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ORIGINAL PAPER

Descending from the Summit: Aftercare Planning for Adolescents in Wilderness Therapy

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Abstract Despite substantial gains adolescents and families can make in the intensely therapeutic and structured environment of wilderness therapy, regression is still a significant risk at the time of discharge. Accordingly, intentional and comprehensive aftercare planning is crucial to support adolescents and families internalize the changes begun in wilderness therapy. Wilderness therapy is a powerful and focused intervention, but it is not the solution. This article describes why most adolescents leaving wilderness therapy programs transition to longer-term, residential therapeutic schools and programs upon discharge. Although intentional separation of parents and children might appear counterintuitive, these settings often provide the least-restrictive environment. Their therapeutic benefit is explained using Bowen theory and the transtheoretical model of change. Considerations for a successful aftercare plan are identified, including the importance of the family therapeutic process in supporting adolescent clinical growth, and when going home upon discharge is recommended. Lastly, suggestions are offered for treatment providers to support families making difficult aftercare decisions.

Keywords Wilderness therapy · Residential treatment · Adolescent · Aftercare

There is a common expression among mountain climbers that most accidents occur on the descent. 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 2–3 months of exploring one's identity, developing emotional resiliency, and healing fractured family relationships (Russell 2001), these adolescents frequently describe their pride and sense of accomplishment as though standing on the summit. They have clarity, wisdom, confidence, and vision. However, they have not yet internalized that vision into reliable action (Russell 2005). In starting the descent, it becomes more challenging to maintain that vision and confidence, and adolescent clients are at risk of relapse (Russell 2005, 2007). The need for an intentional and comprehensive aftercare plan is paramount for clients transitioning out of residential treatment programs and is well documented across disciplines (Nickerson et al. 2007; Priestley 2014; Russell 2005).

This article 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 can a continued separation of parents and children be beneficial? (3) How is the aftercare plan determined, and what factors are considered? (4) How can treatment providers support families making aftercare decisions? And, (5) Why is wilderness therapy necessary if longer-term treatment is indicated? Throughout this article, 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.

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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 to the old lifestyle. 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). 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 internalizing of gains made in the wilderness environment, and changes to unhealthy lifestyles (Nickerson et al. 2007; Norton et al. 2014). Nickerson et al. (2007) indicate that problematic triggers at home are many and include unhealthy family dynamics, negative peer influences, 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 article, it is assumed that the reader has at least a cursory understanding of the field of wilderness therapy. 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 (Bettmann and Jasperson 2009; Russell 2001, 2002, 2005, 2007; Russell and Hendee 1999; Ferguson 2009). Typically, these students struggle with issues related to depression, anxiety, disruptive behavior, family relational problems, substance misuse, and other clinical disorders (Behrens et al. 2010). Fundamental goals in wilderness therapy include: client stabilization, thorough assessment, initial treatment intervention, and long-term treatment planning (Russell and Hendee 1999).

Wilderness therapy is designed to be most effective in supporting students working through earlier stages of change (Bettmann et al. 2012; Russell 2002; 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 a wilderness therapy program (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; Russell 2005). Parents often express 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 to take action. In other words, approximately 80 % of at-risk adolescents need 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 therapeutic settings, as well as some inpatient settings, have proven ineffective in working through those initial stages of change (Harper and Russell 2008; Prochaska and DiClemente 1983).

Trans-Theoretical Model: Stages of Change

Prochaska and Velicer (1997) describe the trans-theoretical model (TTM) of health behavior change as six basic stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination. It is important to note that this paper is focusing on aftercare support for adolescents in residential treatment. However, rarely are the adolescent's issues unrelated to the family system. It is essential that parents engage in their own change process parallel to their child in order to shift the family homeostasis and allow the adolescent to decrease symptoms (Pozatek 2010; Jackson 1957; Brinkmeyer et al. 2004). In exploring the stages of change below, they are applicable not only to the adolescent, but to the entire family. Because family members are not always in the same states of readiness, continued assessment is required.

Prochaska and Velicer (1997) describe the *pre-contemplation* stage of change (i.e., *before thinking* about change) as a lack of awareness that a problem exists, an externalization of responsibility for that problem to another person(s), or an awareness of the problem but an unwillingness to address it. Interventions in this stage focus on building awareness of the problem by making it too difficult to continue ignoring it (Miller and Rollnick 2002). For many adolescents, being sent to a wilderness therapy program is enough to recognize that a problem exists; reading impact letters from family members further deepens understanding of the problem; and daily feedback from peers and the treatment team (e.g., therapists and field guides) solidifies greater awareness of the problem. 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 books (e.g., Pozatek 2010), journaling, or watching webinars; attending parent workshops; and reading letters written by their child addressing problematic family dynamics.

In the *contemplation* stage, one acknowledges the problem, but is still ambivalent about responding to it (Miller and Rollnick 2002; Prochaska and Velicer 1997). Interventions in the contemplation stage explore the pros and cons of change, as well as the deeper issues underlying behavioral problems. Wilderness therapy interventions might help students discover how they are living out of line with their own personal values, thereby self-perpetuating a shame cycle. In so doing, motivation to change can be fostered. For parents, the same processes occur, though less intensely, as they are still engaged in their normal daily routines. But they have many opportunities to explore and potentially resolve their ambivalence about change via intentional letter writing with their child in wilderness; family therapy at home; practice of new skills at home, both individually and with others; practice of new skills with their child via letters, phone calls, or therapeutic workshops; and other interventions previously described.

Third, the *preparation* stage occurs when clients understand the problem, commit to address it, and develop a plan to create change. Interventions in this 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. And 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 is an excellent environment for challenging one's denial that a problem exists because the problems manifest in that setting just as they do at home (Russell 2005). An expression commonly heard in wilderness therapy is: *Wherever you go, there you are*. Accordingly, 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 time alone (e.g., during solo experiences; Russell 2002). 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 2002).

Additionally, these first three stages of change are further reinforced in wilderness therapy by the opportunities for safe relapses. 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 receive feedback and coaching as they relapse into old patterns (Russell 2002; Bettmann and Jasperson 2009).

However, the power 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). Prochaska and Velicer (1997) describe, the *action* stage of change as the daily implementation of the plan developed in the *preparation* stage. Even when one is emotionally overwhelmed and does not want to use an I-feel statement to express emotions, one does so anyway (or chooses not to use substances, self-harm, communicate with unhealthy friends, argue with parents, etc.). The *maintenance* stage of change indicates having completed *action* and working now to internalize those changes and generalize them across various settings. And finally, *termination*, indicates no desire to engage in the old, unhealthy patterns. It can take years, if ever, before truly reaching that point. Because of the non-linear nature of the change process for most people, it is difficult to determine just how long each stage in the change process will take any person. However, plan for this

process to be slow. None of our unhealthy patterns formed overnight and, as such, will take more than 2–3 months in wilderness therapy to correct. One might estimate 1–2 years of committed effort before solidly experiencing the maintenance stage of change (Prochaska and DiClemente 1983).

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 skills necessary to support their goals (Russell and Hendee 1999). However, wilderness therapy is designed to be a short-term, powerful intervention, not the solution.

Results from outcome studies report that adolescents are typically unable to sustain the significant gains made in wilderness therapy without more continued and 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): adolescents showed awareness of their problems and motivation to address them, and perhaps even a commitment and plan for how to change. However, *desiring* change does not necessarily lead to *action*.

As Russell and Hendee (1999) indicate, wilderness therapy alone is not a cure. In fact, it is commonly said that as difficult as wilderness therapy is, the hard work begins when the adolescent leaves the wilderness program. 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 1 and 2 years, and involve a continued separation of adolescents and their families (Norton et al. 2014). This concept raises an interesting and frequently asked question about how family engagement, a clear predictor of success (Brinkmeyer et al. 2004), can occur when families are so far apart.

Separation of Family

Brinkmeyer et al. (2004) found that increased parental engagement in, and parental satisfaction with, residential treatment were associated with decreased internalizing behavioral problems in adolescent psychiatric clients. In contrast, they discovered that repeat hospitalizations of adolescents were associated with lower family engagement in the treatment process. This result highlights the importance of families being engaged alongside their children in residential treatment. But how can that be achieved when families are hundreds to thousands of miles apart?

Bowen Theory

Murray Bowen, a pioneer in the field of family therapy, developed a theory for family systems upon which many fundamental principles in this field are based (Bowen 1978; Kerr and Bowen 1988). Among his major contributions are two concepts that address the previous question: differentiation and chronic anxiety. McGoldrick and Carter (2001) describe *differentiation* as "… a measure of the extent to which individuals are able to think, plan, know, and follow their own values and self-directed life course, while being emotionally present with others, rather than living reactively by the cues of those close to them" (p. 284). In other words, a higher level of differentiation is preferable so one can distinguish one's own set of values and identity from those of others, while being able still to attune and connect with others.

The second concept, *chronic anxiety,* refers to the level of anxiety in a family system. Kerr and Bowen (1988) describe anxiety as a normal human experience: within a certain range, anxiety is biologically adaptive. However, they further assert that families that become stuck in a pattern of chronic anxiety, accompanied by lower levels of differentiation, experience reduced adaptability under stress. The implication of this reduced adaptability is the perpetuation of unhealthy emotional reactivity, which manifests as social, physical, or emotional symptoms. Important goals for families are to increase each member's differentiation and to reduce the level of chronic anxiety in the system.

For some families, the best way to achieve this goal is to create physical separation among the family system (Russell 2002, 2005). The space created allows family members to increase their differentiation levels because they are not experiencing the daily stressors and triggers in their relationships (McGoldrick and Carter 2001). Norton et al. (2014) found wilderness therapy to be an effective means to facilitate higher levels of differentiation. But again, those gains must be reinforced by longer-term support. Otherwise, the greater family system, that inherently cannot change as quickly as the adolescent who is exposed to constant therapeutic intervention, is likely to interfere with the internalization of change due to basic homeostatic family tendencies (Jackson 1957).

An important distinction is that physical separation alone is not responsible for family or individual growth. Separation must be accompanied by intentional engagement of the

family system in the therapeutic process and viewing the *family* as the client, rather than just the adolescent. Not all programs employ this philosophical approach and it is an important consideration in evaluating the efficacy of any residential or wilderness treatment program (Harper and Russell 2008; Behrens and Satterfield 2006).

Adolescent Neuroscience

One additional way to respond to the question of how physical separation of adolescents from their families can support growth is highlighted in the neuroscience literature. In *Brainstorm*, Dan Siegel (2013) reviews important findings about adolescent brain development, perhaps the most fundamental of which is that the brain is still developing late into the third decade of one's life. For adolescents, the brain is quite malleable and capable of change. Siegel highlights that this adaptability is true also for older adults, which is significant because change needs to occur in parents as well as in their adolescent children in order to support long-term, systemic growth (Brinkmeyer et al. 2004; Jackson 1957).

Drugs, mood disorders, trauma, and entrenched patterns of behavior or interaction can alter the brain's connectivity and interfere with healthy brain development. Adolescents experience surges of dopamine with risky behaviors, social connections, and novel experiences. While these experiences are fundamentally important for healthy human development, those surges can reinforce unhealthy styles of meeting one's core needs for power and control, love and belonging, fun, freedom, and survival (Glasser 1998). Fortunately, Siegel (2013) highlights, "Knowing that the brain continues to change across the lifespan and that healing relationships of all sorts, including the one you have with yourself, can support the growth of new integration, can help give you a sense of strength, hope, and direction" (p. 205). Even when family system or individual patterns are entrenched, change is still possible with enough space and support to reduce chronic family anxiety and increase differentiation of self (Kerr and Bowen 1988; Bowen 1978).

The previous sections are not written to suggest that *every* adolescent should be removed from their family. Rather, there is a specific population that benefits from this separation. This includes adolescents who are at risk of serious harm to oneself or others, and/or are in a physically or emotionally unsafe environment.

Navigating Aftercare Planning

Aftercare simply refers to whatever *care* comes *after* the current treatment. Given the typical complexity of issues facing adolescents and their families preceding wilderness therapy (Russell 2002), every adolescent and family will need to develop an aftercare plan (i.e., a plan for how to support their continued growth after discharge). Interestingly, only about 80 % of wilderness therapy clients report believing that they were adequately prepared for aftercare (Russell 2007). This is such a crucial component to allow time for the seeds that have sprouted in wilderness to fully 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?

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 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 2007), 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). This treatment is typically followed by a return to the family system (whether in the home, a traditional boarding school, or an independent living option). At this level of care, it is necessary to incorporate various outpatient treatment services (Nickerson et al. 2007). Due to the tremendous gap of 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 greater clinical focus than academic focus; to *therapeutic boarding schools* or *emotional growth schools*, which provide a balance of therapeutic support and academic focus (Norton et al. 2014; NATSAP 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).

According to Behrens and Satterfield (2006), there is an important distinction between private-pay RTC's and publically funded RTC's. These two program types, while similar in intention, typically serve different populations and likely employ different treatment modalities. Behrens and Satterfield also state that families that are able to pay privately for residential treatment typically are of a higher socioeconomic status and are more commonly Caucasian; while those in public RTC's are more commonly of lower socioeconomic status and minority races. Though they further indicate that not enough research exists at this time to delineate outcome differences of the two residential settings, it is noted that wilderness therapy students typically transition to *private* RTC's or TBS's after wilderness.

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. And, Duerden et al. (2010) argue that a strong residential program should incorporate a *positive youth development philosophy* (*PYD*) 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; (h) and 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 that 15 % difference of families not following the 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 counterintuitive 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 (i.e., lower differentiation level and higher emotional reactivity amid family system anxiety; Kerr and Bowen 1988)—often related to past experiences. Parents might fear rejection or angry outbursts from their child, or fear their child will feel abandoned by the parents. Sometimes parents are just starting to feel less grief related to the loss of their child in wilderness therapy 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: 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*, the child can see the parents doing things differently. It is so important for parents to be engaged in their own therapeutic process to increase their levels of differentiation and emotional resiliency (i.e., the antidote to emotional reactivity).

When is Going Home Recommended?

The short answer is: not often. 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 simply a blanket 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 shift 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 under stress (e.g., particularly inclement weather, very 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. Similarly to their children, parents should at least be in the preparation stage of change and demonstrating consistent commitment to change and action to support that commitment. They 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). 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 do better at home, with more stress, than they have done in wilderness 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. As described earlier, 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; (h) peer restrictions; and (i) 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 and exercise plans, and (c) a home transition program that can offer coaching, mentoring, and therapy. These specific recommendations will be based on the adolescent's and family's specific 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 is 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. This hopeful thinking is best explained by the *bargaining* stage of grief (Kubler-Ross and Kessler 2014) and it can be a risky bargain. If the adolescent is not successful at home, a return to wilderness therapy for a few weeks is often required to re-stabilize 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, as aforementioned. And 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 to descend from the summit while maintaining clarity, vision, confidence, and momentum.

Despite the many layers of support a family can create when bringing a child home post-wilderness therapy, they still pale significantly in comparison to the level of support offered in the residential treatment center or therapeutic boarding school. The importance of following the recommendations made by the wilderness therapist cannot be overstated here. Parents should also 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 family separation in supporting long-term change and struggle with the same counterintuitive process parents do. Again, the aftercare planning process is a wonderful opportunity for parents to

demonstrate that they are engaged in their own therapeutic process, practicing emotional resiliency skills, and doing things differently than they have in the past.

Educational Consultant

Many families enter wilderness therapy programs upon the recommendation of an *educational consultant* (Wilder 2011; Open Sky 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, the 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 stays 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 also advocates for the family during such placements. The website for 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."

While wilderness therapists tend to know various residential, therapeutic programs, it is not within the scope of practice for them 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. Their research helps them know the many programs that exist, which are reputable and accredited, the various treatment approaches of each, the peer milieu at any given time, and members of the treatment teams (Sklarow 2011). These are components that the wilderness therapist cannot adequately address, and that are even harder 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 student, and is therefore able to compile a list of the student's aftercare needs, such as: (a) level of care; (b) degree of family engagement; (c) clinical specialization (e.g., trauma or substance recovery); (d) therapeutic modalities; (e) school size; (f) single- or co-gender; (g) duration; etc. The educational consultant then filters those needs through researched, visited, and reputable programs to generate a list of a few specific names of 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 program for aftercare, and the school 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 start 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 get exposed or damaged. For adolescents leaving the wilderness that has been home for 2–3 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 tend not to 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 where they are headed. While many families do transport their children 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; (b) when parent–child dynamics are emotionally unsafe; (c) when parents are susceptible to manipulation by their child who does not want to attend the next program; (d) or when physical safety for the adolescent is a concern (e.g., self-harm, running away, accessing drugs). While many parents struggle with the thought of someone else transporting their child for financial or emotional reasons, sometimes 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. When 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

2 days maximum, and without a visit home during the transition) to prevent increased emotional stress, and therefore emotional reactivity. Parents need to consider how much, if any, access their child should have to internet, electronic devices, phones, television, social media, music, different foods, and other types of stimulation. These are things the student typically has missed and will want to access, but they can be problematic in exacerbating grief about the aftercare plan, resentment toward parents, and shame about not being ready to return home. Ideally, these topics are addressed while still in wilderness, but 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.

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 a child ever be ready to go home?" The process of deciding next steps after residential aftercare placements 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 work through the aftercare planning process to make the next set of aftercare decisions. New and renewed 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). In the experience of this author's collaboration with many therapists among wilderness therapy programs, residential therapeutic schools, and outpatient settings, the goal is typically to reunify families, and students do often return home with outpatient aftercare support following the initial aftercare placement in a residential therapeutic school. However, as asserted throughout this article, sometimes families are not ready for this level of care.

Supporting Families Making Aftercare Decisions

Despite an eloquent, logical presentation by a wilderness therapist or educational consultant of how residential placement will best serve the needs of a family, it is not often a simple, rational decision for parents. Instead, parents frequently experience a discrepancy between their logical thinking and emotional experiences, related to their own levels of differentiation and past experiences that affect decision-making (Kerr and Bowen 1988). Parents often need guidance to sort through the logical, emotional, financial, and other aspects of aftercare planning.

Sometimes it is sufficient to simply highlight the dynamics of this process for parents, particularly helping them understand the logical versus emotional aspects of this decision. When they understand the painful emotions they feel in the context of a grief process, 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 serve their child and the family better 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 expected to experience, 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.

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 levels of differentiation interfere with the aftercare decision 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. And 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 these 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, believe in, and align with their decision. That way, families are much better prepared for long-term success.

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 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). 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 have a part in the generation of the child's problems, and therefore in the solution, thereby validating their child and expediting the therapy process.

Mindfulness

Significant research has emerged supporting the efficacy of *mindfulness* to increase emotional resiliency, develop empathy, improve relationship satisfaction, and enhance positive affect, as well as decrease symptomology of many mental health disorders (Gambrel and Keeling 2010; Gillespie et al. 2015; Bogart 1991; Miller et al. 1995). Gambrel and Keeling (2010) suggest a simple definition of mindfulness as *nonjudgmental awareness*, and they demonstrate the beneficial application of mindfulness to marriage and family therapy in improving family health, communication, and relational wellbeing.

Kim-Appel and Appel (2013) presented their research correlating mindfulness with Bowen's concept of differentiation: as differentiation increases, so does mindfulness. These findings indicate that mindfulness practice can improve family system health, which usually is at least partially routed in differentiation levels. They further identify that this correlation is evidenced most clearly between the *emotional reactivity* dimension of the Differentiation of Self Inventory—Revised (DSI-R; Skowron and Friedlander 1998) and the *non-judgmental acceptance* dimension of mindfulness, as measured by the Freiburg Mindfulness Inventory (FMI; Walach et al. 2006). This finding might offer some insight and guidance to therapists trying to support families faced with difficult aftercare decisions. Treatment providers can help parents face and confront their own experiences of powerlessness and grief in an effort to help them move toward acceptance of these hard decisions. Typically, parents know *cognitively* that their child needs more support than will exist at home immediately after discharge from wilderness. Treatment providers can support parents to *accept* this cognitive insight by exploring and processing the related *emotions* via mindfulness.

Stages of Change Revisited

Parents often need support in moving from their own state of pre-contemplation into preparation or action (Prochaska and Velicer 1997) regarding aftercare plans. For many families, this process must be slow and deliberate. In some instances, parents need to explore multiple aftercare options (e.g., bringing their child home, or selecting a residential therapeutic placement). Walking through multiple options can help them explore the outcomes predicted for each setting. Sometimes, realizing how difficult it will be to continue progress and success if their child returns home immediately can help parents make difficult decisions.

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, it needs to be held in context of this success occurring in an incredibly structured, therapeutically supportive environment, significantly more so than can be achieved at home. Success in wilderness does not directly translate to success at home, and is usually indicative of what conditions the child needs (e.g., more structure or nurturance, social success, or physical wellness). With the help of the wilderness and home therapists, parents should answer these questions: (a) Are my child's actions congruent with intentions under stress? (b) Has my child demonstrated repeated successes in difficult conditions? (c) How transferrable will those experiences be to the home environment? and, (d) How ready am *I* to support my child returning home?

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, therapeutic double binds (Haley 1993) can help parents make these decisions by challenging parents to role model the things they are asking their children to do.

Lastly, 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 then make predictions for what to expect when they bring their child home. It is also helpful for families to identify clear behavioral markers that will indicate their home plan is proving ineffective, at which point they should engage their backup plan (usually a residential placement).

If Residential Treatment is Necessary, Why is Wilderness Therapy?

This article 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 do wilderness therapy at all? This question warrants a book entirely devoted to answering it, but the answer will remain concise in this article.

Wilderness therapy is an intense, short-term, powerful intervention designed to enable adolescents and parents to move more 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 2 years after wilderness therapy that they believed they would not have been successful without their wilderness intervention.

For adolescents with multiple mental health risk factors in their home environment (including family, school, peer group, etc.), in which home is not physically or emotionally safe, a long-term residential, therapeutic school can be the least restrictive environment (Russell 2005). However, 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

Returning to our mountain climber standing proudly on the mountain's summit, this article describes the importance of a slow and methodical descent, one in which the climber is able to protect the gains made on the ascent. Answers were provided for five essential questions regarding aftercare planning: (1) More treatment is needed after wilderness therapy because only the beginning stages of change can truly be addressed in a wilderness program. In order to best support continued progress, many adolescents require a therapeutic, residential placement post-wilderness, involving a continued separation from family. (2) Though counterintuitive, this separation can foster family growth by decreasing the emotional reactivity in the family system, thereby enabling greater differentiation and wellness. (3) There are many considerations in aftercare planning, including: readiness for change, progress in wilderness therapy, family system health, long-term goals, etc. Once an aftercare plan is determined, there are even more considerations to individualize the plan for the needs of the child. Educational consultants play an important role in helping families navigate this process. (4) Families struggling to make difficult aftercare decisions often need focused intervention and support from the treatment team. This support can be in processing grief, exploring value-based decision-making, educating about outcome research, practicing mindfulness, or demonstrating the behaviors parents request of their child. And, (5) Despite residential placements being recommended for many adolescents, one should not necessarily jump straight to that level of care. Wilderness therapy provides a very powerful and focused transitional experience to prepare clients for change.

As this field is still fairly new, it will be interesting to see how future research supports or shifts these current aftercare trends. As new programs emerge designed to bridge the gap between wilderness therapy and home environments, new research will need to direct best practices for this industry. Much is likely to be revealed as researchers study outcomes for adolescents transitioning out of wilderness therapy programs into a variety of aftercare settings.

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