viable option to impact both the individual and family, and should be considered when removing a child in an effort to support families in crisis. In fact, considering consistent research in which youth report significant clinical improvements after OBH participation, it would only follow logic that as families are more integrated into OBH treatment, these outcomes would strengthen with consistent impacts beyond the youth to the family system.

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