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JOURNAL OF THERAPEUTIC SCHOOLS AND PROGRAMS (JTSP) is published once a year by the National Association of Therapeutic Schools and Programs to provide a forum for the exchange of information and opinion on theory, research, and practice in providing comprehensive care for adolescents, young adults, and for families receiving services from member programs.

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MANUSCRIPTS The Journal of Therapeutic Schools and Programs (JTSP) publishes articles that assist readers in providing comprehensive care for adolescents, young adults, and families receiving services from member programs. The editors welcome manuscripts that are the original work of the author(s) and follow the style of APA as presented in the fifth edition of Publication Manual of the American Psychological Association. Manuscripts and related correspondence should be emailed to Dr. Ellen Behrens, Guest Editor, JTSP, ebehrens@westminstercollege.edu.

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PREFACE

A Case for Clinical Case Studies

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Since the early 1900's, mental health research and practice have been informed by clinical case studies. I imagine that we all remember some of the cases we learned about in our Introduction to Psychology courses. Do you recall the case of Clever Hans, the horse who was widely acclaimed for his ability to calculate mathematical equations? From that case, Pfungst learned that even animals could respond to the observer-expectancy effect, fundamentally changing our ways of conducting research and understanding cognition (De Sio & Marazia, 2014). Do you recall Little Albert? Watson conditioned him to fear white rats and sadly, via stimulus generalization, to fear men wearing white beards that looked disturbingly similar to Santa Claus. The case of Little Albert changed the way we thought about learning and behavior (Powell, Digdon, Harris, & Smithson, 2014). Do you recall the case of Little Hans, a young boy whose fear of horses nearly left him homebound? From his work with Little Hans, Freud gained insight into the Oedipal complex and phobias (Lachmann, 2010). These cases, and cases like them, laid the foundation for mental health research and practice. They resonated because they were real, organic, and rich. Their impact was lasting and notable: clinical case studies led the founders of our field to great discoveries that still inform our practice today.

By the 1930's mental health research had shifted its focus to newfound research methods and statistical analyses. The positivist, empirical tradition took hold and was positioned at the center of knowledge (Fishman, 1930). However, in recent years, there has been a call for a return to the use of clinical case studies. Leary (2014) recently argued that qualitative research, based on clinical case studies, is essential for advancing our knowledge of mental health and human behavior. He argued that qualitative research is unique in its ability to counter the "blindness" we have in terms of "seeing" the most salient aspects of human behavior. He wrote:

> It is not enough to have techniques and data, whether observational, experimental, or clinical. Techniques do not yield meanings or interpretations on their own, just as data do not speak for themselves. Techniques and data are crucially important; they do in fact constrain what can and should be said. But there is always more than one thing that could be said about them. It takes a sentient human being to discriminate what that ought to be: to see what the techniques afford and what the data mean, especially in relation to qualitatively described human experience (Leary, 2014, p.31)

Leary's (2014) voice is congruent with the chorus of voices calling for the increased use of clinical case studies (e.g., Carlson, Ross & Harris Stark, 2012; Ernst, Barhight, Bierenbaum, Piazza-Waggoner, & Carter, 2013; Jenson, Abbott, Beecher, Griner, Golightly, & Cannon, 2012; Macgowen & Wong, 2014; Ogilvie, 2004). Many prestigious mental health journals have recently issued calls for clinical case studies (e.g., Psychotherapy Research, Review of General Psychology, Clinical Practice in Pediatric Psychology, Couple and Family Psychology: Research and Practice, and Group Dynamics: Theory, Research, and Practice). Even the American Psychological Association's Presidential Task Force on Evidence-Based Practice (APA, 2006), arguably one of the most authoritative statements on the role and function of evidence-based practice in mental health, acknowledged the vital role of case studies in building the evidence base. Perhaps the most outspoken voice in the recent effort to integrate clinical case studies into the evidence base is that of Daniel Fishman (Fishman, 2001; Fishman & Messer, 2013) who issued a wide call for the use of case studies in mental health research and has also

created an open access, online, public depository for peer-reviewed case studies (http://pcsp.libraries.rutgers.edu/index.php/pcsp/index). He calls for us to "start from the point at which knowledge is ultimately applied," the case study, which he describes as the "basic unit of knowledge" in mental health (Fishman & Messer, 2013, p.159). In sum, this critical mass of support suggests that clinical case studies have an important place in the evidence based practice movement and are unique in their ability to generate "practice-based evidence" (Jensen, Abbott, Beecher, Griner, Golightly, & Cannon, 2012).

With the increased presence of case studies in published journals and e-journals, researchers are beginning to create innovative ways to analyze and aggregate information across case studies using new qualitative methodologies (Hill, Know, Thompson, Williams, Hess & Ladany, 2005; Iwakabe & Gazzola, 2009). Fishman (2001) calls us to analyze groups of case studies to explore themes that inform our clinical practice and our research agenda. Likewise, the APA Task Force on Evidence Based Practice (2006) noted that case studies are best when they are "aggregated—as in the form of practice research networks—for comparing individual patients with others with similar characteristics" (APA, 2006, p. 274). Iwakabe and Gazzola (2009) recommended the aggregation and analysis of groups of case studies using a process called "meta-synthesis", involving cross-case analysis of themes in sets of case studies.

The Journal of Therapeutic Schools and Programs seeks to join the efforts of these respected authorities by dedicating this Special Issue to clinical case studies. The JTSP editorial board certainly places high value on empirical research and celebrates the critical mass of research that has accumulated in the last decade within the NATSAP network, much of which has been published in this journal. The JTSP Editorial Board seeks to add to our fund of knowledge, to our evidence-base, by devoting this Special Issue to a collection of clinical case studies.

Our goals for this Special Issue are three-fold. First, we hope this Special Issue will stimulate NATSAP network-wide dialogue about the themes aggregated across the clinical cases. Perhaps we can aggregate these case study data in the manner suggested by Iwakabe and Gazzola (2009) or Fishman & Messer (2013). Regardless of our methodology, systematic and deliberate dialogue about the themes that exist across cases is likely to yield rich outcomes for the NATSAP network. Second, and flowing from dialogue with the NATSAP network, we hope that we can engage in rich discussions about our practice patterns, perhaps leading to discussions about practice standards or practice guidelines that are applicable across the NATSAP network of programs and comparable to those of other mental health organizations (e.g., American Psychological Association, http://www.apa.org/practice/guidelines/ and the National Association of Social Workers http://www.socialworkers.org/practice/standards/clinical_sw.asp). Finally, we hope the case studies and dialogue resulting from them can help to define a clinically informed research agenda. We are confident that researchers in the NATSAP network are interested in studying the questions and issues salient to our clients and clinicians. We hope these clinical case studies will enrich the flow of information between clinicians and researchers.

The clinical case studies in this Special Issue illustrate work done at each program type within the NATSAP network (i.e., wilderness therapy programs, residential treatment centers, therapeutic boarding schools, transition programs, and young adult programs). The cases feature important components and collaborators in NATSAP programs (e.g., parents, psychologists, and educational consultants). Each case is presented in the most complete manner possible, from preparation for placement to completion of treatment, and in some cases beyond. Though we directed authors to include a common set of essential topics (e.g., diagnostic information, treatment information), we encouraged them to prepare each case using the unique "voices" of the clinician/s, clients, and caregivers. Each case study has been de-identified. All names are pseudonyms and identifiable details have been changed and obscured. The authors have obtained written consent for each case study. The cases were written by senior licensed clinicians, and in many cases by leaders and mentors within the

NATSAP network.

The Editorial Board of the JTSP holds these case study authors in the highest regard and owes them a debt of gratitude. The authors are presenting their work for our public review – something we imagine only happens when any sense of vulnerability is outweighed by a firm commitment to quality care, evidence-based practice, and practice-based evidence. We hope that you enjoy reading the work of your colleagues and you will join the Editorial Board and others in NATSAP as we commit to a public dialogue about our clinical practices and research agenda.

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WILDERNESS THERAPY CLINICAL CASE STUDIES

Healing Sexual Trauma in the Wilderness

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Abstract

This case study depicts the therapy of a sixteen year old male in wilderness treatment. His diagnoses included Bipolar I Disorder, PTSD, ADHD, and multiple substance use disorders. His treatment goals were:

1. Stabilize and reduce stress,
2. Assess for and create a safety plan,
3. Ongoing evaluation of diagnoses,
4. Treat trauma via Cognitive Processing Therapy, psycho-education, and graduated exposure,
5. Encourage program engagement, physical activity, and connection to the group to
    a) promote positive feelings, reduce depressive symptoms, and
    b) increase empathy for others to address depression and conduct related problems and,
6. Reduce treatment resistance.

Based on his significant improvement, at the end of treatment Johnny received a token called "Winged Heart", which represented his ability to let go of old feelings, developing desire to be successful, and a demonstration of leadership, empathy, and support of his peers in his group.

Introduction

Estimates are that as many as 1 in 6 boys and 1 in 4 girls are sexually abused by the age of 18 and that 300,000 American children are sexually abused each year (APA, n.d.). Wilderness therapy is emerging as a treatment of choice for sexual abuse. This case recounts the therapeutic treatment done with Johnny, a sexual abuse survivor in a wilderness therapy program (WTP).

Johnny was a 16 year old Caucasian male who lived with his parents in a large metropolitan area in the Midwest. He had two older half-brothers and an older sister. Due to a recent arrest for substance intoxication and possession of drug paraphernalia and immediately prior to his admission in the WTP, Johnny was court mandated to treatment. Johnny's outpatient program declined his application for admission on the grounds that he was not likely to benefit from treatment, a determination made based on his lack of improvement after two inpatient and three outpatient drug rehabilitation program placements. Johnny's parents believed that wilderness therapy was essentially Johnny's last option, aside from Juvenile Detention. They were committed to placing him in a WTP because they were convinced that his needs were best met in a therapeutic system, not the corrections system.

Johnny had a bevy of issues and psychiatric diagnoses. He had been diagnosed with bipolar disorder and was prescribed several medications including Lamictal, Seroquel, Trazadone, and Wellbutrin. Johnny said the medications helped him to manage his moods and anger. Johnny had a history of suicidal ideation and suicide attempts. In fact, he attempted suicide twice, by drug overdose. He reported a history of both restrictive and binge/purge eating patterns. Furthermore, he had issues with shop lifting, physical aggression, and truancy. Johnny had fallen one year behind in academic credits.

Nine months before beginning the WTP, Johnny reported that, when he was 6 years old, he had been

sexually assaulted by a neighbor. The disclosure was made in the context of a heated argument during which his father implored Johnny to explain why none of their efforts on his behalf were "working". It was at that moment that Johnny yelled he was "raped" by a friend's older brother. Johnny's parents immediately sought trauma-focused therapy. Unfortunately, that treatment had not been progressing well; Johnny was not interested in continuing this therapeutic work.

Johnny's family history was positive for mental illness. His mother had bipolar disorder which developed in adulthood, after her first pregnancy. Her mood was stable at the time Johnny began treatment at the WTP, likely due to psychotropic medication. Additionally, Johnny's family history was positive for drug and alcohol-related problems. Johnny's paternal grandfather was reported to have a history of alcoholism and his maternal uncle and great grandfather reportedly abused substances. Finally, one of Johnny's brothers was diagnosed with Post Traumatic Stress Disorder (PTSD), secondary to his combat experiences in the Iraqi war. Given his family history, it was likely that Johnny was at risk for bipolar disorder and substance use disorder.

Initial Assessment and Therapeutic Goals

Johnny entered the WTP with a history of numerous psychiatric diagnoses including Major Depressive Disorder, Bipolar Disorder, PTSD, Polysubstance Dependence, Attention Deficit/ Hyperactivity Disorder (ADHD), Eating Disorder, and Conduct Disorder. Each diagnosis was carefully evaluated using interviews with Johnny, gathering psychosocial history through his parents, and behavioral observations while in the WTP. In cases such as this, with co-occurring disorders and diagnostic complexity, it is necessary to engage in systematic, long-term evaluation. Indeed, care was taken throughout his stay in the WTP to reevaluate his diagnoses. Until the end of treatment we conceptualized his diagnoses as "working diagnoses" so that we could be maximally responsive to additional data. However, it is worthy of note that many of the diagnoses made at the point of admission to the WTP remained in evidence throughout his treatment and were the diagnoses with which he was discharged, though some became "Rule Outs" once in longer term treatment and under close supervision of a psychiatrist. Additionally, psychological testing was needed to confirm neurological deficits consistent with ADHD, which was not performed while in the WTP. Finally, Johnny's Eating Disorder was monitored closely, and was in remission throughout his stay in the WTP.

There was evidence of multiple substance use disorders, each present at the moderate to severe levels. He was diagnosed with Substance Use Disorders related to Simulants, Opioids, Anxiolytics, and Cannabis. His problem behaviors related to substance use included impaired control, social impairment, conduct problems, aggression, truancy, and risky use.

There was evidence of a Bipolar I Disorder. He reported a history of depressive episodes, with symptoms including apathy, depressed mood, anhedonia, suicidal ideation/attempts, malaise, weight loss, insomnia, and fatigue. Though not present at the time of admission to the WTP, Johnny's history was positive for suicidal ideation/intent and suicide attempts. Johnny reported manic episodes as well, marked a decreased need for sleep, racing thoughts, distractibility, grandiosity, heightened risk-taking, and irritability. Certainly his family history of mood disorder heightened his risk. The diagnosis of Biploar I Disorder was substantiated. At the time of admission his mood state was blunted and irritable.

Johnny had symptoms of PTSD. His symptoms included hyper-vigilance, shortened sense of future, depersonalization/dissociation, avoidance, and a heightened desire for risk. Given Johnny's reported sexual assault as well as the severity and course of his symptoms, the diagnosis of PTSD

was substantiated. Note that because many of the symptoms of Bipolar I Disorder overlap with the symptoms of PTSD, care was taken to ensure the symptoms were present in such a manner that they clearly were associated with each disorder. This being said, PTSD could exaggerate mood related symptoms and when treated may have positive impact on reduced functioning associated with mood problems.

Johnny's history and symptoms were consistent with ADHD. He had long standing academic difficulty, impulsivity, distractibility, lack of focus, and behavioral hyperactivity. That being said, it was recommended that the family pursue neuropsychological testing to evaluate a neurocognitive etiology for these symptoms in light of the presence of sexual trauma at age six.

Finally, there were signs of conduct disorder. While Johnny did not display aggression unless he was provoked, he had used weapons in fights. Furthermore, he repeatedly broke social norms by stealing, running away, truancy, aggression towards others, and a general hostility towards authority. It should be noted that no conduct disorder signs were evident with the clinician during the assessment process. As such, this diagnosis was uncertain. It was necessary to explore this behavioral pattern as well as its meaning to Johnny and his treatment.

Given the various symptoms and complex diagnoses in Johnny's case, it was crucial to develop clear treatment goals and interventions. The clinician found the following to be important treatment goals.

1. Stabilize and reduce stress for Johnny by creating strong therapeutic relationships with therapist, field staff, and his peer group.
2. Assess for and create a safety plan to diminish likelihood of self-harm and harm to others, which included regular emotional check-ins; vigilance of student behavior and affect; and monitoring fluctuations/changes in attitude, mood, and behavior.
3. Ongoing evaluation of diagnoses including Substance Use Disorders, PTSD, Bipolar I disorder, ADHD as well as the possibility of Conduct Disorder via behavioral observation and assessment interviews.
4. Treat trauma to the degree client was willing and ready to engage in this therapeutic work. Cognitive Processing Therapy was the preferred method which involved weekly evaluation of PTSD symptoms, psycho-education of PTSD and trauma recovery, and graduated exposure through writing assignments and talk therapy.
5. Encourage program engagement, physical activity, and connection to the group to a) promote positive feelings, reduce depressive symptoms, and b) increase empathy for others to address depression and conduct related problems.
6. Reduce treatment resistance by engaging Johnny with past success experiences and with therapeutic modalities with which he previously reported benefit including 12-step Narcotics Anonymous work and a continuation with his psychotropic medications.

Preparation for Treatment in the WTP Experience

Following the initial assessment, the next step was to prepare Johnny for the unique experience of wilderness treatment. With Johnny's past treatment history in inpatient and outpatient settings it was important to educate him about how WTP would differ and to educate him about the norms and expectations in the WTP. This pre-treatment work with Johnny is meant to help ensure success in the program and reduce the likelihood of early termination.

Johnny seemed particularly well suited to wilderness therapy. He expressed to his parents on many

occasions that he found nature and the outdoors to be relaxing and "grounding." This method of treatment also appealed to Johnny because of his interest in the outdoors and his interest in physical exercise. Additionally, it is likely that because the WTP was presented as an alternative method of treatment and way of avoiding placement in Juvenile Detention, it seemed especially enticing to Johnny.

Johnny's preparation for the wilderness treatment experience began when he came to the WTP with his mother, directly after the court hearing that mandated residential treatment. In this session, the clinician explained the general responsibilities and tasks related to living in both a primitive wilderness setting and in a group milieu. During the interview Johnny denied any hallucinations or delusions and appeared to have an appropriate mental status, making him a good candidate for this type of treatment model. The types of WTP treatment interventions and focus on mood management, anger management, and substance abuse were presented to Johnny. Additionally, the clinician explored with Johnny the potential of working on treating his sexual trauma. Johnny denied thoughts and plans of harming himself or others. He denied having thoughts of running away from the program and not only assented to treatment but expressed a distinct interest in participating in the WTP program.

Treatment

Wilderness therapy is a useful treatment modality for adolescents who have exhausted nearly every other treatment option. One of the key therapeutic benefits of the WTP program is the experience of living and working in a group milieu; especially in the simple and primitive environment of the wilderness where there are fewer distractions to engaging with the other members. As a result, the foundation of Johnny's treatment was living with a small group of boys who experienced similar issues related to mood dysregulation, behavioral problems, trauma and substance abuse. The group was structured as a continuous flow group (Russell, Hendee, and Philips-Miller, 1999) which had the boys living together for approximately eight weeks. Continuous flow groups involve a group of peers in which a new member joins the group as an advanced member graduates from the program. This provides a consistent group culture and group norms. The benefit of a continuous flow group for Johnny was that he had more therapeutically advanced peers to help support his growth and development when he initially arrived, and as he became a more advanced member of the group he had ample opportunity to practice empathy, teamwork and characteristics of citizenship. This feature made significant impact on his previous conduct related problems, developing empathy for others, and rebuilding trust with people based on emotionally close relationships.

In the WTP, Johnny and the other boys hiked and practiced nomadic style backpacking daily. Interventions for Johnny included teaching him wilderness based skills and activities such as making bow-drill fires and climbing mountains. Other interventions included problem solving initiatives, help with academic work and skills, and therapeutically guided activities and assignments, which will be described below. Each of these interventions were connected to metaphors and examples of daily life at home, so Johnny was able to imagine and apply his experiences to his home life. For example, Johnny was taught that working through his challenges with relationships with the other boys and staff in the wilderness group is much like learning to be assertive in his relationships with his family. Also, that trying new and novel experiences such as back packing and mountain climbing is much like replacing drug seeking and using behavior with more pro-social activities.

During treatment Johnny was asked to be a "group leader" and lead 12-step groups and 'gathering discussions' on specific topics (i.e. fears and insecurities, relapse prevention planning, identity formation). These opportunities allowed Johnny to demonstrate his mastery of the skills being taught

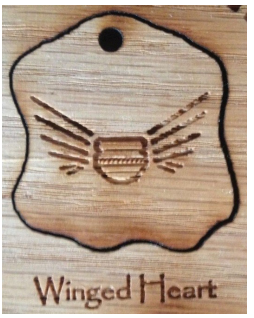
in the program and helped develop his ability to relate to others and his leadership potential. Further, his treatment gave him the opportunity to engage in experiential activities (i.e. carrying a rock/burden and leading a hike), read relevant books (i.e. Touching Spirit Bear, Anatomy of Peace,), communicate with his family through letter writing, and complete focused written assignments on substance abuse and character development. These opportunities worked in conjunction with other empirical treatments interwoven into the WTP program including, Dialectical Behavior Therapy, Cognitive Behavior Therapy and Cognitive Processing Therapy (CPT).

Johnny's sexual trauma was a crucial issue to address in his wilderness therapy. However, Johnny did not initially want to discuss his past trauma and instead preferred to discuss his anger, aggression, and substance abuse. So, responding to his needs and readiness for change, the therapeutic focus was initially placed on his anxiety, anger and substance use. After two weeks of developing rapport and trust with his therapist, Johnny felt comfortable to move into treating the sexual abuse.

The preferred intervention to treat this issue was Cognitive Processing Therapy (CPT), a progressive cognitively-based exposure treatment. Initially, Johnny was taught about PTSD and how it develops. He learned concepts including "Stuck Points", assimilation and accommodation, and how events, thoughts and feelings are connected. He learned that PTSD develops out of the avoidance of stressful triggers and not learning to tolerate or learn to view the trauma differently. Johnny began to learn that many of the views he developed of himself, others around him, and the world at large came through the lens of fear, helplessness, and assaultive relationships. Johnny was encouraged and supported not to avoid thinking about his past abuse and associated feelings. As Johnny developed more courage and confidence to address his past, he began engaging in CPT interventions which involved writing his Impact Statement which involved the memories he has of the sexual abuse. Following this, he reviewed this history several times privately by re-reading his story. After he developed increased comfort with reading the story, he read it to his therapist and later to his group. Johnny was taught emotional coping strategies to help him tolerate the distress that came as a result of the continued exposure to the stressor. Additionally, engaging in physical exercise (e.g. hiking/backpacking) greatly helped him manage mood and anxiety states. He was successful in applying these skills to help him approach, rather than avoid, the therapeutic work necessary. Each session involved Johnny completing a PTSD symptoms survey that evaluates changes to symptoms. Johnny began to develop increased comfort and confidence in working with the content and process of his sexual trauma. He still displayed limits even once the WTP was complete and was encouraged to continue to address this treatment area in his future.

Over time, his positive relationships in the WTP and the preparatory work done with CPT helped to reinforce feelings of trust that allowed Johnny to address his past sexual abuse. In Johnny's case, the trauma work also focused on Johnny's behavioral and emotional symptoms of aggression, irritability, mistrust of others, risk taking, substance use, difficulty sleeping, inattention and poor focus, and conduct problems, which were framed as an expression of his past trauma.

Over the course of several weeks, he was asked to write his Impact Statement pertaining to his sexual trauma and re-read daily. One example of an adventure intervention of note, Johnny conducted a "letting go" ceremony in which he carried a stone to the top of a mountain the group climbed. The stone represented the event that occurred (sexual abuse) and the mountain represented the long and difficult journey he had been on. Once at the top, he shared his trauma with his peer group and field staff. Following this disclosure and receiving milieu support, he "threw" the rock off the top as a metaphor of letting go of his burden. During this period, Johnny's PTSD symptoms were greatly reduced, he displayed less anxiety surrounding the event, and he began to let go of anger



and aggression associated with the trauma. He was also able to see that many of his behaviors and attitudes about himself and others, as well as his mood dysregulation, were at least partially related to the trauma. In weekly reports of his trauma-related reactions and symptoms he noted improved levels depression, sleep, fear and intrusive thoughts. Overall, the therapist observed clinically meaningful improvements in his PTSD related symptoms, most notably a reduction in fear of and trust in others, reduction in anger and mood fluctuation, reduced trauma avoidance strategies and developing a future focus and a desire for life. Based on his significant improvement, at the end of treatment Johnny received a token called "Winged Heart" which represented his ability to let go of old feelings, developing desire to be successful, and a demonstration of leadership, empathy, and support of his peers in his group.

Finally, over the course of the WTP, Johnny recognized that he needed more trauma focused psychotherapy, chemical dependency treatment, mood and anger management, and academic remediation before returning home. This insight lead him to believe that his future had improved and expressed a renewed desire to obtain a high school diploma. Overall, he showed a reduced level of irritability, increased willingness to trust others, and tempered his irrational responses to stressors such as improved effectiveness in communication

Post Treatment Evaluation

When the WTP was complete, Johnny recognized he needed additional residential support and was provided a choice of three different programs. He chose the residential program with the longest treatment duration based on his desire to remain sober, grow emotionally, and make academic progress. Additionally, a vocational assessment was recommended to help Johnny explore various career options and job experiences and to help him develop a more comprehensive plan for his future.

The WTP was remarkably helpful for Johnny. Overall, Johnny developed a renewed belief in his interest and ability to complete high school. He believed in his therapy, his future, and himself. He was able to reduce his aggression and anger towards others. Johnny showed a sincere commitment to sobriety. His symptoms of PTSD all improved following intervention in the WTP. In effect, it seemed that Johnny developed trauma-related symptoms that mimicked other disorders and confounded prior treatment attempts.

Wilderness Therapy, unlike other forms of treatment, was able to respond favorably to Johnny's initial defenses and promote his engagement in the treatment. It afforded an unmatched opportunity to observe and evaluate his issues and complex diagnoses. And, it provided a safe, supportive milieu within which he was able to fully engage in trauma-focused treatment. In the process, it became apparent that many of his previous symptoms of conduct disorder, mood disorder, and ADHD were actually secondary to PTSD. Providers and loved ones were left to wonder "what if"? What if he hadn't had this form of treatment? Would he have been destined for escalating involvement the Juvenile Justice system? Would he have been considered a "bad kid"? It was through the healing process of a WTP that we saw that Johnny was truly a Winged Heart – that his life was and will be a life of healing, promise, and hope.

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A Theoretically Anchored and Multi-Modal Treatment Approach in an Outdoor Behavioral Healthcare Program

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Abstract

This case study is about a 16-year-old male treated for oppositional behavior, emotion dysregulation, family conflict and academic underachievement in an Outdoor Behavioral Healthcare program. The three primary goals for the functional approach to treatment were: 1) Work through the client's resistance to engage and participate openly in treatment and the group process, 2) Engage in age appropriate behaviors with peers and authority by maintaining empathetic relationship with peers, staff, and therapist and, 3) Improve family relationships. One year follow up data is provided.

"David" was a 16-year-old Caucasian male from a European country. He was referred to treatment at RedCliff Ascent, an Outdoor Behavioral Healthcare program, for oppositional behavior, emotion dysregulation, family conflict and academic underachievement. David's parents reported he was being referred for treatment due to "total oppositional behavior at home." They reported that David had been out of school for six months and refused to return. He had refused counseling. David was spending most of his time play video games, and when the video games were restricted, David became emotionally volatile and threatened to harm himself. Prior to being placed in treatment, David was reportedly not speaking to his parents and refused to engage in activities (e.g., school, sports, travel, work).

David's parents reported that, until months prior to his placement, they had a close relationship with their child. David's mother, Juana noted that her family was highly affectionate and that, throughout childhood, David had reciprocated the affection. Charlie, David's father, described his relationship with David as close, however, he noted that as his relationship with David deteriorated he spent more time at work to avoid conflict.

David's parents described him as being intelligent and academically gifted, as evidenced by his acceptance in a highly prestigious high school academy. They noted that David was also a talented athlete.

David was diagnosed with depression one year before entering treatment. He received outpatient counseling and medication for the depression. In addition to depression, a psychiatrist suggested that David may have Autism Spectrum Disorder, Level 1, which was of a type that, prior to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013) was considered Asperger's Syndrome. However, David's parents noted that the diagnosis was never formally assessed and diagnosed.

Three months prior to being referred for treatment David's parents required that his video game use be conditioned upon positive engagement in life, outside of gaming. In response, David became highly oppositional. He refused to attend school or any participate in other outside activity. David had lost his scholarship and status at his prestigious school. He refused to communicate with his family and even

refused to leave the couch. His parents noted at time of admission that David had not left the couch for the two previous months, even to bathe. They believed that he took that stance in an attempt to persuade his parents to return his gaming console.

DIAGNOSIS/ASSESSMENT AND THERAPEUTIC GOALS

When David arrived for treatment, his parents identified three treatment issues. First, they were concerned about his isolating behaviors. They noted he was in a "deep hole" socially. He had lost his school placement, which he worked hard to obtain. He has lost his friends and was currently pushing his family away. Thus, the family's hope was that David would reengage in daily life and activities that would lead him to be an independent and self-sufficient adult. Second, they wanted David to improve his relationships within the family. Historically, the family had close relationships. They wanted to be able to interact without argument or manipulation. Third, they wanted David to be more flexible and open to others. His parents noted that David did not compromise or negotiate. If David wanted something he would be persistent until he obtained what he wanted.

When David was asked about his treatment goals he said, "I wanted to teach my parents they cannot control me." He said that he wanted to deal with his problems and resolve them independently. David denied feeling depressed, addicted to gaming, or having Asperger's syndrome. When asked about past treatment, David noted that he has been treated for depression, which he described as "unnecessary". Furthermore, he said that his prior treatment for gaming addiction was flawed because it was "not a real disorder". Last, he noted that the assumption that he had Asperger's disorder was "incorrect." David noted that he wanted to focus on his lack of motivation in school and work.

Psychological Testing

David was referred for psychological testing to establish treatment and aftercare recommendations. The testing showed that David fell within the high average to superior range across all domains on the Wechsler (intelligence) tests. His academic achievement scores fell within the very superior range for math and vocabulary subtests. Perceptual and motor tests investigating organization and sensory input and output were within the norm for his age group. Indicators of mood disturbance and eccentric personality characteristics were evident on personality inventories. Particularly noted was a passive-aggressive tendency and a tendency to be ruminative and obsessive. Depression was evident throughout the testing. David did not meet criteria for Asperger's Syndrome based on testing; rather, his presentation was consistent with avoidant personality features, coupled with obsessive tendencies, as well as major depression, school, parent – child relational issues and transition to adulthood difficulty.

In light of David's negative reactions to labels and diagnoses, a functional approach was taken in his treatment. This was done by deemphasizing the treatment of diagnostic labels and, instead, focusing on improving his personal, family, and social functioning.

The three primary goals for this functional approach to treatment were:

1. Work through the client's resistance to engage and participate openly in treatment and the group process
2. Engage in age appropriate behaviors with peers and authority by maintaining empathetic relationship with peers, staff, and therapist
3. Improve family relationships

Ongoing Assessment of Treatment Goals

Many assessment tools were used to track David's treatment progress. Miller, Duncan, Brown, Sorrell and Chalk (2006) found that ongoing treatment assessment can significantly improve treatment retention and outcome. This technique of using scheduled, repeat administration of assessment measures is called progress monitoring. The goal of progress monitoring it to use assessment data as a source of "real time" clinical feedback to the client and to incorporate that feedback into treatment plans (Goodman, McKay & DePhilippis, 2013).

Both goal attainment measures and process oriented feedback measures were used to monitor David's treatment progress. Goal attainment measures are used during the treatment process to track progress on therapeutic goals. Two goal attainment measures were used. First, was the Outcome Rating Scale (ORS). The ORS is a valid and reliable instrument which measures 4 areas of client functioning a) individual, b) interpersonal, c) social, and d) overall (see Appendix, Graph 1, Campbell & Hemsley, 2009). For the second goal attainment measure, we created and administered an individualized staff report scale based on David's treatment goals (see Appendix, Graphs 3-5). The issues measured in the staff report scale were a) "acknowledgement of issues leading for need to be in treatment" (treatment goal 1), b) "commitment to participating in the group community in a responsible manner" (treatment goal 3), and "commitment to allow parents to function in the role of parents (treatment goal 4).

Multiple studies have found the therapeutic alliance to be a critical component of treatment outcome (Orlinsky, Ronnestad, & Willutzki, 2004). The process oriented feedback tool that was used to track the therapy process was the Session Rating Scale (SRS). The SRS is a valid and reliable instrument used to assess and track the therapeutic alliance (Duncan, Miller, Sparks, Claud, Reynolds, Brown & Johnson, 2003). The SRS measures four aspects of the treatment process a) relationship (therapeutic alliance), b) goals and topics, c) approach or method, and d) overall (see Appendix, Graph 2).

Finally the Youth Outcome Questionnaire 2.01, a standardized measure of global functioning, was used to track treatment gains (Ridge, Warren, Burlingame, Wells & Tumblin, 2009). It was used to establish a baseline of functioning at admission and to track functioning six months and one year after treatment (see Appendix, Graph 6).

TREATMENT

Initially, David was highly resistant to treatment. When David arrived he continued with his pattern of disengaging as a form of passive resistance. In the first session, David stated that he would not participate in treatment. David said he intended to "wait my parents out" believing that, eventually, similar to past experiences, they would give in. However, David was careful to note that he did not intend to be disruptive to his treatment group; he only intended to disrupt his parents.

Resistance

In order to prepare David for treatment, his resistance needed to be addressed first (Sherwood, 1998). In fact, Walsh and Golins (1976), in describing the Outward Bound Process Model (OBPM), identified motivation as the "primary condition" and "crux" of an effective wilderness experience.

Building a working therapeutic relationship was a slow process. David was quite invested in convincing me of his "correctness" and the "errors" of his parents. This caused noticeable strain in the therapy sessions (see Graph 1, "Goals and Topics" and "Method or Approach"). A careful balance was necessary to avoid being seen as a threat, thus pushing him away; while also avoiding to validate inappropriate behavior, which he was seeking. To do this, techniques from Lundberg and

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Lundberg (2000) were used to listen, reflect, and ensure that David felt heard. His emotions were validated without validating negative behaviors or decisions. For example, when David discussed not communicating with his parents for months, his feelings were acknowledged and validated with a response such as, "David you must have been very frustrated with your parents during those months."

The next part of working through David's resistance was setting healthy boundaries. David was skilled at "doing nothing" which caused his parents great anxiety and which, in turn, led them to give in to David's demands. Family therapy was a critical component at this point. During this time of treatment David's parents were learning to differentiate from their son. They learned to validate without taking responsibility for behaviors and emotions.

Finally, intervention was needed to disrupt David's pattern of disengaging. David was very good at getting others to resolve his problems. When someone set a boundary with him he tended to disengage until the boundary was removed. One of the ways this pattern was disrupted was through letter writing. Letter writing was the primary form of communication between David and his parents. Interaction patterns were identified in the letters. His parents learned new ways of responding to David. David's parents also learned how to match David's level of investment in the relationship and David experienced his parents in a new way.

Ongoing Treatment

In the fourth therapy session David stated he wanted to "try something different." He noted that he was not happy with his current situation and current relationships. That week David set his weekly goal to do what he "needed" to do regardless of what he "wanted" to do. David began to engage in the wilderness curriculum. This was noteworthy because this was one of the first moments David showed flexibility in response to his environment.

In the weeks that followed, David began to meaningfully engage in group and individual therapy. He was increasingly receptive to feedback from his peers, field staff, and therapist. He started providing helpful feedback to others. David became highly involved in the wilderness activities. David also engaged in family therapy using a narrative approach and communicated frequently with parents through letters (see Appendix, therapeutic goal tracking scores on Graphs 3-5).

Group Dynamics/Adlerian Therapy

Russell and Phillips-Miller's (2002) qualitative study with adolescent participants identified peer dynamics as one of the significant contributing factors to the success of wilderness therapy. David's treatment was consistent with this finding. David began to benefit from giving and receiving feedback and David's group became a space for reality testing and trying new behaviors. Below are some examples of group interventions used to accomplish David's third therapeutic goal of engaging in an age appropriate way with peers and people in authority (see Graph 3).

David participated in an experiential feedback group. Adler believed that human problems were social and interactive by nature (Carson, 2006). As a result, Adler viewed treatment in a group dynamic as the most appropriate model of helping. The experiential feedback group is an excellent application of Adler's model. It is designed to focus on group goals or group areas of struggle. The group was creative in developing tangible ways to give feedback. For example, they created a line in their camp with each end of the line representing a different end of a continuum. On one end would be "no trust." The opposite end would represent "absolute trust." Each member placed the other peers, guides and therapist on the continuum. They gave feedback as to why they were given their place on the continuum. They also gave constructive feedback on what they could do to move up the continuum.

In order to help the group interact with each other and better understand human interactions, David and his group learned a model called the "Ego States." The Ego States model is a developmental and communication model found in Transactional Analysis, designed to help people understand interactions with each other, using the constructs of Parent, Adult, and Child Ego States (Clarkson, 2013; James & Jongeward, 1996). In one activity, the Ego States role play, each member of the group was assigned to act in a way based on a specific dysfunctional Ego State. While they were role playing their dysfunctional state, the group was given an assignment to do, such as a camp chore or another experiential task. Afterward, the group would process what it was like working with someone behaving from a dysfunctional Ego State. The experience was then connected to interactions at home or within the family.

Wilderness Activities

A unique physical environment (the wilderness) provides the stage for the therapeutic and wilderness based activities. Walsh and Golins (1976) describe the unique physical environment as a contrasting environment that allows adolescents to "see the old" with new perspectives and options available to them. For David, this was a critical part of breaking free from "the old." After four weeks of disengaging, David adapted to his environment and began trying "something new." The resolution of dissonance is achieved by what Walsh and Golins (1976) call "mastery" or completion of a task.

Mastery is an important concept in David's treatment. Alfred Adler described mastery as the path to competency, one of the basic human needs (Carson, 2006). At discharge David identified two wilderness living and backcountry skills that contributed to his progress. The first was hiking. David became proficient at hiking. He and his group hiked far beyond what was expected of them, often 15+ miles. They hiked up the three major peaks within the program's field of operation. David did not need external influences to motivate him to hike; he was motivated because he had a superior control of the task or "mastery" of the task. This same phenomenon occurred with the primitive fire making methods. By the time David completed treatment he had bowed 10x the minimal expectation of fires, well over 100 fires. David completed these tasks not because they were required but because of the competence he experienced through mastery.

Mastery of wilderness living and skills is an important part of developing personal competencies. However, there is one area of mastery that is particularly important for the development of competence. This is the mastery of structure. David realized that he no longer needed to defeat the structure through disengagement. He began to follow rules and meet social and family expectations.

Satisfaction in the Mundane versus Entertainment

An important concept of the wilderness living activities is fostering motivation through finding satisfaction in the mundane. Most of the daily wilderness activities (i.e. chores, hiking, fire making, and wilderness curriculum) are not intrinsically entertaining. The tasks are designed to mirror life outside of the program.

Prior to being placed in the program for treatment, David struggled with the daily tasks of life. However, he was easily motivated by entertaining activities, such as video games. While in treatment David fostered motivation by mastering and finding meaning in routine tasks. Approximately ¾ of the way into David's treatment he mentioned during a session that he enjoyed the hikes. What had changed for David was not the activity, but his ability to find satisfaction in mundane activity. This same pattern was found in the primitive fire making and the camp chores. Second only to the role of the therapist and staff relationships, David noted that the hiking and camp chores were the most helpful parts of his treatment.

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"All truly great thoughts are conceived by walking" - Friedrich Nietzsche

Wilderness becomes a mirror for adolescents, a place of self-reflection. Treatment requires participants to look inward for comfort and solutions. While hiking David was left alone with his thoughts and feelings without distractions. David also participated in a 48 hour solo that included self-reflection assignments. At the end of the solo, David reported that he felt calm and content being alone. When asked about his reaction to the lack of entertainment, he commented that he was okay with the quiet and calm.

Narrative Family Therapy

Narrative Therapy was relevant for David's treatment for many reasons (Nichols & Minuchin, 2010). Logistically, many of the interventions of Narrative Therapy can be done at a distance. It involves storytelling and other concepts that theoretically fit in a wilderness living setting. The theory of change in Narrative Therapy is theoretically consistent with other approaches used in David's treatment (i.e., OBPM and Adlerian therapy). Narrative therapy helps individuals change their relationship to their life story and their family story (Morgan, 2000).

David was given structured assignments that guided him in "telling his story" in family therapy. These assignments were known as his "personal autobiography". In addition, each week Juana and Charlie were given similar assignments to tell the family story from their perspective. These assignments were called the "parent narratives." In all, eight personal autobiographies and parent narratives were shared. The autobiographies and narratives followed a developmental progression looking at different phases of life within the context of the primary developmental tasks at that phase. Clinical emphasis was placed on significant events that led to "problem saturated stories" (Nichols & Minuchin, 2010). In the end, David identified at discharge that the most valuable thing he had taken from his time in wilderness was how it "helped improve my family relationship" (see Appendix, Graph 4).

POST INTERVENTION, TREATMENT AND FOLLOW-UP

The parents spent two days in the field with David as a standard part of the graduation ceremony. During the graduation, the family participated in a multi-family experiential activity using Djembe hand drums which serve as a metaphor for post treatment issues. The sons were not involved in this activity: only family members were involved. The families went through a series of drum experiments. First, the families played with no structure or instruction. The experience was chaotic and unpleasant. The family members were then taught technique and given a rhythm to follow, called the "heartbeat." At that point, everyone played in unison and the experience was powerful. The heartbeat became the metaphor for the growth their sons had experienced in treatment. The metaphor was described as follows. Most adolescents and families enter treatment in a state of chaos. While in treatment they develop a "heartbeat" that allows them to be in harmony with their bodies, their peers, adults and their family. The heartbeat represents the skills, awareness, and competencies necessary for adolescents to manage themselves (intrapersonal functioning), their peers (social environment), their families (interpersonal relations), and societal expectations (behavioral functioning). The goal of post treatment and aftercare is to provide the optimal environment for the "heartbeat" to continue strong post wilderness.

Maintaining the Heartbeat

David and his family participated in a reunification ceremony in the wilderness field. The location was important as this allowed for the family to experience David in his newly mastered environment. David showed his parents many of the skills he had learned. They bowed on David's bow drill set, they

cooked on the fire together, and they joined in various other wilderness living activities with David. They reconnected with David through various group and semi-structured activities.

Graduation was a time of consolidation of learning for David. Generalization of learning is one of the challenging tasks in treatment. David participated in various activities to consolidate and apply what he learned from the program. The experience was powerful for the family. They agreed that their "time in the wilderness went by too fast."

Aftercare Recommendations

There were distinct, obvious complexities with this international placement. First, it was unsettling for the family to place their son away from their home, and additionally outside of their country of residence. However, David's father had been schooled in the United States and his family had lived and traveled the United States. Therefore, a long-term school placement in the United States seemed appropriate for David and his family. Second, the school would need to provide an academic 'bridge' to a university, either in the United States or their home country. They wanted to select a school that had a 'track record' of working with students who had his particular psychological profile. It was also important to the family that the school have the resources to support David's emotional and behavioral issues, including individual and community therapy, positive peer milieu, family/parenting input and counseling. Third, and most importantly, they wanted to select a school that did not discriminate against those experiencing emotional turmoil and embraced cultural and social differences.

An academy in Virginia was selected after spending hours of interviews and days of active exploration. David's parents were relieved. They also felt good about the quality of communication between the parties involved in the transition planning: the wilderness therapist, the psychologist consultant, and the therapeutic enhanced school. When David was informed of the decision he was nervous and scared. He wanted to return home to a familiar academic setting and the uncertainty of an American academy caused him to feel anxious. However, he was readily able to work through his fears and anxiety and arrived at the school open minded to the experience.

One Year Follow-up

At one year post treatment David and his family were interviewed about their emotional, social, and behavioral functioning. They were also asked about the treatment process. David started his response by stating, "I think the most important part of RedCliff to me was the space that I found there. I was in the most remote place I had ever been and I didn't feel like I had to be anything. Whereas before I was just whoever my parents thought I was. At RedCliff, I began to become who I am." David continued by saying, "I think (I learned) to sit with myself and being okay with who I am." David's parents noted that David "grew faster than he had done for years, he became mature" by learning "to take responsibility for his own actions, and he stopped blaming his past behavior on the people and circumstances around him." David's parents said that David "discovered he had important qualities to offer as a friend" and "realized that communication is key for success in life." Finally, they noted that David "learned to interpret and respond to other people's feelings."

David's parents noted that treatment was helpful for the family because it" helped us understand David, his concerns, his fears, and his needs." In addition treatment "made us think about our relationship with our son, and how our role might have had an influence in David's lack of development". Treatment helped David and his parents take full responsibility for their actions and "restored our roles as parents, … gave us reassurance that we could be good parents and that making changes as parents is not failing but the opposite" (see Chart 6 for follow-up assessment).

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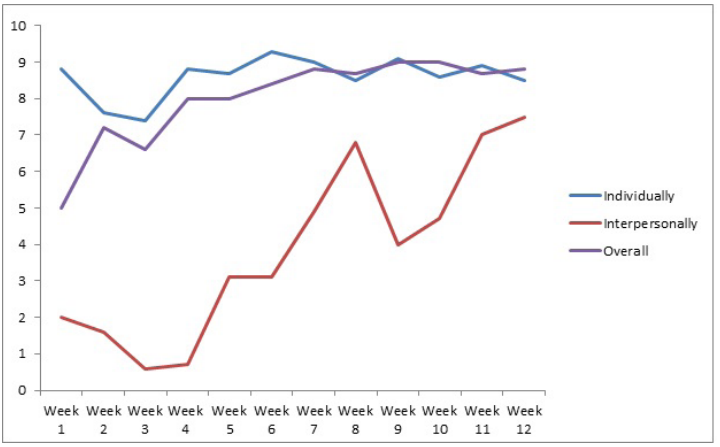
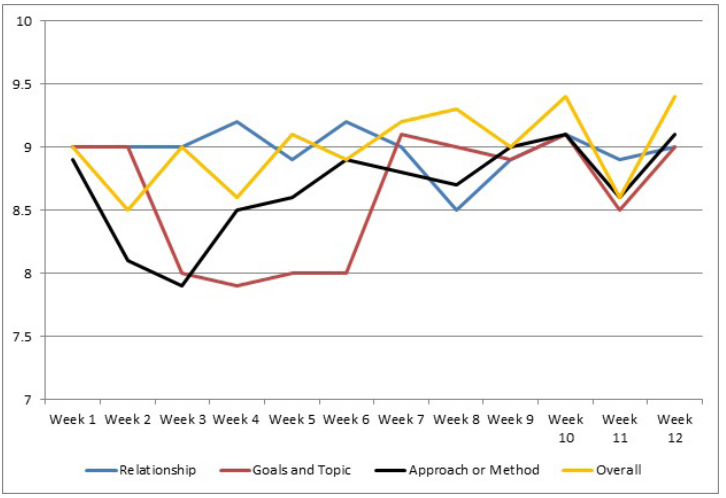
When David was asked about the aspects of the program that influenced him most he responded, "Definitely the people. One of my favorite parts of my stay at RedCliff was the environment, but in reality, the people are what mattered to me. When I was first at RedCliff I didn't want to do anything, but my friends were the first people to question that. Some of my friends there were students and some were staff, it made very little difference." David continued, "The main activity I remember was the lines [the experiential feedback groups]. I remember how impactful they were to me. They showed me how I was being irresponsible and where I was doing well. Most of the smaller groups were helpful too, because they helped me see that there were better choices available to me other than feeling like crap all the time. I personally loved hiking and solos, purely because I was passionate about them."

Appendix

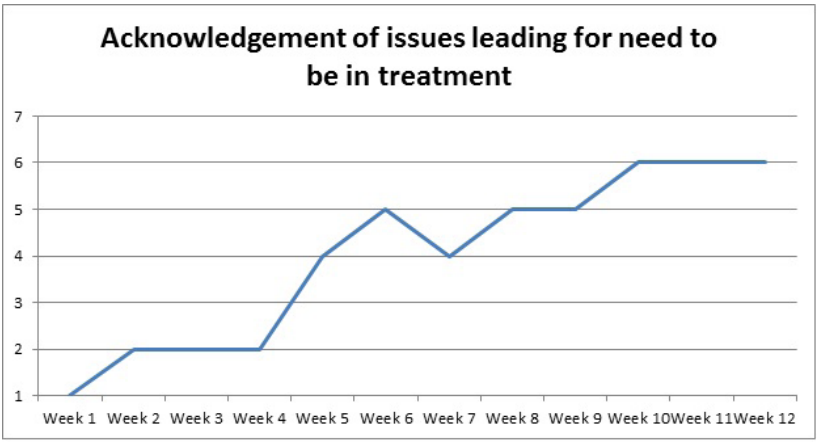
Graph 1. Outcome Rating Scores (ORS)



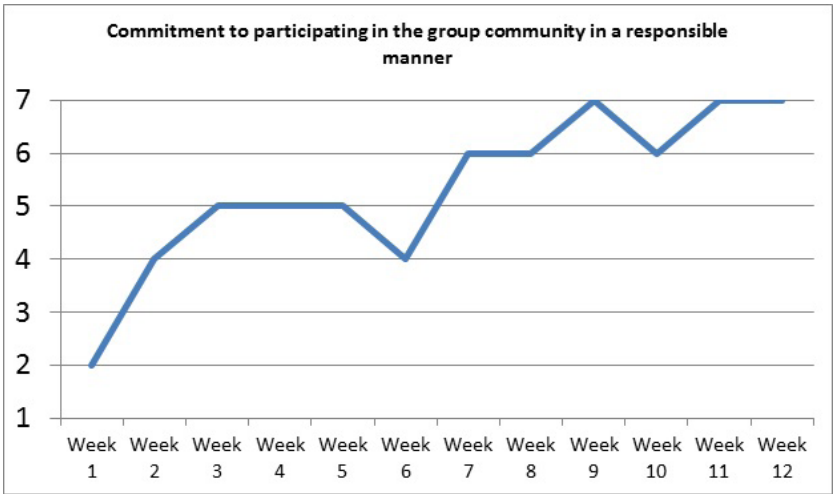
Graph 2. Session Rating Scores (SRS)



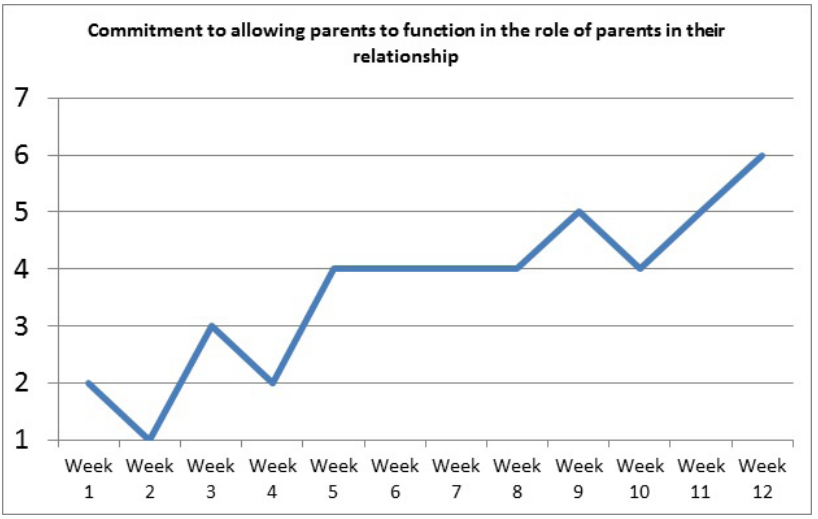
Graph 3. Clinical Rating Score. Therapy Goal 1



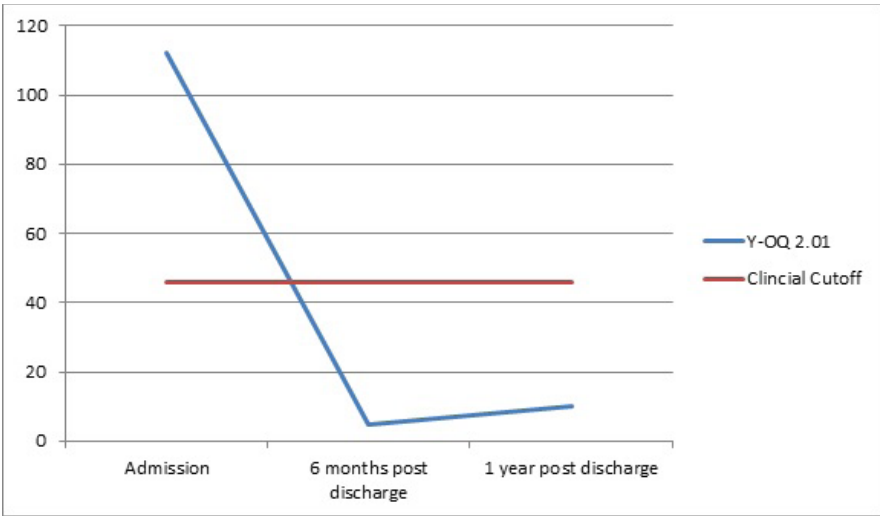
Graph 4. Clinical Rating Score. Therapy Goal 3



Graph 5. Clinical Rating Score. Therapy Goal 4



Graph 6. Youth-Outcome Questionnaire 2.01



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A Mother's Story of Adolescent Substance Abuse

"Elizabeth Douglas"*

**Pseudonyms are used for authors to maintain their anonymity due to the personal nature of the article.*

I am a mother of two children, a daughter who is 17 and a son ("Tom") who is 15. Their father, my first husband, died when they were 8 and 10. I have since remarried and my husband is a captain with the local police department. He is a career officer and has worked in juvenile services for many years, including a decade as the detective sergeant of family services. While we both knew raising teenagers together would be challenging, we had no idea just what "challenging" really meant until my son began to use drugs and alcohol. It has been almost two years since our first incident with Tom and I find myself grateful every day that my son is alive and healthy, my daughter is growing into a lovely young woman, and my husband and I maintain a close and strong relationship. My main purpose in writing this story is that I hope to help other parents who may be experiencing similar problems in their own family, as well as to give a parent's perspective to mental health and dependency treatment professionals.

At the end of 8th grade, Tom was turned in by another student for possessing marijuana on the school bus. I was in a meeting when I saw the school number flash on my cell and stepped out to answer the call. I couldn't really hear very well because of a bad connection but I got the idea. Stunned, I searched for a better cell connection and I will never forget what the principal said: "I have been doing this almost 15 years. I don't believe that Tom is guilty of this, there is no way." I desperately wanted to believe her. But he was guilty, admitted that the pot was his, and subsequently was suspended from school for a week. Our wild ride through the world of drugs, alcohol, and the mental health and juvenile justice systems had just begun.

Reflecting back, I knew something was wrong and I had for months (it's hard to pinpoint when a mother's worrying begins). It was difficult to decipher what was the portion of a typically moody adolescent claiming independence, and what was the part of an early indication of a serious problem. Did he pull away from the other neighborhood children he had played with since he was a toddler because he wanted to form new friendships outside of my close-knit social circle or was it for some other reason? When did he start hating school and all his teachers so much? It seemed as though several days a week I was fielding phone calls and email from the teachers and school administration. Tom was disruptive in class, he didn't do his assignments, and he was too busy being the class clown to get any work done. He routinely lied about assignments (e.g., "No homework again?"). When did my son get so elusive and angry?

At the end of his 8th grade year when he was caught with marijuana, we struggled to do the right thing. I had always maintained a structured home where appropriate rules and consequences were administered. He increasingly chafed under any authority at all, even arguing when I asked if the home he was visiting was supervised and turned furious when I called the parents to find out myself. There were two school-based consequences to the marijuana incident: community diversion and a LADAC (Licensed Alcohol and Drug Abuse Counselor) evaluation. Tom was required to attend an 8 week community-based drug and alcohol education diversion program. My personal opinion is that this well-intentioned early intervention program was a complete and utter waste of time. Not only did all the kids simply sit in the chairs and restlessly wait for the end of the two hour, $400

class, but I believe it turned into a counterproductive social networking opportunity. Tom graduated knowing more about drugs and alcohol, who used them in his community, and more knowledgeable on how to get them than he did when he started the class. The findings of the required LADAC assessment were equally terrifying: it determined Tom was at high risk for using drugs again because he simply didn't see anything wrong with doing so. This was the core of a battle we would fight over and over. In the months before we pulled him out of public school and placed him in a wilderness therapy program, he just would not stop using and saw no compelling reason to do so. He was unafraid of authority. He was not going to be "scared straight."

Over the summer and ensuing months, Tom grew more and more angry, moody, and seemed to lose interest in almost anything except his friends. He would no longer read books, go anywhere with us, etc. He would not even go into the same room as any other family member or sit at the dinner table without a major battle. He didn't really enjoy sports anymore and demanded to quit the lacrosse team. He begged to be assessed for ADHD, which I resisted. I simply thought he needed to show more discipline in his school work. However, the LADAC professional discussed this with me and encouraged me to have him assessed, as there is a high correlation between early drug use and ADHD. I certainly didn't want to be closed-minded because of my own feelings that ADHD is over-diagnosed—after all, I had been wrong before! I reviewed the research and this correlation seemed valid, so I had him evaluated by the psychiatrist.

This was done through a series of surveys to the child, parents, and teachers. I was called in to review the results, which the psychiatrist said were "compelling." I looked at the "compelling" evidence and I saw what I thought to be marginal results for ADHD behaviors. Not one teacher had ever mentioned ADHD before. Like me, they believed Tom simply preferred not to pay attention and liked joking with his friends more than math class. However, I was pushed by Tom, the psychiatrist, and my own sense of wanting to do something – anything - to make things better. We decided to give a low dose of the medications a try. The drug of treatment choice, Vyvanse, did seem to help with the mood swings at first, although he later grew more aggressive and I wondered if this behavior was in part due to the side effects of the Vyvanse (i.e., Lisdexamphetamine).

Our lives became worse when high school started in the fall. Beginning in October, Tom's drug use, mood swings and deviant behavior started to escalate. I began to regret agreeing to the ADHD treatment when I learned by reading a text message from one of his friends that he was pocketing the medication and selling it at school. I put an end to that, hiding it in my room and literally placing the medication in his mouth each morning. I kept an inventory of the pills. Having a drug with high street value in our home was one more maddeningly stressful element of our lives. We took away his cell phone permanently. He started football, once his favorite sport, but was routinely seen cutting or going late to practice. He showed up high to the last game of the season and broke his thumb during the last play of the game.

We began to suspect Tom was using marijuana on a much more frequent basis. Although wildly popular at school, his peer group changed exclusively to kids I knew smoked pot (and more) on a regular basis. One of his friends overdosed on mushrooms and another on ADHD medication. Tom failed a home drug test for marijuana, and was put on restriction until he passed. He asked twice to have another home urinalysis to prove he was clean, and both times I discovered that he faked the results (once with urine that wasn't his and once with warm, dyed yellow water). When I asked him to turn his pockets out before the second home drug test, a $50 bill dropped to the floor. I began to get more and more alarmed and had a terrible sense that I was losing my son and there wasn't one thing I could do to stop it. He just didn't seem to care about doing the right thing, respecting

authority, or following the simplest rules. His grades went from bad to worse, and he failed a course because he didn't like the teacher and refused to complete the work.

His teachers began to call and email on a regular basis that he was disruptive, disrespectful, and inappropriately aggressive in class. He was sent to the principal's office on a regular basis, and by the end of the winter he was missing hours of class. I apologized so many times to the school staff they probably stopped reading my emails. I began to notice that petty cash was missing from my wallet and Tom's sister began to report her babysitting money was gone. He took his new (Christmas) iPod to school against my wishes and when pressed on its whereabouts, he told me that it was "stolen" from his locker. I suspect that he traded or sold it.

His behavior began to worsen still. He changed his morning routine, leaving early, skipping breakfast, and rushing out the door to meet friends. I found out he had begun to stop at a friend's house on the way to school to meet a group of boys to smoke pot. His language and behavior became threatening, intimidating, and even menacing. He is a big kid—at 14 he was 5'10" tall and 175 pounds. He used his size to scare us, screaming and swearing at all of the family. He began to come and go as he wanted, telling me to "fuck off bitch" when I told him "no." He destroyed his bedroom, taking a golf club and smashing holes in the wallboard. He broke two wooden doors, four telephones, and the TV remote. The police - my husband's employees no less - were regulars at our house. Every time Tom opened the front door to come home, my stomach clenched and I felt myself hold my breath. I was in complete overdrive because of stress, fear, and the unknown. Would he be angry? High? Would he threaten us? Or would he just go to the TV room and refuse to interact with us the rest of the day? School was a nightmare. Once he was caught cutting class to get high. When he was returned to campus, the principal gave him a detention. When he was given Saturday school as a consequence, and he proceeded to shred the write-up and throw it at the principal while screaming and swearing at him. He routinely received detentions, Saturday school sessions, and suspensions. Nothing slowed him down or gave him pause to consider the consequences of his actions. He had no remorse for his behavior.

In November of his freshman year he was arrested for possession of marijuana. The prosecutor filed a juvenile petition for drug possession and a CHINS (Child In Need of Services) petition for his behavior at home and school. We went to court, my first interaction with the juvenile legal system. I am grateful every day that I had my husband to help me navigate the complex and completely foreign world of the juvenile legal system. For example, it never would have occurred to me that we should hire a defense attorney for him until my husband told me it was part of the process. We had to pay legal bills with no information and no input—in fact, by following the mandates of his job the defense attorney often worked against us. As a parent, it was the first time I experienced being a bystander in the outcome of a serious event which would affect the life of my child. During the hearing, I sat quietly in the galley as Tom, his defense attorney, and the prosecutor made their case. No one asked me any questions. He pled "not true" to the juvenile petition and true to the CHINS. We had been prepared that the State would ask for placement, as it was felt by the prosecutor he might benefit from being removed from our home for a period of time. However, the judge met with him for over a half hour in chambers (which was highly unusual), and determined that with support services he could come home. Tom was given probation for a year and his juvenile petition was placed on file. We were assigned a probation officer and home-based family counseling services. We were required to find him an individual counselor (previously he had always refused to go) and the court ordered a new psychiatric evaluation.

A MOTHER'S STORY

All of these things worked for a while. Tom was drug tested and stayed clean. He obeyed curfew, stayed away from the friends from whom he was court ordered from having any contact, and was courteous to his probation officer. While he deeply resented us his aggression lessened somewhat. A new psychiatric evaluation determined that indeed he did not have ADHD, and the psychiatrist withdrew the Vyvanse and Tom was placed on a low dose anti-anxiety medication that helped with the mood swings. No one was able to answer if the Vyvanse contributed to the anger and aggression and his seeming inability to control it, but these symptoms improved when he was taken off the medication. He participated, albeit reluctantly, in family therapy.

Through all this, what I missed was that Tom was passing the drug tests because he was drinking. I was always looking for signs of marijuana use, but I was wrong. Yet as we moved from winter into early spring, I knew something was wrong and I worked obsessively to figure out what it was. I researched the side effects of mushrooms, which I knew could not be tested for in a urine kit. I even contacted a national expert on psilocybin through my research connections. I described Tom's behavior and he told me in an email, "nope, not mushrooms." Reflecting back, my only hint was that he wore cologne. I took it away, but it kept re-appearing. Then my husband came home early one Saturday afternoon and found Tom and a friend, passed out on his bedroom floor with a bottle of vodka next to them. I had literally been gone for 45 minutes when he came home and found the boys. It was March.

I knew something had to happen or we were going to lose our son. The principal mentioned in passing about having worked at the National Outdoor Leadership School, and that maybe a program like that would help him. This was the first idea that I thought, "Okay, that makes sense." So I did what I do best: I researched, read, emailed, and asked. I finally connected with faculty who evaluated wilderness programs. When I talked to admissions staff and read the websites of some of the highly regarded programs I was stunned: Many of the case studies described my son. I contacted the one most highly recommended program and arranged his intake.

We went to the high school at 9:30 on a Tuesday morning; the probation officer called early that morning to say the judge had signed the order allowing him to be placed in private treatment. I had taken the day off and we had packed his things after he left for school, put them in the back of the van, and drove a surprised, sullen, and angry Tom for 2-1/2 hours to begin his wilderness program. When we pulled out of the driveway of the treatment center I felt an immense sense of relief. For the first time in months I was not going to worry where he was, what he was doing, and who he was with. He would be safe.

Tom confessed later he entered the program intoxicated. I have to admit, we just didn't understand how bad it was and I am not sure we ever will know everything that happened. Over the next weeks in the program, Tom slowly began to improve. He responded well to the structured environment of the program. We had weekly conference calls with the therapist and Tom, who became less angry as the weeks passed. Over time he became an active and engaged participant in the program, and seemed proud of his newly found wilderness skills. The staff truly liked him. He stopped talking obsessively about drugs and started to think about the future, particularly about wanting to go to college. Surprisingly he began to realize that he could not go back to his high school and his old friends, and he agreed to research boarding schools with the staff and other students. Our conversations were not continuous arguments about privileges he wanted restored when he returned, or obsessions about the friends he left behind. The program moved him from a dedicated drug user to someone who wanted to have a future, and when he made mistakes he contemplated the consequences of his actions. I believe the combination of a high staff ("guide") to participant ratio, the demand for accountability

in all aspects of the program (e.g., outlining their own treatment goals, packing their own backpack, doing assigned chores), and the intensive and relentless group and individual therapy were key elements of the program. The staff were excellent and clearly able to connect well to teenagers. As he progressed through the levels of the program, he was able to assume more responsibility, until he told us proudly on his last week that he had planned a "tough expedition" for his team. Tom later told me that he didn't think a "pure wilderness" program would have worked for him. "I would have just been pissed off that I was in the woods all the time. I needed wilderness and the program at the center," Tom later told me.

He graduated from the program in six weeks and transitioned into the program's school and therapy program. Altogether, he was in treatment for three months. There was one interesting occurrence at the end of his stay at the program. He had graduated the program, successfully completed the school year, and was looking forward to coming home. However, his behavior became more and more confrontational, agitated to the point I believed that he was in danger of relapsing at home and losing all of the hard-won progress he made. Reluctantly, I went to pick him up and when I was 15 minutes away, I received a call from the lead clinical therapist—himself quite surprised, indicating Tom wanted to stay another week. It seemed this behavior was attributed in part to his own internal conflicts about being home and using substances. This was a real turning point in Tom's ability to recognize the magnitude of his dependence on drugs and alcohol. He told me he had an "epiphany" and wanted to stay until he felt more ready to transition home.

At his graduation ceremony I could not believe all the wonderful things his guides, therapists, teachers, and peers said about him. They talked about his sharp sense of humor, his intelligence, and how he was a great leader and a peer they could look up to. Tom spoke of his time at the program and how he felt he had changed, and chose a single parting word to describe his time in the program: "brotherhood." He chose this because he felt his team were brothers and were always there for each other. I wept not only because he made such amazing progress, but because for the first time in years I was hearing really nice things about the son I love so much. The day he was discharged he came home, and for the first time in two years we spent the afternoon together. We talked and laughed, and at one point over dinner he said how very sorry he was. That wasn't why I sent him to treatment, and it wasn't what I needed to hear—it was the fact that he finally had empathy for those around him. And one more thing that I thought was the most dramatic: when he went into his program, he had $20 which was kept until he was discharged. When we were shopping at Walmart, he picked out a pair of clippers for cutting his hair and asked if he could have them. I said, "sure." When we got to the counter he gave me the $20 to put toward the purchase without being asked. That he voluntarily gave me $20 and didn't hide it away to use for drugs was the most small, yet powerful indication that he had started to change.

Learnings to Share with Others

There are several things I learned from our experiences that I would share with other parents. First, if you think something is wrong, there is something wrong and it's probably worse than you think. Follow your instincts and don't listen to people who give you some version of "kids are kids, they outgrow it." That is true, some kids do. But be honest with yourself and about your child's problem. Assess if your child's behavior is a phase or if your child needs help to quit. No matter how much of a problem your child has with addiction or other issues, no expert knows your child better than you do. Don't let things continue because your kid has convinced you that you are "crazy" or "irrational." At the height of his substance abuse, these were Tom's favorite words for me. Address each and every thing when it happens, no matter how exhausted it makes you.

Second is use your connections. Get to know other parents, teachers, and community members and talk to them. Ask people to share any suspicions and be open to hearing negative "rumors" about your child and his or her friends. We caught Tom skipping school to get high one day because a neighbor happened to be home and saw him walking up the street with a friend he knew used drugs. He texted me immediately, and Tom was caught within 25 minutes of leaving school (the school did not yet know he was gone).

Third, if you allow your child to use Facebook, require that you are their "friend." Many children leave their privacy settings on low, and you'll learn a lot about what your child and his or her peers are doing in their spare time. Information is power, even if it is painful.

Fourth, do not wait to act or think it will get better. It won't. One reason I believe that Tom was able to make these changes, or that the treatment "worked," is because he was so young and we caught his problem relatively early. Many parents wait until the child is in their late teens when the family is finally so desperate there is no other conceivable option. That's more years of using, which makes it much harder to quit.

Fifth, think hard about what kind of program might work for your child. Conduct extensive research, get referrals, and ask to talk to other parents who had a child go through the program. Take this very seriously. These programs are exceedingly expensive, often not covered by insurance. You want it to be the right fit for your child and your family. After careful research, I chose wilderness not because it would be tough or make my child "think twice about the comforts he has," but because my son is a physical, athletic child who I knew could be successful in wilderness. In my opinion, he needed success to start to feel good about himself and begin to work on his addiction issues.

Sixth, and the most difficult thing I would say: *You cannot put your child through treatment and then put them back in the same community or school with the same friends and expect different results.* I do know two other parents who did so, paying for expensive wilderness treatment with dramatic results, only to see the changes erode almost immediately when the child returned to their old crowd. As the secretary of my son's school told me, "He can't come back here, the other kids really just wait for them to get out of treatment." In many ways, having my son attend boarding school is the only option for him—our family can't move to a different community, although it breaks my heart to have him live away from us. But I would rather have him sober and away from home than being at risk of making life-altering choices which threaten his future.

Tom is only 15 and I know we are far from "out of the woods." The parties, the pressure, and the lure of drugs and alcohol will be everywhere around him. But I know we won't ever go where we were before. Under his own initiative, Tom selected and enrolled in a private boarding school this coming fall and wears his new school shirt with pride. We took a family vacation to visit prospective colleges for his sister and it was actually fun! These everyday things, these simple pleasures are hard won and I intend to enjoy each single day with my son and my family

A Modern Application of Transactional Analysis in an Adventure Therapy Milieu

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Abstract:

This case example describes the use of an adaptation of Eric Berne's Transactional Analysis (TA) with a highly-resistant 17-18 year-old male client in an adventure therapy program (the client entered as an adolescent and turned 18 while in treatment). Through TA the client learned to identify his ego states and thereby developed a proficiency at recognizing faulty thinking and problematic motivations. Upon admission, the client expressed that he'd become frustrated with his inability to sustain quality friendships and that his relationship with his parents was wrought with problems. The client's family and other professionals recognized that he was dealing with a budding addiction to drugs and alcohol and that he was showing co-occurring signs of mental illness. The TA model enabled the client to more effectively and efficiently analyze his primary relationships, analyze his motivations and decision making, and also helped him to devise and implement strategies for improvement.

Transactional Analysis (TA) is a model developed by Eric Berne in the 1950's and popularized by the broad dissemination of his book **Games People Play** in the 1960's. The TA model is comprised of six ego states (ES) all of which are typically evident in human transactions as early as the age of three. Each ego state is defined by a set of motives, perspectives, and cognitive patterns. Once an individual learns to identify his/her current ES, he or she can swiftly identify problematic assumptions and motivations that are guiding personal decision-making.

The following description of TA is the authors' adaptation of Berne's methodology developed over the past 13 years. Most adjustments to the labeling and description of the Ego States were made in an attempt to lead clients into a more intuitive comprehension of the model and the underlying dynamics between the different states. Parenthetical references are added below where an adjustment to Eric Berne's original language has been made.

Primary Assumptions about the Ego States:

1. Five of the six ego states are critically flawed in perspective, motivation, and thinking. They function as "unreliable narrators" and skew decision-making. Remaining in the healthy Executive ego state is the most efficient and effective path for relationship development.
2. When a person is in the Executive ego state his own chances for successful endeavors and relationships are highest.

Ego States:

Natural Child

Primary Motivation: Feel good now

Perspective: Limited to the immediate past, present and the immediate future

Typical Behaviors: Neglecting responsibilities in order to have fun. Self indulgence. Tantrums, pouting and outbursts.

Assumptions: Happiness can only come from feeling good now. To feel bad is to be unhappy. Feeling good now should come at any cost.

Rebellious Child

Primary Motivation: Resist and challenge authority

Perspective: Limited to the immediate past, present, and the immediate future

Typical Behaviors: Arguing, aggression, hostility, arrogance, disregard for the feelings of others.

Assumptions: True freedom is to be without rules. Rules are oppressive and rob you of your identity.

Chameleon (Adaptive Child)

Primary Motivation: Avoid conflict. Hide from being known.

Perspective: Limited to the immediate past, present, and the immediate future

Typical Behaviors: Unquestioned compliance to the expectations of others (particularly significant others or those in a position of perceived power)

Assumptions: Conflict is dangerous and destructive. It will be worse for me if people know how I really think and feel.

Critical Parent

Primary Motivation: Bring a sense of order to perceived chaos.

Perspective: Deep into the past and present, and far into the future.

Typical Behaviors: Use of sharp sarcasm, condescending tones, aggressive or hostile language or body posture, objectification of others.

Assumptions: Because I'm right, I don't need to be bothered by how other people feel. Because I'm right, you need to do what I think is right. My needs are more important than your needs.

Enabler (Nurturing Parent)

Primary Motivation: Reduce the suffering of others (in reality, reducing their own suffering)

Perspective: Deep into the past, present, immediate future.

Typical Behaviors: Unable to hold and maintain boundaries when others appear to struggle, disallowing others to meet life's challenges on their own terms, over-involvement in the lives of others.

Assumptions: It is harmful to struggle. I am a good person as evidenced by my helping nature. I will be happier if everybody around me is OK.

Con (Little Professor)

Primary Motivation: Get what you want

Perspective: Far into the past, present, far into the future

Typical Behaviors: Lying, cheating, coercing, manipulating, disregarding the needs of others unless doing so improves the quality of the con.

Assumptions: That morals, ethics, and the needs of others are interfering with getting what you want and deserve. The ends justify the means.

Executive (Adult)

Primary Motivation: The win/win. Finding balance in decision-making that includes the needs of others, ethics/morals, and wisdom.

Perspective: Far into the past, present, far into the future.

Typical Behaviors: Treating others with respect, patience, and kindness. Considering history, current circumstances, and possible ramifications for the future.

Assumptions: Doing things thoughtfully, honestly, and with respect for others is the only path to happiness and life satisfaction.

Case Example

Identifying details have been altered to protect the client's confidentiality. The client requested that the authors use the alias Brick or Blade in place of his real name. The authors chose Blade. All other names and other identifying details have been obscured to protect the family's confidentiality.

Blade entered the adventure therapy program as a Caucasian 17-year old male. He was the oldest of three sons and two younger daughters, raised by still-married parents in an upper middle class home in the central United States.

Blade's father is a successful, Ivy League educated Caucasian male, with close ties to his community. He is dedicated to his role as a father and is active and present in his family's life. Like many parents with struggling children, Blade's father hoped that his son would meet or exceed normal developmental milestones, and he struggled with the idea of having his son in treatment. He acknowledged that, at times, he could err on the side of being too firm with his children and preferred a more control-oriented approach to parenting. It was the therapist's view that his successful career was due, in part, to being quite good at bringing order and decisiveness to chaotic situations. It seemed sensible that Blade's father would prefer to play to his strengths as a father as well as a professional.

Blade's mother, an attractive and intelligent Caucasian woman, chose family over career. As a deeply introspective woman who has achieved significant insight into her own motives and into the mechanics of her relationships, she self-identified as sometimes being too closely involved in the lives of her children. She listened carefully to the many professionals that she'd worked with in the past and had developed an impressive ability to absorb, process and apply the skills she'd been taught.

Both parents were counted by the clinical team as assets to Blade and their involvement and continued dedication to their son proved to be most valuable. Blade, however, would probably disagree with this evaluation.

Blade, also a highly intelligent and articulate young man, was physically fit and attractive. He was a talented athlete and had done well in school formerly but was struggling academically due to anxiety and drug and alcohol abuse. Though he'd experimented with other drugs, his habitual use had not progressed to intravenous or powder drugs. At the time of his admission to the adventure program

he acknowledged that his pot smoking had gone out of control. He didn't recognize that he had a problem with alcohol and did not believe that he was an addict. When asked in the initial interview to describe what he wanted to accomplish during treatment, Blade responded that he desired to learn better relationship management, to address his selfishness, to prioritize his schooling, to manage his impulsivity and to go to college.

In the few years prior to admission to treatment, Blade had become more preoccupied with smoking marijuana and partying. His athleticism had declined as his attention was diverted to other matters. His grades had fallen and he was struggling both socially and academically. Additionally, Blade had inherited a degenerative eye condition that prevented him from meeting the minimum legal requirements for obtaining a drivers license. This condition proved to be a significant obstacle for Blade as he began to feel developmentally behind his peers without autonomous transportation. Blade began to blame his parents for his condition and treated them with an increasing sense of entitlement... as though they owed him for dealing him such a poor hand.

Blade's parents had grown increasingly concerned for his welfare and also for the welfare of their other children who were being influenced by Blade's example. It appeared that Blade was having a profound influence on the culture of the family, as one of the other boys had begun to use marijuana and pills, was dismissing his parents in a similar style to Blade, and had also begun to struggle academically.

Blade had been involved in outpatient therapy before and had been prematurely discharged from a treatment program just prior to his present admission because he ran away and was too disruptive for the treatment milieu.

His mother described the reason for Blade's immediate placement: "Our relationship has grown increasingly strained due to Blade's defiance, disrespect, disregard of house rules all which are related to his continued abuse of marijuana and alcohol. Attempts to repair the relationship typically end when a consequence is enforced. Blade feels we are over reacting and does not see he has a problem. I believe he senses my disappointment with the above behaviors and his lack of achieving even a minimum academic standard. It's been extremely difficult to foster a positive relationship without him meeting me half-way with the most basic of expectations."

In the initial interview Blade appeared to be open and honest. He explained that his drug use had become problematic and that all of his primary relationships, including parents and friends, were very strained. He reported that over the last year he'd been losing long-standing friendships because he was selfish and didn't care much for other people.

Blade believed that his parents were overbearing and that their primary intention was to control him. He treated his parents dismissively and only sought to nurture their relationship when he believed that doing so would result in physical benefits such as gaining access to transportation, cell phone, money etc...

Within the first two weeks of treatment it became clear that Blade intended to discharge himself from the program the day that he turned 18 (approximately one month after admission). He explained that his parents were essentially forcing him to be in treatment and that he was certain that he could make it on his own if only he were 18.

He openly acknowledged that though he felt confident that he could make it out in the world without his parents, he was sure that it would be easier to live with his parents. He recognized that if he were on his own he would spend much of his time earning a meager living and would have little time left for school. He was honestly motivated to finish high school and go to college. Blade maintained that the primary issue with his parents, was that they wouldn't let him smoke marijuana and drink alcohol like

"normal students", and that it was unjust that they would not allow him to live in their home or pay for his schooling while he was engaging in these activities. He desired to live at home but without any regulation of his activities.

Blade's parents clearly explained that he would not be allowed to move back into their home and receive financing for college unless he completed treatment and remained sober. Blade, with a smirk of confidence on his face, arrogantly stated on several occasions that though his parents were saying that they would hold this boundary, he was certain that they would be unable to turn him away if he were to discharge himself from treatment and show up on their doorstep.

Blade appeared to have developed a sense of identity based on his ability to resist and work around the rules and expectations of his parents, teachers and other authority figures. He arrogantly prided himself in his ability to dismiss authority figures and do whatever he pleased.

Case Conceptualization

Blade was admitted with a historical diagnosis of depression and anxiety. He'd worked with psychiatrists and had been prescribed several medications over the prior years with limited success in symptom reduction. He stated that he wanted to become better at managing his anxiety and that he believed his depression was a result of feeling anxious. He reported a pattern of feeling increasingly anxious in social situations, avoiding social situations to decrease anxiety, feeling lonely, and then feeling depressed.

Through analysis of the case history, client report, and real-time observations, the clinical team identified Blade as being in the contemplation stage of change regarding anxiety management. It was also believed that he was in the pre-contemplation stage of change regarding the parent/child relationship, frequency of drug and alcohol use, and incorporation of pro-social behaviors. The team theorized that the client's minor depression and increasing social anxiety were heavily influenced by his inability to establish and maintain healthy primary relationships. Consequently, treatment planning included empowering the client with evidence based strategies for managing anxiety and the use of TA to help the client re-conceptualize management of his primary relationships.

Analysis of the homeostatic family and social relationship dynamics revealed that Blade was most commonly found in the Rebel and Con ego states and consequently often at odds with significant others in his life. In the Rebel state his thinking became distorted and he openly argues from a position common to the Rebel, i.e., that rules and boundaries are the enemy, that any attempts to influence him were motivated by coercive interests, and that if he ever complied with expectations he would lose his identity. His Con and Rebel often worked in tandem to introduce a component of selfish deception into his relationships, thereby further distancing others by being commonly dishonest and sneaky in his attempts to meet his needs.

TA Introduction and Acceptance

Both Blade and his parents were introduced to TA. Blade quickly absorbed and responded positively to TA. Prior to treatment Blade had read many self-help and psychology-related books and had developed a strong ability to understand and integrate this type of information. He favored this intellectual strength and had successfully found personal relief from learning about depression, anxiety, and the brain. He appeared to have an intuitive understanding of each ego state upon the first introduction and self-identified with the Rebel and the Con.

Blade's parents also readily accepted the model and used it fluently when processing historical, current and future scenarios. Though the model was not used as intensively with the parents as it was with

Blade, it proved to be a useful and efficient tool during the weekly one hour phone calls and during the interactions between the therapist and parents after Blade discharged from treatment.

During a normal weekly session, Blade was instructed to formulate an agenda to direct the content and direction of the next therapy session. Sessions typically began with the administration of a Youth Outcome Questionnaire and then the time was turned over to Blade. When appropriate opportunities arose, as the client related his experiences and feelings, the therapist asked the client to interpret his experience in terms of what ego states were at play in his varied scenarios. At other times, the therapist asked the client to identify what ego state he was currently in. Through this method, the client improved the quality of his session planning and began to arrive at sessions with questions about how to identify the Executive ego state. He explained that there were times that he thought that he was in the Executive but found that he was actually in the Chameleon, Rebel and/or the Con. At other times he arrived at sessions animated with frustration that his attempts to remain in the Executive were frustrated by other members of his ego council.

The client was instructed to conceptualize the ego states as individual members of a council whose primary mission was to appeal to his decision making center, the Executive. The diagram of the ego council was sketched out on paper with the following ego states sitting at a half-round table: Natural Child, Rebel, Chameleon, Critical Parent, and Enabling Parent. In front of the table, and sitting face to face with the council, was the Executive. Off to the rear of the table, sitting behind the members, was the Con. It was explained that the Executive was the rightful decision maker and that he was the only member of the council who possessed the appropriate title, perspective, and disposition to be making decisions. It was then discussed what predictable outcomes would result if any one member of the council, other than the Executive, were to be given free range for decision making. Blade showed that he had a good sense of how his life might play out if any non-executive ego state had dominant control over decision making.

It was likely that Blade's Chameleon and Con were at play during the process of learning the ego states. As is common in wilderness treatment settings, the therapist is often viewed by the client as the "gatekeeper" to graduation. This dynamic, especially for clients in the pre-contemplation stage of change, often tempts the client to misrepresent his level of investment in the treatment process. The therapist was aware, at times, that Blade was hoping to win his approval (through the Con) by learning and showing some mastery of the ego states. The therapist chose not to challenge this dynamic, however, because the client was successfully learning and applying the model regardless of his motivations to do so. As the client began to demonstrate autonomous use of TA, questions from the therapist about the model became more about helping the client to analyze his own experience than to teach him about the model...though instruction was always an ongoing process.

Illustrative example:

On one occasion Blade's wilderness group of guides and clients woke to find that someone had failed to use the latrine and instead had defecated on a log just outside of camp. The program did not allow this behavior as state law governing adventure programming required specific procedures for the management of waste material. At this point in Blade's treatment he'd been experimenting, from the Con ego state, with maintaining the appearance that he was complying with the program's expectations. His plan was to look the part so that he could graduate from the program earlier.

Blade was the person who had failed to use the latrine. He was then caught in a bind because he knew the field guides would not relent on solving the problem, and to confess was to reveal that, when left alone, he was still making Rebel/Con decisions. The issue became a central focus in the group and plans for the day were suspended until the problem was solved. For hours the group waited

for someone to admit responsibility. When Blade finally took responsibility, clients who considered themselves his friends were angry with him for waiting so long. They recognized that Blade was making a selfish choice without any regard for their feelings. When they confronted Blade with this realization, he flippantly dismissed their position and laughed at how funny he was.

This incident was processed in session. Blade acknowledged that he was in the Con when he waited to confess. He chuckled as he told the story, still making light of the situation, but he accurately and honestly broke down his motivations and decisions according to ego states. He explained that he was reluctant to come forward to the guides because he was afraid that he'd be kept longer at the program. When he did come forward he did so from the Natural Child as he was tired of waiting to move on with the day's activities. When he discovered that the other group members were upset with him for taking so long to confess, he laughed and made fun of them from the Rebel and Con ego states.

The therapist then worked with Blade to trace his decision making backwards through the beginning of the incident. Blade explained that he'd struggled to find the latrine in the dark and, from the Natural Child, decided not to search for his head lamp and to use the most convenient location instead. Blade recognized that had he used his executive and had he chosen one of several other more honest options, including the option to simply take ownership the next morning and to handle the problem, he wouldn't have been trapped as he was. He went on to acknowledge that had he used his Executive ego state, even after failing to use the latrine, that he would have gained a more favorable impression with the guides.

Upon turning 18, Blade "walked" from the program as promised. To "walk" was to discharge himself from the program against clinical advice. Because Blade had consistently communicated his plans to walk, both parents were well prepared for him to do so. They were coached by the therapist on how to hold the boundaries and were committed to do so. They clearly communicated, in writing, that they would not allow him to live in their home if he were not sober and had not completed treatment.

Blade did walk, but became afraid that his plan to get all of the way home was going to be too difficult to execute and he returned to the program. Over the next four to six weeks he attempted to walk on three other occasions. Each time he advanced his plans a little further than the time before, as though he were testing and refining his plan. For example, he was initially dropped off at a homeless shelter. He managed to secure a ride from the shelter to the airport and to make phone calls to arrange a plane ticket. His plans hinged on getting the ticket immediately but he found that it might take more time and he didn't want to stay in the airport. So, armed with this experience, he colluded with another client and attempted to find a place to stay for a few days on his next attempt so that he had more time to coordinate his travel. (His parents had deactivated his phone and shut down his credit cards).

Each walker attempt was processed in therapy sessions. Blade identified that he was in the Natural Child, Con, and Rebel ego states. There were moments when he attempted to persuade his therapist that he was in the Executive ego states when planning and executing his walker attempts. For example, he said that he'd walked from the program to show his parents that he could, indeed, make it on his own and that he wanted to impress his father by leaving the program and showing up on their doorstep. He argued that to walk from the program was to evidence that he was making adult decisions and that he was ready to move on with his life. The client/therapist relationship had progressed to such a point that the client would often stop mid-rebuttal and start to chuckle as he could see how ridiculous his attempt must appear to the therapist. Often, they laughed together and then moved toward exploring what the Executive would do under the circumstances.

After the 3rd walker attempt the client/therapist relationship shifted. It was the therapist's interpretation that the client was experiencing a shift from the pre-contemplation to the contemplation

stage of change. The client stated that he could see that he was almost always in the Rebel or Con ego states as he cared little about other people and was constantly strategizing to get his way with others. He was struggling to identify the Executive ego state and instead of moving out of the Con and Rebel to explore the state he invited the therapist to debate with him about the pros and cons of being in Executive.

It was the therapist's interpretation that this attempt to "debate" was the client's attempt to externalize the conflict that the client had been experiencing internally between the Con/Rebel and the Executive. In fact, these states were engaged in an internal power struggle that the client verified was creating a great deal of tension and anxiety. Blade confided that he was afraid to move out of the Rebel ego state and preferred to try to work out the problem through debate while he was arguing from the Rebel. He believed, and clearly stated, that if the Rebel relinquished decision making power to his Executive that Blade himself would lose his identity.

The therapist reflected that this fear of identity loss was a common indicator of the Rebel ego state, and that from the Rebel mindset, the world is viewed through a lens that interprets all relationships as struggles for power. Either the Rebel is in control because he can force his will on others (quickly shifting to Critical Parent) or is in control because he can resist the attempts of others to have control over him. Therefore, the therapist could not take an antagonistic role without occupying the Critical Parent ego state and thereby reenact the power struggle the client was experiencing within his own ego council. The therapist also recognized that to engage the client from any other ego state than the Executive, even momentarily, could destroy the therapeutic alliance. This request to debate became a typical pattern for a few consecutive sessions and was consistently resisted by the therapist. The therapist continued to focus on assisting the client to work out the power struggle on his own ego council rather than to attempt to do so, externally, from the Rebel ego state.

While Blade was unable to recreate the power struggle with his therapist, he was able to recreate it with select field guides and other program personnel. These conflicts effectively generated tension between program personnel and served to put pressure on the therapist to move toward a more punitive approach with the client. There were multiple situations in which the client behaved in a particularly disruptive way and some program personnel felt that he should receive consequences for his actions. They reasoned that if his actions went unpunished he would get the message that his behavior was appropriate. They feared that a non-punishing approach would actually invite more disruptive behavior.

It was the therapist's interpretation that Blade was recreating components of his family dynamic within the program milieu. His Rebel had effectively drawn forth a Critical Parent response from a few program personnel just as he'd done on many occasions with his parents at home. Restoring a sense of order through coercion or control, as stated above, motivates the Critical Parent ego state. The therapist recognized that to move into a punishing mindset would be to entangle himself in the very power struggle that the Rebel wanted to elicit. Such a move would be a trap, as the Rebel feels justified in further rebellion if the Critical Parent becomes punishing and disrespectful. The therapist recognized that he must maintain an executive approach and thereby undermine the power struggle and preserve the therapeutic relationship.

After multiple attempts to test this relationship in such a way, Blade's trust in the therapist grew. Parallel to the growing trust, however, was the client's increasing level of anxiety. Blade began to perceive that without making real changes he would not be discharged from the program in the immediate future. At this point in the treatment process he'd been in the program for more than an average number of days for an entire program stay and was feeling impatient as he saw other clients come and go from his group.

At this point he decided to fully follow through with his intentions to discharge himself from the program against clinical advice. He was transported by program personnel to an urban center a few hours drive from the program and was dropped off at a homeless shelter. Blade had colluded with another client in his group and had plans to squat at a family property. The property owners, however, learned of the plans and blocked Blade from fulfilling his plans. Blade, it was discovered later, successfully persuaded some of his friends from home to pitch in money to purchase a plane ticket back to his home town.

His parents held the boundaries, as promised, for a time. During this period before he returned home, he was experiencing schizophrenic-like symptoms and dealt with intense social anxiety and paranoia. Additionally, he'd experienced a violent physical reaction to a relatively small dose of alcohol, which frightened and confused him. He would learn later that this reaction to alcohol could be a possible evidence of Lyme disease, as presence of the bacteria can increase a person's sensitivity to foreign substances. Blade came to his parents asking for more treatment.

His parents brought him home for a brief period and then admitted him to a residential treatment facility. After completion of the program Blade returned home with the intention to finish high school and move on to college. His paranoia and anxiety became so overwhelming, however, that he was unable to sustain his school attendance. He became sedentary and spent days on end in his bedroom, resisting his family's attempts to encourage him to be more active. He purchased drugs, though he reported that he rarely had the desire or energy to use them.

During this period, Blade became aware that Lyme disease can cause schizophrenic-like symptoms and he became convinced that he'd contracted the disease through sexual transmission. It was confirmed that his ex-girlfriend did have Lyme disease thereby adding plausibility to his belief. He was tested for Lyme but his blood work was not processed at the time of this report, though it appeared that he might have Rheumatoid Arthritis in his knees, a common symptom of Lyme disease. Blade seemed to have an obsessive fascination with the possibility that he had Lyme disease. The fact that many of his symptoms could be explained by the disease complicated his parent's ability to discern whether he was manipulating or suffering from the disease...or both. With Lyme disease and also symptoms suggesting bipolar disorder, prodromal schizophrenia or other mood disorder or severe psychiatric disorder, being a real possibility, his parents were confused and frustrated because they did not know what to do. It was not clear to them whether they should push him to get back to school or allow him to stay in his room until the results came in.

It is important to note that Blade and the therapist maintained contact at Blade's request after he discharged from the program. The client/therapist relationship shifted after he discharged from the program as the therapist was no longer in the gatekeeper position and had taken on the role of life coach. This shift in dynamic resulted in candid discussions between the client and therapist through which important details about Blade's experience were disclosed.

Approximately three months after ACA discharge, the client wrote a few pages about what had happened in treatment and he read these to the therapist. Included in his text were explanations about why his anxiety increased simultaneously with his increasing trust of the therapist. The client wrote that he'd been living an "impeccable deception" and until the relationship with the therapist, this deception had not been effectively challenged. When he realized that the therapist could see through the deception, he simultaneously trusted the therapist and also felt exceedingly threatened. To be known, fully, was to be exposed to the need for real change.

Before his Lyme results were examined, Blade left home and began using heroin intravenously. After binging for several days, he returned home with an infection in his arm and once again asked his

parents for treatment. They admitted him to a detoxification facility. His parents identified a quality residential treatment program but Blade refused to attend and became demanding that they give him options in a warmer part of the country that happened to coincide with close proximity to a girl that he had met in treatment and that he'd recently used heroin with. This behavior was interpreted by both the therapist and parents as manipulative and entitled. The therapist reinforced the parent's position that they would finance only one treatment option and that if the client was unwilling to take that option he'd be on his own.

His parents were unwilling to negotiate on the matter and Blade dramatically resisted. His parents, however, held the boundary and on the morning that he was to be discharged from the detoxification hospital he called to ask if they would pick him up. His mother responded that he would only be picked up if he planned on flying to the treatment program that they had arranged for him. He agreed to do so, and at the time this case example was written he'd calmly and willingly flown to the treatment program where he was admitted.

Summary

Blade arrived at an adventure therapy treatment program while engaged in a developmental struggle with his parents. He was dealing with two exactly contradictory needs: 1. Become independent from his parents 2. To have his basic needs met by his parents. Blade's strategy for handling this struggle was to engage his Rebel and Con ego states to satisfy both needs. His tenacious commitment and rigidity in this strategy may have been heavily influenced by an organic disease or disorder but test results were not yet known at the time this example was written. Regardless of the outcome of his Lyme disease testing, or the diagnosis of Schizophrenia or any other disorder, Blade's use of freewill was the target of therapy.

This target was narrowed through the use of Transactional Analysis, adapted. Through TA, Blade was able to develop an autonomous ability to assess his own ego state and thereby able to meaningfully organize his experience and relationships. Knowingly, Blade continued to choose non-executive actions in many circumstances yet managed to seek treatment when needed, maintain a relationship with caring professionals and ultimately decided to accept his parent's treatment offerings.

Through establishing and maintaining boundaries, Blade's parents played a key role in his ultimate decision to engage in additional treatment. Blade's common strategy was to deftly identify his parent's greatest fears and weaknesses. He appeared to keep track of these details and, in a selfish effort to manipulate circumstances in his life, exploited these fears.

Discussion

It was surprising to the therapist that the client was interested in maintaining the relationship after therapy, as the client appeared to be very frustrated with the therapist when he wouldn't entertain the client's attempts to engage in a power struggle while in treatment. The opportunity to remain in contact with the client after he discharged from the program provided the therapist with unique and valuable insight into the mechanics of the relationships at play between the client, the therapist, the broader treatment program, and the client's family. In the vast majority of cases this level of contact is not feasible.

The client's level of intelligence, insight and his ability to articulate his experience proved to be double-edged. On the one hand, the client used these skills to manipulate the people and circumstances around him. On the other hand, the client allowed the therapist direct access to the truth about what the client was experiencing and thereby reinforced and also challenged the therapist's approach. Though it wasn't clearly described in the case example, Blade was usually very honest. His

manipulations were usually not built on lies, but instead on clever leveraging of relationships. He'd learned that his honesty often presented an obstacle to authority figures if he could render clear reasoning for what he'd done or intended to do. His level of candor proved valuable in helping the therapist to understand more about Blade's processes.

The therapist's decision to maintain focus on his expectation that the client assume and maintain the Executive ego while in session proved to be an effective approach, as did his rigidity in remaining in the Executive ego state when working with the client. Though this approach did not ultimately result, in most cases, in the client making executive choices in regard to abandoning the power struggle with his parents and the treatment program, it did appear to increase the client's awareness of what he was doing. The client was making more informed decisions despite the lack of wisdom he often displayed.

The therapist and the client had many clear conversations after treatment in which the client stated that he knew that he was in the Rebel or the Con and was simply unwilling to move into the Executive. In these conversations it is possible that the client was in the Executive while describing his experience. It was the therapist's impression that after treatment the client had little reason to deceive or manipulate the therapist because the therapist had no real influence in the client's life other than his ability to influence the parents' decisions about parenting. With motivation for deceiving the therapist at a low level, the client appeared to be genuine in his explanations that he simply didn't want to make wise choices. All therapists, and parents alike, can be stymied when free will is used in a self-destructive way. In these cases even the best reasoning and most clever strategies can be rendered useless.

The therapist and members of the clinical team discussed the possibility that, when dealing with clients in the pre-contemplation stage of change, therapy looks a lot like deft attempts to persuade the client to develop a desire to change. These attempts take many forms for therapists and parents alike--i.e. psycho-educational pleas, benevolent manipulations, bluffing, arguments, etc... Ultimately, even in cases of profound mental illness, therapy is an appeal to free will and the ability to influence the client through sound relationship principles.

Just prior to discharging from the detoxification hospital, and before the client had decided to attend the last treatment program mentioned, the client asked the therapist to predict what he thought was going to happen. The client reminisced that the therapist had predicted at the adventure therapy program that the client would ultimately discharge himself ACA from the program, go and test the parent's boundaries, return to using drugs, and fail at his attempts to begin a successful young adult life. The client had seen this very scenario play out and asked the therapist to predict the next step. The therapist replied that as long as Blade continued to sustain the power struggle with his parents, that he would likely spend a period of time homeless, and probably begin having encounters with the law.

Just prior to asking for this prediction, the client had exclaimed his dedication to beating his parents at their game. After hearing this prediction, the client paused and soon after the phone call ended. The therapist related this exchange to the parents and recommended that they brace themselves for the client to resist going to the treatment program. The next morning, however, the client willingly and quietly got on the plane to go to treatment. It is not clear whether the prediction had any impact on the client's ultimate decision to go to treatment, but it is believed that through the therapeutic alliance and application of the TA model, the client's Executive was given momentary control over decision making.

Finally, it is important to mention that Blade was clearly pre-contemplative regarding his status as an addict. Through psycho-education, addiction-focused group and individual therapy, and through testing the limits of his drug and alcohol use, the client did come to admit that he was an addict.

Self, Experience, and Family: A Case Study of One Young Adult's Journey Through a Wilderness Therapy Program

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Cascade Crest Transitions, article is in reference to previous work at Evoke at Entrada

Abstract

This case study depicts the family and intrapersonal journey of an adult client through a wilderness therapy program. The client was a bright eighteen-year-old male of blended racial identity who presented with low self-worth, substance use, persistent manipulation, under-achievement, and impaired relationships within his nuclear family. This case study illustrates how coordinated intrapersonal and family systems work can coalesce to produce meaningful change within the wilderness therapy setting. It demonstrates how technology expands opportunities for family engagement. It also explores how clients, who are able to skillfully use avoidance strategies in outpatient therapy settings, are challenged in the experiential setting of the wilderness. The use of field staff as mentors, the power of outdoor experiential learning, and the integration of clinical treatment planning are all highlighted in this case study as salient facets of the wilderness therapy experience.

John was an eighteen-year-old male of mixed ethnicity who lived in a large metropolitan city. John's parents divorced when he was a young child. He grew up dividing time between one parent's lenient, effusive, soft, and progressive household and the other parent's more authoritarian, respect-based household. The family constellation also included two older siblings whose only involvement in the treatment was through minimal letter writing.

John was a gifted artist who spent years living abroad while training at an institute of art. He was extremely bright, with a verbal IQ in the top one percentile. Despite his high level of intelligence, he required significant support in school. In his own words, he "pulled across the finish line to barely graduate high school." John had participated in various forms of inpatient and outpatient mental health treatment, attended multiple boarding schools, and worked with tutors and mentors.

John's resistant stance was fed by his complex, dichotomous, and reactionary family constellation. John's mother was permissive and determined that John be happy, perhaps as a response to what he saw as John's father's rigid, cold, and authoritarian style. Kerr and Bowen (1988) succinctly describe the state of John's family when they describe how "the lower the level of differentiation, the more likely the family, when stressed, will regress to selfish, aggressive, and avoidance behaviors" (p.93). John avoided his father's disapproval and consequences by cutting off contact with him. He took advantage of his mother's leniency and spent weeks living in his mother's house indiscriminately using his mother's credit card.

John enrolled in the wilderness therapy program (WTP) as a result of his parent's and home therapist's insistence. Their concerns included stealing money from his mother ($20,000), daily marijuana use, failure to maintain employment or education, conflict with his parents, running away from home, persistent manipulation, and anger outbursts. Although John agreed to enroll in wilderness therapy, he did so reluctantly. He appeared dismissive, arrogant, and minimally committed in the WTP. He seemed intent on manipulating the process, just as he had done in prior therapy settings and with his mother. A preliminary diagnosis and treatment plan was established for John based on the information and

experience gathered through an initial interview with John, consultation with the referring professional and home therapist, speaking with both of his parents, reviewing previous discharge reports, and the observations of the field staff (who when trained can serve as the eyes and ears of the therapist) of John's behavior over time. John's diagnoses were: Dysthymic Disorder, Identity Problem, Attention Deficit/Hyper-activity, Parent/Child Relational Problems, and Alcohol and Cannabis Abuse. His mood and identity issues presented as perpetual apathy, a lack of meaning, diminished interest in activities, and a tendency to be a chameleon in social settings. He was highly impulsive, lacked executive functioning skills and struggled to put words into action. John was saturated with information but lacked the self-control, self-awareness, and self-efficacy to translate the information into action.

Helping John experience his emotions, understand his defense mechanisms, peel back his façade, and family systems were quickly identified as the primary treatment goals. The deceit, substance use, stealing, and manipulation were all seen as secondary to the core issues. His treatment seemed to fit well with a process-oriented, psychodynamic, and experiential approach coupled with family work that would free him up from his calcified role as the identified patient and allow him a safe place to peer inward.

This article focuses on three essential parts of John's treatment in the WTP:

1. The unfolding self: his existential efforts to explore and accept his identity.
2. Pushing past information into new experiences: his participation in experiential therapeutic activities supervised by a therapist and field staff.
3. Re-aligning the family system: growth in the relational and emotional unit that enabled John to increase his differentiation and modify his behavior.

Two weeks after John graduated from his WTP, the author asked him to comment on each of the three themes of his treatment. His responses are shared with the hope of capturing the "true" essence of his experience.

The Unfolding Self

Prior to enrolling in the Wilderness Therapy Program (WTP) John rejected his father. He spent time with older, "cool" friends. In the midst of his oppositional stance, he believed that he failed to live up to his potential. Though he had projected an image of confidence and self-assuredness, he was aware of perpetual underperformance and shame. His identity was poorly defined and he felt upset about that. To cope, he portrayed a false self, which, though it lacked authenticity, enabled him to form superficial connections with others. The establishment of pseudo-self (Kerr & Bowen, 1988) reduced his sense of panic about his poorly defined identity but failed him when faced with emotionality. For example, he often lied to cover his irresponsible behavior, spent a significant amount of money on materialistic items to impress friends, and made jokes mocking his racial identity.

He was asked "how did you explore your identity in wilderness?" and he responded saying:

Coming to terms with my identity was one of the most important facets of my progress in wilderness. Being multicultural and from a unique ethnic background was one of the reasons I ended up at wilderness therapy. I was feeling lost and confused about what (someone of my ethnicity) looks like and whether or not I was being true to my racial identity. In wilderness, I worked with a staff member who had the same exact nationality as me and the one-week I had with him was life changing. Coming to the conclusion that my identity is vastly unknown and dictated by me and my actions going into the future was empowering to say the least. My exploration of identity ultimately looked like getting vulnerable, being honest with myself, and most importantly accepting and loving what I found in that excavation.

SELF, EXPERIENCE, AND FAMILY

Wilderness provided a safe, stable environment for John to acknowledge his internal strife that was triggered by his lack of self-definition. A psychodynamic approach was utilized that focused on identifying defense mechanisms and recognizing his transference in relationships. In essence, the WTP provided a mirror that reflected that which John projected to the world. Starting a fire is an imperative part of survival in the wilderness. Kish was forced to look at his intellectualization and deflection patterns when, two weeks into the process, he had yet to take the risk of asking for help in how to start a fire. He was able to see his reflection as his attention shifted from intellect to emotions. The wilderness provided natural consequences to facilitate that shift, especially when he lacked responsibility or initiative. Metacommunication, the process of switching from content to process to interrupt the relational cycle being enacted, was utilized in therapy sessions to bring his relationship patterns into focus (Safran & Muran, 2000). Additionally, peers and staff gave him feedback that helped him to recognize the disenfranchised parts of himself, defense mechanisms, and lack of a solid sense of himself. Consistent feedback allowed for modification as he worked to increase his emotional awareness and adjust his behavior patterns. Through this John was able to go through a process Freud called "working through" that enabled his insights to be integrated both intellectually and emotionally to the point that he could give up his old patterns (Kahn, 2001).

John seemed likely to benefit from interventions that focused on identity development. The staff thought that a solo would be helpful in that regard. Solos are intervention experiences often utilized in wilderness therapy. A solo provides a couple days and nights for a client to focus entirely on self, without the distraction of dialogue with others. The clients are asked to stay in their assigned location while staff make regular rounds to make visual contact to assure for safety. Solos force the individual to fully experience him or herself. Although a solo seemed beneficial, WTP staff had concerns about John's ability to refrain from impulsive activities. Furthermore, John was anxious about going into the experience because he was unaccustomed to facing boredom with only his internal resources and because had concerns about managing his impulses. Despite these concerns, and after building safety plans, John embarked on his solo. He spent his first day distracting himself by physical tasks, climbing trees, and singing to himself. However, as time passed he engaged in self-reflection and by the end of the solo experience he reported he had found a sense of pride and a greater commitment to being authentic. He discovered a growing ability to regulate emotions without external support and subsequently was able to begin shedding his previous defense mechanisms. He also began to shed his internalized narrative as an immature and impulsive kid who lacked a sense of self, and replaced with one of emerging competency and clarity. Throughout his stay he continued to wear a necklace staff had given him as a memento during the solo closing ceremony that symbolized his ability to practice self-control. He also seemed to let go of the pseudo-self he had carried previously and exhibited more confidence in being his true self.

John did not say that he could clearly articulate his identity as a result of the WTP. He did not say that he "found himself". Instead, he reported that he embraced various parts of himself and accepted the fact that he did not know who he was. In fact, as a result of the WTP, he was excited to embrace the unfolding process of self-discovery. Safran and Muran (2000) suggest that "when an individual has an emotionally immediate awareness in the present, it means that he or she is seeing things from a new perspective as a whole-integrated organism" (p.51). John's increased self-awareness, coupled with his increased ability to tolerate ambiguity, allowed him to accept his thoughts and feelings and embrace his personal story.

Pushing Past Information into New Experiences

John's verbal intelligence was in the 99th percentile for his age. Furthermore, he had many privileges that enhanced his intellectual potential: private education, tutors, boarding school, and extensive

psychotherapy. John was rich with information and intellectual resources. However, he lacked insight. John had a tendency to over rely on unproductive intellectual activity that was divorced from his true internal needs, issues, and goals. He lacked a sense of how to use his intelligence to form new, healthier experiences. He was trapped "in his head" and the more he ruminated on what to do, the more paralyzed and stagnant he became. Conceptual understanding has a place but if there is an "absence of new experiences therapy remains an intellectual exercise" (Safran & Muran, 2000, p.48). New experiences helped John integrate his insight into his conscious practice and break a pattern of his action perpetually falling short of his and other's expectations. The treatment goals focused on direct awareness of here-and-now, as opposed to retrospective reflection (Safran & Muran, 2000). Therefore, his treatment plan contained a variety of experiential activities that sought to minimize his tendency to intellectualize and maximize his insight into intrapersonal needs and issues. Assignments included sharing a vulnerability a day with his peers, identifying emotions in the moment through staff prompting, and carrying around symbolic representations of his emotional baggage. This took the place of talking about what he used to do or passive exploration of what he could do in the future. He was asked to reflect on the question: What experiential activities stand out to you as the most impact-full and why? He responded by sharing:

One experimental activity that stands out to me is an assignment that my therapist assigned to me my second week in wilderness. My mentality at that point into the program was one of minimal commitment, (expecting to be there only for the initial (45) day agreement that I made with my parents), lazy attitude, and apathy. I went through my whole second week not using the tools in the program like check-ins or feedback to further my progress; instead I did almost nothing. My therapist then assigned me to the ingenious task called the "bluey intervention". This meant that I had to carry a 5-gallon container of water with me everywhere I went, and could only pour out water for other people if I shared a vulnerability, check in, or gave feedback. The symbolism behind this was the emotional baggage that I'm not sharing is weighing me down figuratively, and the tangible object I was carrying was a reminder of how difficult my life is if I don't share it. Outside of this specific assignment, the talk therapy tools in the program were something that made my therapeutic progress so much smoother during my time in wilderness. Feedback allowed me to assertively voice concerns about others, and check-ins allowed me to validate strong emotions I was feeling and not try and restrain them.

Given John's issues, it seemed that he was most likely to make meaningful changes outside the context of traditional, "talk" therapy and inside the context of experiential therapy. It was therefore critical that the treatment team carefully select and facilitate experimental interventions. This philosophy fits within emerging research showing that cognitive growth and ability is not as directly correlated to success in life as once thought (Tough, 2013). Instead "what matters is whether we are able to help [the client] develop a very different set of qualities, a list that includes persistence, self-control, curiosity, conscientiousness, grit, and self-confidence. Economists refer to these as non-cognitive skills, psychologists call them personality traits, and the rest of us sometimes think of them as character" (Tough, 2013, pp. 79-80). John had received substantial support and push to hone his intelligence, but had been allowed to shy away from character developing experiences.

There were many factors that seemed to promote the effectiveness of John's experiential activities. The staff structured activities that were designed to push John outside of his comfort zone, in a manner that rendered him incapable of manipulation or avoidance. In addition, his peers responded to his vulnerability with insight and encouragement, which seemed to resonate with him. The use of metaphor and experiential activities allowed for John to externalize his struggles in a way that made the process of exploration less threatening. Through activities John had a felt sense, as opposed to an intellectual sense, of his coping mechanisms. Through these experiential processes he realized the

repercussions of not changing, developed the grit and courage to be vulnerable, and cultivated a desire for change.

Re-aligning the Family System

The growth of the individual cannot be separated from the functioning of the family emotional unit. They are intertwined on both conscious and unconscious levels as "the thoughts, feelings, and behavior of each family member…both contribute to and reflect what is occurring in the family as a whole" (Kerr & Bowen, 1988, p. 9). As John began to take more ownership of his emotional well-being it freed his father to shift out of the role of the "over-functioner" and provided the impetus for his father to soften his emotional barriers. His increased willingness to explore his identity and his relational patterns provided a template for his mother and mother to do the same.

John's family was entrapped in a triangle in which John played the role of the victim, his mother the rescuer, and his father the persecutor. Kerr and Bowen (1988) assert: "the triangle is the basic molecule of an emotion system. It is the smallest stable relationship unit" (p.134). Conceptually, John and his mother were the insiders in the triangle and his father was the outsider in the system. In this triangle John was in the role of the anxiety generator, his mother as the amplifier who struggled to stay calm, and his father as the dampener who used emotional distance to control his reactivity to the situation (Kerr & Bowen, 1988).

While John was making intrapersonal changes that fostered his ability to make changes within his family system, his family was likewise preparing for change. First, the family was encouraged to shift the "identified patient" from John to the family. Shifting the focus allowed the family to notice the patterns that led to a calcification of each family member's roles. His mother recognized how her own untreated depression and anxiety led her to become overly reactive and controlling. His father recognized how his frustration with John's previous failures led him to remain emotionally guarded and perpetually skeptical.

The WTP parent program had many different components. The first was weekly phone calls with the therapist coupled with feedback and coaching on their weekly letters. Each week they were each assigned appropriate archived webinars provided by the WTP that offered pschoeducation in a nonthreatening and easily accessible format. Similar material was available through the Family Journey Packet that contained literature on the same concepts found in the webinars. These topics included enmeshment, healthy boundaries, successful communication, co-parenting, and anxiety. Furthermore, each parent was encouraged to engage in their own therapy and attend parent support groups put on by the WTP in their home city. The goals of the group were to provide psycho-education and foster connections with other parents going through the WTP process. Lastly, the parents were able to slowly begin putting new ideas into practice through therapist moderated satellite phone calls with John.

John was asked to respond to two questions: How have your family relationships shifted as a result of your work in wilderness? What did you and what did your parents due to lead to those changes? He responded that:

My family relationship has shifted dramatically from my time in wilderness. Before coming to wilderness, I kept my family, especially my parents in the dark about everything I did, especially things like my substance abuse, dishonesty, and stealing. I felt like I was falling into the hole that I was digging and it was getting deeper by the second. Wilderness was a healthy environment to come completely clean about my actions and mistreatment, and also examine the unhealthy dynamics that have appeared in my family in the last couple of years. From my parents' perspective, a lot of their work looked like examining enabling tendencies and rescuing. As of now my relationship with my parents is constantly

open and full of assertive communication and honesty, the polar opposite of what my relationship looked like in the past

John's summary touches on his increased accountability and his parent's increased insight into their role and behaviors in the family system. This awareness precipitated an increased differentiation of self for each member of the system. As the differentiation of each member increased, emotionality and subjectivity had less influence on the family functioning with each member more capable of managing their own internal process (Kerr & Bowen, 1988).

Traditionally parents visit the WTP at the conclusion of the experience. However, there is value in doing a mid-program visit that becomes a working visit, as opposed to a celebration of completion and transition. For John, it was particularly beneficial to have a mid-program family therapy visit. Though it would have been easiest for John to have his mother visit that risked perpetuating the enmeshment. Therefore, John and the treatment team agreed that it would be more valuable for his father to visit. He set a goal of working on his pattern of distancing from his father. The visit was difficult. However, John and his father focused on forming a connection and John focused on tolerating his father's skepticism about his authenticity and commitment. Connecting with his father in a supportive environment, where he was not afraid of others perception of his cultural identity, helped him to openly explore his ethnic heritage. This visit seemed to have a profound effect on John. From thereon, he proudly wore a bracelet that represented his culture, which his father gave him.

John's mother's anxiety and doubt re-emerged as John was preparing to complete the WTP. Prior to the WTP, John took advantage of his mother's desire to make everything "right" for her son. An incredibly poignant moment occurred when John had a satellite phone call with his mother. His mother expressed doubt and anxiety around if they were making the "right" decision and if John would be happy with his next step out of wilderness. John maturely responded: "Mom, you cannot spend the next ten months worrying about whether or not I am happy at my aftercare program. That is up to me." John's direct and caring feedback served as a stark example of his increased differentiation, personal insight, and commitment to new family roles.

Concluding Thoughts

Each client and family is unique in their relational patterns, differentiation, symptomology, and clinical needs. However commonalities exist in a young man's search for autonomy and self-definition in a culture littered with invitations to lose oneself. Furthermore, clients' emotional and character development is often lagging behind cognitive growth or what others have told them is there "potential." There are also many family units entrenched in reactive and compensatory triangles. John's journey through a wilderness therapy program highlights some of the possibilities this dynamic and creative treatment modality offers clients and families. It shows how wilderness can provide a safe, reflective environment where clients can engage in character enhancing activities that promote insight and systemic change. The combination of multiple different therapeutic factors from nature, to group work, and staff as role models creates a potent approach to healing for clients who have struggled to respond to traditional talk therapy. Hopefully, continued research on the process and outcomes of WTPs will continue to expand the effectiveness and reach of the wilderness therapy experience.

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Emotional Expression, Systemic Shifts, and Psycho-Education in Approaching Complicated Grief: A Case Study of One Adolescent's Experience in Wilderness Therapy

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Abstract

This case study focused on a fourteen year old boy in wilderness treatment for Major Depressive Disorder, Other Specified Trauma-and-Stressor-Related Disorder, persistent complex bereavement disorder, and Depersonalization/Derealization Disorder. Treatment focused on three main areas: (1) helping Bradley to acquire skills in emotional identification, acceptance and expression, (2) systemic family shifts to allow for the expression of grief, and (3) psycho-education on systems theory, systemic family grief, dissociation as a trauma response, and male socialization.

Client Overview

Bradley was a fourteen-year-old Caucasian male who lived in a large Midwestern city. Bradley's father John died suddenly at home three years prior to Bradley's enrollment at True North Wilderness Program (TNWP) and since that time his mother, Susan, had raised Bradley, his older brother, and his younger sister as a single parent. Susan was a business owner and the family was financially comfortable. Throughout his childhood Bradley had always been socially, academically, and athletically successful. He was well liked, well mannered, highly verbal and socially astute. Prior to John's death no major concerns had been reported in any area of Bradley's functioning or development.

In the months following John's death Bradley continued to excel academically and socially, and he denied to family and helping professionals that his father's death had significantly impacted him. However, a year after the death, Bradley began to exhibit depressive symptoms and his childhood imaginary friend, Sebastian, who had been gone for years from Bradley's life, began to return regularly. Bradley used Sebastian as a tool in early childhood to process and resolve problems. As a re-emergent tool Sebastian expressed feelings of anger, and often told Bradley to hurt himself or others. Bradley's reality testing was intact during these experiences; he knew that Sebastian wasn't real, but the experiences of hearing him were unsettling for Bradley. Bradley also began to avoid his house and frequently stayed overnight at a close friend's house nearby. Bradley saw a therapist regularly and began taking a benzodiazepine. Nonetheless, his growing depression resulted in two hospital visits in close

succession. Throughout his struggles with depression, Bradley continued to thrive academically and maintain friendships, avoiding concern from peripheral acquaintances. One month before enrollment in TNWP Bradley took a large dose of his medication and attempted suicide by hanging. He had written a suicide note to his family. His mother found him a minute after this attempt, removed him from immediate danger, and he was hospitalized for a third time. Bradley did not sustain any permanent physical damage from his suicide attempt and after a short-term hospital stay he asked his mother to support him in getting help.

Preparation for Treatment

Susan sought the guidance of an educational consultant and consequently chose TNWP to provide a short-term intensive therapeutic intervention, clinical assessment, and post-wilderness transition. Bradley elected to attend TNWP on his own after his suicide attempt, indicating a readiness for change (Prochaska, 1979). Bradley and Susan attended the initial phase of Bradley's enrollment together, which was facilitated by a Master's level therapist. In this meeting Bradley and his mother were given information about the enrollment process and program structure in order to demonstrate transparency. Bradley's field guides and therapists were described to him as important resources. Susan was also assigned a dedicated parent therapist. Prior to outfitting, and as standard protocol, Bradley was given a drug screen, which indicated no presence of illegal substances.

Initial Presentation

Upon enrollment, Bradley demonstrated strong patterns of "people pleasing" and stoicism. Staff consistently observed Bradley placing importance on his concern for others above his own personal responsibilities and emotional work, and minimizing or masking his struggles. He often offered to do more than his fair share of group chores, expressed inauthentic pleasant feelings, and presented a cheerful façade.

Juxtaposed with this cheery façade, Bradley experienced several dissociative episodes while in the early and mid-phases of his stay. These episodes were twofold: auditory misperceptions (hearing the voice of Sebastian, his childhood imaginary friend) and depersonalization, (sensation of being separate from his body). During these episodes Bradley's reality testing remained adequate: Bradley consistently recognized that Sebastian's voice wasn't real, and he was able to tell staff members when it happened and ask for help. In therapy, it became evident that the episodes were his unconscious attempt to stifle the sadness and anger associated with painful thoughts and memories of his father.

Case Conceptualization

Bradley's father John was described as a family man with a big personality that was central to all areas of family functioning, from where to picnic on weekends to how to pay the bills. When John died, Susan needed to learn to manage the household and daily routine as a single parent, while also coping with her grief as well as that of her children. Though Susan's grief was immense, her instinct was to "keep the family moving". She compartmentalized her sadness. She often broke down emotionally when alone so as not to expose her children to the depth of her grief. She attempted to create happy experiences for her children and when they expressed sadness she assured them that "it will be OK" and ushered them towards more pleasant experiences.

Bradley witnessed his mother trying to keep the family together. He also witnessed his older brother demonstrating more overt emotional expressions of grief and Bradley, a middle child that excelled at caring for others, stifled his own expressions of grief in an attempt to lessen the burden on his family. He continued to thrive academically and socially in an attempt to mask his struggles. He dissociated

from his suicide attempt, reporting that he did not remember it. He stated that the cause "wasn't me", but that the attempt had entirely been a side effect of his medication. The re-emergence of Sebastian was conceptualized as another form of dissociation. Bradley's grief, pain, and anger were powerful, but Bradley did not believe it was acceptable to express these emotions; therefore, Sebastian became an external container for this emotional energy.

Diagnoses. The death of Bradley's father was viewed by his clinicians as a trauma, and his dissociative and depressive symptoms as a stress response. Using the DSM-5, Bradley was diagnosed with Major Depressive Disorder, Recurrent, Moderate 296.32, Other Specified Trauma-and-Stressor-Related Disorder, persistent complex bereavement disorder 309.80, and Depersonalization/Derealization Disorder 300.6 (American Psychiatric Association, 2013).

Wilderness Treatment

The therapy program provided Bradley with a simplified daily routine that revolved around primitive outdoor living in a small group of up to six students with a 3:1 student to staff ratio. In addition to the field guides who provided 24/7 support, Bradley had two Master's level clinicians who met with him twice weekly for hour-long sessions. Following the clinical model of the program, the therapeutic alliance, the most agreed upon common factor and most robust predictor of positive therapeutic outcomes (Greencavage & Norcross, 1990), was an integral part of Bradley's treatment. Also, in keeping with the program's model, Bradley was initially encouraged to experience the natural consequences of his thoughts, emotions, and behavior in order to help him identify maladaptive behavior patterns. In this group setting, Bradley was provided with daily opportunities to receive both positive and constructive feedback in the moment, along with daily structured process groups. These factors, in addition to the healing power of close connection to the natural world (Doherty, 2010), provided Bradley with a supportive, validating and structured setting in which to explore his emotional experience and test new healing behaviors.

Therapeutic Approach and Interventions

Bradley's treatment focused on three main areas: (1) helping Bradley to acquire skills in emotional identification, acceptance and expression, (2) systemic family shifts to allow for the expression of grief, and (3) psycho-education on systems theory, systemic family grief, dissociation as a trauma response, and male socialization. Interventions in each of these areas occurred within the context of individual therapy sessions, group work, family therapy, individual reflection through therapeutic assignments, and daily living.

Identification of behavioral patterns. Early in his stay Bradley's clinicians identified his patterns of pleasing others and emotional stoicism. Bradley's verbal and cognitive abilities were above average for his age and it therefore was appropriate to engage directly with him in conversations about these behaviors.

Client response. Bradley was interested in engaging in conversations about his patterned behaviors, and was easily able to connect his behavior in the group to his presentation at home. Bradley began exploring family dynamics through these conversations and identified his intention of protecting his mother and siblings from his unpleasant feelings, along with his belief that emotions such as sadness and anger were not acceptable to express. Bradley was also able to acknowledge that emotional stoicism had been maladaptive for him and contributed to many of his current unwanted symptoms.

Goal creation and group work. With the help of his therapists, Bradley created an initial therapeutic goal. Bradley's initial goal centered on authentically expressing his emotions to his group members and

staff in real time, while subsequent goals progressively focused on gaining comfort with vulnerability in front of others and self advocacy. Bradley's stated his goal out loud daily and he was given frequent feedback from peers and staff; both congratulatory when he made progress towards emotional expression, and constructive when he was not honest or forthcoming about his emotional experience.

Client response. Bradley engaged willingly in the goal creation process and felt connected to his personalized goals. In his group setting, Bradley practiced in-the-moment emotional expression. Bradley initially struggled with this, wanting to avoid inconveniencing or upsetting his peers. Eventually, Bradley shifted his emotional expression dramatically, exploding by screaming and ranting to his group mates about aspects of his life that he was angry about, and stating that he didn't care how his outbursts affected his relationships. With time, Bradley balanced these two extremes, avoided emotional buildup, and expressed difficult emotions in the moment. With support and feedback from his group, Bradley became more comfortable with emotional expression. The content of Bradley's emotional expression also evolved over time. Initially, he practiced expressing frustration over inefficient group functioning, and as he gained proficiency he progressed to expressing anger about his father's death and his own need for emotional support, and finally to sadness and grief over losing his father.

Psychoeducation. Psychoeducation on a variety of relevant therapeutic topics served to normalize, rather than pathologize Bradley's symptoms and family experiences. In addition, psychoeducational conversations helped Bradley to self-identify progressive therapeutic goals. Throughout his treatment Bradley was educated about individual and systemic family responses to grief, systemic concepts of homeostasis as it related to group and family dynamics, dissociation as a stress response, and the contribution of male socialization to his pattern of emotional stoicism.

Client response. Bradley frequently expressed interest in psychoeducational topics. Understanding that dissociation can be a psychological symptom of trauma/stress helped Bradley to decrease his shame around this symptom. Bradley's imaginary friend Sebastian was normalized and conceptualized as a part of him that held unwanted and difficult emotions and thoughts. By approaching Sebastian in this way Bradley was able to shift his perception of this symptom and reintegrate fear, sadness, and anger into himself. Discussing grief responses created a bridge that allowed Bradley to approach a difficult topic safely while also normalizing and gaining insight into his family's experience. At one point Bradley noticed that when he started expressing more difficult emotions to his group members, his peers became uncomfortable. They were used to Bradley presenting himself as regulated and happy and confused supporting him with attempting to remove his difficult emotional experiences. Systemic concepts of homeostasis and negative feedback: that families systems tend to reinforce expected behavioral patterns, even when unhelpful and destructive, (Watzlawick, Bavelas, & Jackson, 1967) were explained in order to help Bradley understand and predict how others might respond to his individual change. Gaining this knowledge highlighted the importance of explaining and advocating for appropriate support to his group members and family.

Parent therapy. The program provides a separate parent therapist for each family to engage parents in discussions about their families or origin, values, interpersonal boundaries, and how these contribute to systemic family dynamics and their children's presentations. Susan engaged wholeheartedly in the parent program and through that she identified her fear that her children would be swallowed by grief. She recognized that through her behavior, she had encouraged Bradley to stifle unpleasant emotions and appear happy. Susan began to make significant shifts in the way in which she responded to her children's sadness, creating room for the expression of grief rather than trying to pull them out of it.

Impact letters. Parent therapists supported Susan in writing an impact letter to Bradley. In this letter, Susan told Bradley about her own emotional experiences as his parent and described her grief process after John's death, in addition to her reaction to finding Bradley during his suicide attempt. She shared

with Bradley her insight into how she had reinforced Bradley's behavior of stifling his grief. Susan also expressed her intention to allow for and encourage a full range of emotional expression in the family. Bradley was profoundly touched by his mother's letter and engaged fully in the response process. He utilized reflective listening and validation skills to reflect what Susan had shared, and expressed his own internal experience of John's death, and his subsequent depression and suicide attempt. Especially notable in this letter was Bradley's ability to identify the emotional triggers behind his suicide attempt and take accountability for it as his own behavior, rather than dissociating from it.

Family workshop. Three-quarters of the way into Bradley's stay, Susan attended an in-person family workshop with Bradley, which was facilitated by a Master's level Marriage and Family Therapist. An art therapy activity, during which Bradley and Susan drew a representation of their family dynamic before treatment, fostered a dialogue about problematic individual and family behaviors and hopes for the future. Bradley was clearly able to identify the disconnection he felt from Susan and other family members after John's death, his inability to ask for help, and the inauthentic smile that he wore to mask his grief and depression. Bradley and Susan engaged in heartfelt discussions during which they expressed their desire for emotional honesty and communication and laid the groundwork for a new family tone that welcomed the expression of unpleasant emotions.

Client response. Both Bradley and Susan identified family work as very impactful and integral in the healing process. Given Bradley's current developmental stage and desire to protect his family, it was essential that his Susan take the first steps by identifying maladaptive family patterns and take accountability for her role in their creation and maintenance. Through these actions she was able to lead Bradley towards self-acceptance and self-expression. By fully engaging in the therapeutic process herself, Susan implicitly gave permission for Bradley to do the same.

Experiential exercises and metaphors. Experiential exercises were often used to supplement and enhance therapy sessions. When discussing male socialization, Bradley engaged in an emotionally powerful exercise in which he placed emotions that are socially acceptable for men to express inside a box of sticks. Bradley was able to take this exercise a step further, by identifying emotions that his father freely expressed in contrast to emotions he was uncomfortable showing. This experiential moment provided a moment of connection between Bradley and his father, which led to an emotionally cathartic moment and shared vulnerability. Later, Bradley facilitated a group conversation about male socialization using the same exercise. Bradley also decided to write his father an impact letter. This personal exercise allowed Bradley to deepen his connection to the memory of his father and experience additional emotional release. Wilderness-based metaphors were also frequently used and helped Bradley to develop a language with which to talk about his struggles. For example, in his impact letter to his mother he wrote that just like carrying a pack that was too heavy, he had carried too much emotional weight for too long and was learning to lighten his load.

Transition. Bradley's mother decided to bring him home after completing the wilderness program based on the progress in emotional identification and expression, his high level of functioning in other areas, and the personal shifts that she was able to make. Bradley's final two weeks at the program focused on preparing for the transition home. He expanded communication to include his siblings and friends: Bradley wrote to his siblings, telling them about the changes he had undergone while in therapy and the emotional changes they could expect to see when he returned home. This was followed up with a face-to-face family session post-graduation in which Bradley was able to verbally discuss his growth. Bradley and his mother also worked together to create expectations for home. During this process, they both identified aspects of the program that had been helpful for Bradley's emotional development, including frequent emotional check-ins, family therapy work, leadership roles, structured times for emotional processing, and service to others. Together they developed a list of

specific and clear expectations that would hold Bradley accountable to this continued level of self-care at home. Susan also sought out an appropriate family therapist and a clinically informed male mentor for Bradley at home. The therapists discussed Bradley's progress and treatment transparently with these professionals in order to increase collaboration and clinical cohesion.

Conclusion

The group environment, in which Bradley was provided with 24/7 therapeutic support, was integral to his progress. The safe and caring nature of the setting and group relationships, along with the constant presence of clinically informed staff, allowed Bradley to receive the in vivo feedback that he needed in order to exhaust his patterns of stoicism and people pleasing and experiment with new behaviors.

In addition to Bradley's insight into the need for a full range of emotional expression and his ability to practice this, several aspects of the clinical approach were fundamental to his treatment. Susan's ability to provide Bradley with an emotional road map by identifying maladaptive family patterns, taking responsibility, and making systemic shifts to allow for the expression of discomfort was essential. Susan's emotional work gave Bradley permission to make the changes he needed. Finally, by educating Bradley about dissociation and conceptualizing Sebastian as an externalized part of him, the shame around this symptom was decreased and Bradley was able to intentionally work towards reintegrating difficult emotions back into himself.

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RESIDENTIAL TREATMENT CLINICAL CASE STUDIES

Treating a 17 year-old with Moderate to Severe Anxiety Disorder

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Abstract

This case presents the treatment of a seventeen year old male for anxiety disorder. The treatment focused on cognitive exposure therapy and in-vivo exposure for family and school-based concerns. Since the completion of treatment, the client has had success at a traditional boarding school and has had not been limited by anxiety.

Background Information

Jack arrived at WayPoint Academy at the age of 17 years and 6 months. He grew up as the only child of single mother, Mary. His biological father had a brief relationship with his mother but they never married. Jack's interaction with his father was intermittent and sporadic, as his father lived in a different state. There were times that Jack had no contact with his father for years.

During the pregnancy, Mary reported her first episode with Obsessive Compulsive Disorder (OCD), which was evident primarily in contamination fears. Convinced the world around her was contaminated, Mary was propelled into a host of compulsive rituals. She thought the public water supply was contaminated and hence she purchased "pure" water in one-gallon bottles. The "pure" water usage ranged from personal hygiene (showers, brushing teeth) to washing dishes and drinking water for the family and the family pet. The cost of the "pure" water prevented the family members from taking regular showers and the timely washing of clothing and bedding, which, paradoxically contributed to the decline in overall hygiene of the home.

Mary's contamination fear morphed into related obsessions. The "contaminated" outside air "forced" the family to stay indoors for long periods of time. Shopping trips were followed with elaborate "cleansing" rituals. Because of the rarity of outside shopping trips, the "pure" water supply was limited and dirty dishes, pots, and pans were found throughout the apartment. The same was true for items of clothing.

By the time Jack entered elementary school, other problems arose. Mary insisted that Jack was being underserved through the public school system. To combat this perceived shortcoming in the educational system, Mary insisted on hours of extra homework. Jack looked forward to escaping from the apartment and his mother by going to school. However, the combination of a) Mary's contamination fears, which increasingly focused on her son, and b) Mary's desire to provide Jack with better education, propelled Mary to periodically withdraw Jack from school. By the time Jack was 17 years old, he had missed 2 years of high school and the associated credits.

Jack's lack of school credits came to the attention of Jack's extended family. While investigating the apparent problem they came to the conclusion to seek academic and psychological help for Jack. With the assistance help of an Educational Consultant, Jack's extended family placed Jack in a short-term residential treatment center. After about 12 weeks of treatment, the decision of his treatment team was for Jack to be transferred to WayPoint Academy, an extended residential treatment program that could aid Jack in further resolving his anxiety.

TREATING MODERATE TO SEVERE ANXIETY DISORDER

Description of the Present Problem

Knowing that he would be referred to WayPoint Academy, Jack called the WayPoint therapist on 3-4 occasions while still in the short-term program. His inquiries were focused on the daily routine at WayPoint, the age of other boys in the program, and who would be his primary therapist. Jack's anticipatory anxiety was quite evident.

When the therapist picked Jack up at the airport, he met a young man, 6ft. tall, and curly hair with an athletic built. Jack was very polite and initially made good eye contact. But, soon after meeting, Jack's eyes began to wander while pacing pack and forth. The therapist told Jack that his mother called a few minutes prior to his arrival, inquiring about his safe arrival. Immediately, Jack had a visible anxiety attack with increased respiratory rate, sweating hands and forehead. He asked permission to sit down. He was emphatic that, during his previous treatment, he was instructed not to call his mother, as any communication with her would "put me in a tailspin."

During the first week at WayPoint, two issues became apparent. First, Jack characterized his relationship with his mother as problematic, suggesting that she treated him much like a prisoner. During the initial stages of individual therapy, Jack repeatedly referred to himself as the "pathological extension of my mother's severe OCD". He spoke of a deprived upbringing, describing the ways that his childhood experience deviated from the norm. Hence, whenever the topic of his mother arose, Jack's emotions vacillated between overt anger and anxiety. Second, in the formal classroom, Jack experienced a great deal of anxiety. He seemed unable to focus, was highly distractible, and had little follow through on assignments.

Diagnosis

Based on a Psycho-Social Assessment, The Burns Anxiety Inventory, a Psychiatric Evaluation, and the Leisure Interest Inventory, Jack was diagnosed with Anxiety Disorder NOS. During the first 2-4 weeks of treatment it became evident that the triggers for his anxiety centered on his mother and the classroom environment. In addition, Jack suffered from diminished self-esteem and issues with identity formation, both of which seemed related to his anxiety.

Intervention

During the initial phase of treatment, detailed information was gathered about Jack's cognitive and affective response to his living environment. Individual and Group Therapy revealed that Jack's anxiety was acquired through a) the prolonged restricted living environment with his mother, b) his innate fear of performing adequately in the classroom, and c) self-doubt about negotiating "real" live in the future. Of clinical significance was the fact the Jack verbalized an intense desire to overcome his anxiety and willingness to do "whatever it takes" to ready himself for a normal, anxiety-free life. Moreover, Jack had a good idea of the etiology of his anxiety. What he needed were tools to increase his distress tolerance.

Jack's most severe panic attacks, both past and present, were centered on interactions with mother. Jack indicated the "... While I never plan to go back and live with her, I need to be able to interact with her without coming unglued". Accordingly, individual therapy focused on cognitive and in-vivo exposure therapy.

Cognitive Exposure Therapy

The initial treatment objective centered on assisting Jack in establishing a fear-hierarchy scale pertaining to his most anxiety-provoking interactions with his mother (i.e. 0 = no anxiety, 10 = severe anxiety). A

score of "zero" represented not thinking of his mother, whereas a score of "ten" represented having a live, in-person conversation with her that centered on Jack's honest disclosure of his experience growing up in her home.

The second treatment objective was to teach Jack relaxation techniques using guided imagery with the aid of a biofeedback machine. With Jack's eyes closed, the therapist guided Jack through a number of visual scenes. The therapist then prompted Jack to "experience" the visual tour with all 5 senses. Concurrently, the biofeedback apparatus would indicate the breathing pattern of Jack. Hence, erratic, short breathing would indicated anxiety, while even, deep breathing for 2-3 minutes would indicated a state of relaxation.

Through a serious of therapy sessions, Jack was incrementally exposed to the triggers on his fear-hierarchy scale. The therapist described a setting consistent with a trigger on his fear-hierarchy scale and monitored his breathing pattern. If the breathing became shallow and rapid, the therapist guided Jack through the "relaxing journey" of a guided imagery until Jack's breathing pattern returned to normal. When Jack was able to maintain a normal breathing pattern while experiencing a trigger on his fear-hierarchy scale, the next higher trigger in his hierarchy was introduced and so on. The use of the biofeedback machine was abandoned once Jack was able to control his breathing through the first half of his triggers on his fear-hierarchy scale.

This process was not linear, as is typically the case with anxiety. For example, at one point, Jack progressed successfully to 3 step on his fear hierarchy, only to cycle back to the bottom of the fear hierarchy scale a week later. However, over a 2 month period, Jack was able to achieve sufficient distress tolerance during high levels of cognitive exposure, as evidenced by the fact that he could consistently deal with increased triggers while keeping his anxiety in a manageable and mild state.

For subsequent exposure therapy, the "finger-method" was employed. Raising the thumb of the hand would signal "no anxiety." Raising the index finger would indicate little anxiety and so on, until the rising of the little finger would indicate high anxiety. Jack moved smoothly thru this level of exposure and realized increased benefit from it.

In-vivo Exposure Therapy

The next series of anxiety treatments focused on triggers that were based on conversing with Jack's mother on the phone. In an ascending order they were a) 5 minutes of small talk, b) 10 minutes of small talk, c) 20 minutes of small talk, d) 10 minutes of processing with mother the reason Jack was in treatment, e) 30 minutes of conversation about why Jack was in treatment, f) explaining to his mother that Jack would not return home after treatment, but would enroll in a boarding school. Since it was not practical to place mother "on hold" during a phone call if Jack became too distressed, it was decided that Jack would terminate the phone call. Any premature termination of a phone call would be immediately followed up with a familiar relaxation exercise. Over a period of 4 weeks, Jack was able to successfully negotiate all of the above-indicated triggers.

The next series of triggers involved having Mary visit Jack at the treatment facility. The ascending hierarchy of those triggers was similar in nature to what was described above. They consisted of visiting with Mary for gradually increasing amounts of time and a shift from benign topics to highly sensitive topics, such as those involving the etiology and consequences of Jack's anxiety disorder. On the top of Jack's fear-hierarchy scale was spending a night with Mary at a hotel. After each step, Jack processed with the therapist. Data was collected about the level of distress along with countermeasure to be employed if the distress level became intolerable. The countermeasure consisted of calling the therapist for assistance. During a 3-day on-site visit with Mary, Jack was able to maintain his distress

tolerance above the distress level and consequently never called the therapist. Jack reported that his anxiety level never rose above a level of two. The last step as part of the exposure therapy was for Jack to visit Mary at her home for a couple of nights. This too was successfully managed. Jack's anxiety level rose no higher than a level of two.

In-vivo Exposure Therapy in the Classroom

Beginning with the enrollment at WayPoint, Jack was placed in the classroom. The online curriculum, implemented with the aid of teachers, allowed Jack to progress at his own pace. During the initial phase of treatment, Jack engaged in an appreciable amount of avoidance behavior surrounding the timely completion of assignments. However, as his distress tolerance rose relative to interaction with his mother, so rose his rate of completion with academic assignments.

Other Components to the Treatment

Prior to treatment, Jack had no contact with his biological father for a few years. Arrangements were made for a series of in-person family therapy sessions between Jack and his father. Consequently, throughout the latter course of Jack's treatment at WayPoint, he spent a number of weekends at his father's house. Jack's response to this newly re-kindled father-son relationship was that ". . . . I no longer feel like a bastard child."

Prior to treatment, Jack had little exposure to the social word around him. Interaction with peers and adults were spotty. The culture of peers at WayPoint and the ongoing interaction with adults, both in formal and informal ways, contributed to Jack's newfound identity formation.

Because of Jack's upbringing, he was only marginally involved in typical food purchasing, selection, and preparation. Consequently, Jack benefited from growing a garden and food preparation, both of which are part of the daily routine at WayPoint. These experiences gave Jack tangible life skills for his future.

Upon admission, Jack's reported that the only activity he had participated in was swimming. Through the daily cardiovascular exercise program and the variety of recreational activities, Jack discovered a host of new interests, all contributing to a new sense of self-confidence and identity formation.

Disposition after Discharge

By the time Jack finished his treatment at WayPoint, he had turn 18 years of age. Because Jack missed much school in the past, following discharge from WayPoint, Jack enrolled in a traditional boarding school. Since his enrollment in the boarding school he has been an "A" student. Jack does not plan to live with his mother in the future, however he visits with her occasionally.

Experience, Strength and Hope: One Mother and Daughter's Journey Through Addiction and Recovery

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* *Pseudonyms are used for authors to maintain their anonymity due to the personal nature of the article.*

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Anna Bissette is a freshman in college, intending to dual major in Art and English. She works on campus and attends twelve step meetings every day. She enjoys hanging out with friends, movies, running, writing and drawing. She loves all animals, even snakes.

Abstract

This story is an exchange between a mother and a daughter during their three-year experience in the recovery system. The purpose of this article is to help others understand the mindset of one parent and one adolescent at different stages of recovery. The mother's mindset progresses from one of trying to find solutions for her daughter to learning how to take a supporting role. The daughter's mindset changes from one of hopelessness to taking responsibility for her recovery. The authors believe the sharing of their experiences, strength, and hope can benefit parents and treatment professionals by providing insight into feelings and lessons of their experience.

Introduction

Mother: Early in 2004 my daughter made it known that she was depressed and cutting. Three years later she was discharged from a long-term stay at an adolescent residential treatment program. Today she is reasonably happy, employed, in college, and active in the community. In addition to depression, she also now knows that she is an addict. Not every child entering a therapeutic school and program is an addict, but many are. For my daughter, the support of a residential program that included twelve-step work was key to her recovery. The purpose of this paper is to share our experience hoping that it will help others. Rest assured that our experiences are not unique—there are thousands of others living their own versions of this story. Names, faces, and events are different, but key elements are the same. Whether you are a child, parent, or treatment professional, it is our hope that you find some beneficial information and strength in these pages.

As I look back, I realize that if "I knew then what I know now" I might have done things differently. As a parent (and human being) I now know I am not perfect, and I am destined to make mistakes. However, I take comfort in knowing that I did the best I could under the circumstances, even though hindsight indicates different actions would have perhaps been better. When my child was in crisis and courting death, my best didn't seem nearly good enough. I wanted to fix things for my daughter—to find the "magic bullet cure" that would make all her problems go away. I know now that no such thing exists, and when I try to fix things for her I get in the way of her recovery. I also know what makes me a good mother is striving, engaging, making mistakes, learning from them, adjusting, and doing the best I can each day for my children and myself. Words cannot express how grateful and proud I am that my

daughter is now living her life on her own terms and wants to share in this dialoge.

Daughter: I am co-authoring this article with my mother because I think it will be helpful to treatment professionals and parents of troubled and unmanageable youth to hear my story. The main point I would like people to understand is that I am the one responsible for my recovery, and the most helpful thing my mother has done for me in my recovery was sending me to treatment and providing an environment for me where I could do what I needed to do to recover. Changing my ways was a decision I had to make myself. I often see parents trying to control their children in hopes that they are keeping them safe. In my experience, there has been nothing anyone could do for me to keep me safe no matter how controlled I was, unless I was willing to live healthfully. I hope that this article is helpful to those who read it and brings more understanding into the mindset of an addicted teenager.

Where We Started

Mother: This story doesn't really begin at any one point in time because for years there were warning signs that my daughter was deeply unhappy. The starting point for this story is January 2004.

What does a mother say when her daughter tells you she is depressed? This memorable conversation took place while I was driving my daughter to Best Buy to purchase a CD that she "had to have now." I had been out of town on a business trip for about a week so I was trying to make up some lost mother/daughter time. This may be familiar to some parents who tried, like me, to make up for their child's unhappiness by buying them things they wanted.

My daughter told me she was depressed. I tried to make light of the situation by saying something like, "Everyone gets sad sometimes," but then she pulled up the sleeve of her sweatshirt and exposed fresh scars on her arm, stating: "But not everyone does this." This was my point of awakening. A voice in my head said, "Something is seriously wrong." I felt panicked. My child was cutting up her arm and I hadn't known about it. As her mother I felt helpless and responsible.

What was I to do? I felt responsible for finding a solution. I started at the doctor's office, which was the only place I could think of. What she got there was a tetanus shot, a referral to a psychiatrist, and a lecture about how good her life really was.

Daughter: At this point in my life I never considered the way my mother felt. I knew she wouldn't get me into trouble or hold me accountable, so that is why I chose to tell her I was hurting myself and I needed help.

Feelings of alienation, self-hatred, depression, anger, and resentment had brought me to a point where I could not will myself into healthy thinking. I did not want help from anyone—I just wanted to quit feeling pain. I told my mother I was hurting because I felt like I would kill myself if I continued to keep my depression a secret. I am not sure where my downhill path began or where my dark moods came from. No matter how good my environment was, and how many people reached out to me, I chose to isolate myself and dwell in emotional pain. I entered a self-destructive mindset where I idolized addiction and mental illness. All of this happened before I picked up drugs. I was sure I wanted to destroy my life and make the biggest bang possible on my way out. Without regret, I chose the consequences I had coming for my behaviors. I could not find emotional relief because I was unwilling to change.

The Rocky Road

Mother: Our "rocky road" covers over a year and a half of trials and failures in the treatment system before my daughter was admitted to her second residential treatment program. For her, treatment

consisted of outpatient treatment from psychiatrists and therapists, five hospitalizations in acute psychiatric units, and a four-month residential treatment stay. I now know that it's not unusual for families of children with addictions to follow a similarly complex and painful path before finding appropriate treatment.

Outpatient treatment for my daughter started with regular visits to a psychiatrist and therapist specializing in adolescents and children with psychiatric problems. The doctor and therapist were the best in the region, and they used everything in their extensive toolbox to help. My daughter's diagnosis changed from severe depression to bipolar disorder. I now believe her bipolar disorder diagnosis to be "over-diagnosed." I have heard of many others who, like her, were diagnosed with bipolar subsequent to depression because of manic reactions to antidepressant medications. During these months it seemed as though everyone was trying to help her, but none of the "helping persons" or I stopped to ask how much she was invested in helping herself. We tried many different combinations of medications and therapeutic support. I felt like we were looking for the medication or therapeutic technique that would make her pain go away. Nothing worked, but that didn't keep me from thinking and hoping that it would. This time of medication trials was very frustrating and emotionally painful. For me, it was a cycle of hope and despair. Hope each time a new medication was prescribed, and despair when it didn't work. The side effects were debilitating and preceded several hospitalizations. The medication trials didn't have any guarantees or end point. That's just how it was. As I understand psychiatric medication today it seems as much of an "art" as it is a "science." There are no specific answers. Treatment professionals searched for the right combination for what seemed like an eternity. In hindsight, I believe there were some organic bases to my daughter's difficulties, but nothing medication could have fixed. Meanwhile my daughter started using drugs and she became worse instead of better.

My daughter's first referral to an acute inpatient psychiatric hospital came as a complete surprise to me. It was a new stage of crisis. It tore at my heart the first time I left her at a psychiatric hospital. Later it became a standard part of her treatment routine. Somewhere during this time she started smoking marijuana, using alcohol, and stealing any narcotics she could get her hands on. I knew some of what was going on, as did her treatment professionals, but she said it made her feel better. I was complicit. All I wanted was for her to feel better. I was manipulated (as were treatment professionals) because we all knew she was using, but we were powerless to stop it. I was in denial about how bad her drug use was, and I hoped she would stop using drugs once she felt better. I now know that this was a false hope. As a parent, I now believe that if you know your child is using some drugs, in reality they are probably using a lot more than you think.

Daughter: When I started receiving treatment. I was too ashamed of myself to be honest about my reasons for being sick. Outpatient therapists and psychiatrists were incapable of holding me accountable and made a very small effort to call me out on all of my deceptions. My mother continued to enable me in all of my unhealthy behaviors. I began to resent her for her constant involvement in my life. I thought I was completely independent and did not need her. The reality was that I was irresponsible, immature, scared, desperate, lonely, and self-pitying (I was the last person who wanted to see that). My drug use started when I manipulated my parents into letting me drink. I believed that psychiatric medications would be the ultimate cure for my problems. From prescribed medications I progressed to illegal substances. I thought I had finally found the solution to my unhappiness regardless of the warnings I received from counselors, institutions, friends, and family. Because I was not using "hard drugs," I didn't think I was an addict. I was so insecure I thought that the worse my behavior became the more people would think I was cool.

I quickly got to a point where I could not function when I was not high. I manipulated my mother and

therapists to let me have drugs. However, there were not enough drugs to fill up the emptiness inside of me. I still believed that I could find a way to successfully get high.

Mother: Around Christmas when my daughter was hospitalized for the fourth time, it became clear that she was too much of a danger to herself to live at home. She needed more support than outpatient treatment could provide. By this time I was incredibly frustrated and felt helpless. With all the resources I had at my disposal (i.e., education, experts, medical insurance), how could I not help my daughter get better? I asked, "Where should I send her for treatment?" No one could give me a specific answer. Her helping professionals had some ideas, but little time to support the process of selecting a facility. It was a difficult position to be in. My daughter was in the hospital and needed to transfer to a residential program, but there was little time. To me, she was in eminent danger and she had to go somewhere NOW. There were so many considerations: proximity, insurance, diagnosis and age, accreditations, and do they have beds and will they admit her? What I didn't know then was that treatment facilities differ considerably, and at the time I didn't know what questions to ask. Some treatment programs are good, and many are not. Some are a good match for adolescents, and others are not. The first question I should have been asking is, "Are they helping adolescents with issues like she has?" Now I would never recommend sending a child anywhere without documentation of treatment plans, family involvement, documentation of outcomes, and references from other parents. At the time, I didn't feel I had enough time or even knew what questions to ask (see the conclusion of this article for more information on questions to ask). The first treatment center she went to did help in some ways. She did not use drugs during that time. She did achieve the minimal level of her treatment goals. Yet I had a nagging feeling during this four-month period that she wasn't really getting better. Our family was only peripherally involved in her first treatment program. At this point I still didn't realize that my daughter was not trying to help herself. Neither this treatment facility (not a very good one), nor any other, could actually do anything for her. All a good treatment program could do was facilitate a process whereby she would eventually want to help herself, and then they could give her the tools she needed. I also now know that substantial family involvement throughout the treatment process is necessary to support a successful recovery.

I signed my daughter out of the first treatment program and brought her home to family chaos. Although she returned to her original high school and continued in outpatient therapy, her drug use escalated. My daughter began skipping school, running away, manipulating, lying, and stealing to get drugs. It became apparent that I couldn't take care of her at home, and my worst fear was that if she continued on her present course she would soon be dead. I started looking for a better treatment option. I sincerely believed she couldn't get better in a clinical environment, and an experiential/outdoor component would be necessary for her to recover. However, my insurance plan required that a program have national accreditation, 24 hour nursing support, and other therapeutic components more common to clinical settings than wilderness programs. However, there are programs that provide both outdoor and clinical components. By now I was prepared to look past glossy advertising for documentation of long-term outcomes. This time, I asked for evidence of program outcomes, and I requested names and numbers of other parents whose children had attended. I decided on Peninsula Village, a residential treatment center in the Smokey Mountains near Knoxville, Tennessee. The third time she ran away, she called me to come get her after being missing for three days, and we left for Peninsula Village that same day. It's difficult to leave your sick child in someone else's care, but I was aided by the knowledge that I couldn't keep her safe at home. I knew I had tried my best, and my best wasn't enough. I also still didn't know she was an addict. This was a decision she would later make for herself during treatment.

Daughter: I started running away, prostituting myself, and stealing money to get high. Every time I ran away, I would come home physically, mentally, spiritually, and emotionally beaten. I would claim I was

going to change my ways and sometimes I believed myself; my desire to use drugs always won out over my commitments to stay clean and safe. I continued to run away. In the end I knew that I was going to be locked up somewhere because my using was taking me to extremes, but I went on drug binges anyway. I thought a one night high was worth months of treatment. When my mother, the police, and my outpatient therapists reached the realization that there was no possible way I was going to recover without being restrained from myself, I ended up going to treatment.

Journey Into Recovery

This section really belongs to my daughter. My role became one of supporting her recovery process. There were three distinct phases at Peninsula Village: Assessment, Outdoor Program, and After-Care. In hindsight, I understand the critical importance of each stage as necessary preparation for the one that followed. And at the start of her treatment I could not have understood what I currently do about the how's and why's of these stages. Fortunately this time I had done my homework; I knew this treatment program had excellent credentials and it was a good fit for her needs. This allowed me to trust the program staff despite periodic misgivings. The lesson I took from this was: Make sure you choose a good program, and then let the program work with your child. Trust the process. I've seen other parents question the treatment program and be manipulated by adolescents who are telling parents they are being abused. I believe any adolescent who needs treatment will try to escape using any means they can, including well-crafted manipulations that target parent's weak spots, and parents need to be prepared to stay the course. If you think your child needs to be in treatment then they probably do. What was going on was far worse than I realized, and I think this is true in many cases. Denial is very powerful, and while it may help parents survive the trauma of having a troubled child, it can be a tremendous obstacle when it obscures the seriousness of the situation.

The Beginning

Mother: It wasn't that hard for me to leave my daughter at Peninsula Village because I was terrified for her safety, and I knew I could no longer keep her safe at home. Her commitment to using drugs combined with her history of outpatient treatment, repeated hospitalizations, a failed residential placement, and more recently, running away, convinced me as nothing else could have. If it had not been for these events, I don't know if I would have had the courage to take her to treatment. The team informed me she would likely have a one to four month stay on the assessment unit. At the time I was convinced she would get through it faster. To me, it seemed like she wasn't doing much except sitting on a bed in a locked unit and participating in groups a couple times a day. I questioned the program and would hint that she needed to move forward. I was concerned that the program was too harsh. They took away things she used for comfort, such as her journal, art, books, and her phone call privileges. I felt sorry for her, but I shouldn't have. It was what she needed. She would make some progress only to break rules and backslide. Every time it looked like she was close to moving to the outdoor program, she'd sabotage herself. At the time, I wanted her to move on to the outdoor program quickly, and I was frustrated with her slow progress. Now I know she was exactly where she needed to be. Everything in the program had a distinct purpose, and even though it didn't always appear therapeutic to me, it was therapeutic and it was working. I now believe that without this time in assessment she would not have been prepared to take responsibility for her own problems.

Daughter: I hated my mother for sending me to treatment. I didn't want to tell the truth about myself so I didn't get any recovery. I spent hours on end daydreaming about getting high and what I should have done differently in order to successfully run away. I wanted to go back in the past or be dead in the present because I had lost all hope for myself. At first, the restrictions of the environment in treatment created an atmosphere where I had to sit with myself. I had been running from my issues for

so long I needed the tough love and hours of thinking time the unit had to offer. Over time, I started complying with the rules in the program because I wanted my life there to be as painless as possible. I eventually became complacent in my recovery because the restrictions of the Girls Adolescent Assessment Unit had become too familiar and comfortable for me to change. As a result, on Tuesday, September 13th, I was pushed from (the polite word for "kicked out") the Assessment Unit to the Outdoor Program. To me, the Outdoor Program was an intimidating war zone where everyone had to learn how to get honest and do 1,000 push-ups. I was the awkward new peer suddenly thrown out into a group of strong young women, who expected me to be more than a sad little girl pretending she was on a different planet.

The Outdoor Program

Mother: When my daughter started becoming a little too comfortable on the assessment unit they placed her to the outdoor program. I learned there were two ways out of assessment: (1) earn it by complying with program structure, or (2) get pushed out by your treatment team. My daughter went through a difficult transition because she was pushed. Peninsula Village treatment teams design an individual focus for each child and "care methods" (i.e., consequences) for poor behavior and rule breaking. Care methods were contrived, but they served as effective metaphors for consequences that would occur in the outside world. One of my daughter's difficulties was respecting rules and authority figures. For this she was assigned push-ups. Another was carrying a Hula Hoop everywhere because she violated others' boundaries. At first I worried that this was abusive, but after watching and waiting I saw her begin to appreciate the structure and learn important lessons from her care methods. She became proud of her pushups and developed respect for rules and authority. Patients earned privileges by progressing through levels. The level system was very difficult, and she was the one who had to do the work. As such, the levels and privileges that came with them were very meaningful to her. She was the one doing the work, and she had something to be proud of. Throughout her stay we had weekly family therapy sessions. As she progressed, the treatment team scheduled off-campus days and weekends so we could learn to live together again in a healthier way.

Daughter: I hated the outdoor program. I went through a lot of pain there because the environment was harsh for patients who were unwilling to recover. I had consequences for my actions and people quit trying to be nice to me. I was called on all of my crap and I didn't have any friends. I realized acting depressed and self-pitying wasn't getting me anywhere. I decided about six months into treatment that at some point in my life I wanted to leave treatment, and I was the one responsible for how long my stay would be. I started talking to my group about my secrets I had previously decided to take to the grave. My staff members and peers introduced me to the 12 steps and I began to work them.

Realization that I am an addict was not a sudden epiphany. As I struggled to change my behaviors I learned that I am a really sick person. I became aware that if I wanted to have any part of a satisfactory life I could not use drugs; however I did not fully understand what being an addict means to me. This is something that I am still learning to accept today. Treatment gave me the roots I needed to fully accept my disease.

Change is a long, slow, painful process, yet I discovered rewards for healthy behavior. There isn't space to describe the spiritual change that took place inside of me. To sum it up into one sentence I would say that every month I was amazed by how my thoughts were rearranging themselves as a result of the work we did in treatment. I learned the skills to live in treatment successfully and started progressing through the level system. Occasionally I was happy, which was a strange phenomenon to me after my previous hopelessness.

EXPERIENCE, STRENGTH, AND HOPE

After-Care Planning

Mother: The last part of treatment was both exciting and frightening. I worked with my daughter to set home rules, and she identified yellow and red flags (i.e. behavioral signs that she was in danger of relapse). While sober and in the therapeutic environment, she determined what course of action she and I would take in case these problems occurred. For example, if she had a desire to use she was supposed to tell someone and call someone in the Twelve-step program for support. We attended a workshop with other parents and patients to work through a family discharge plan. The main thing that stuck with me was the therapist's comment: "You don't have to go back to living the way you were." That's when it dawned on me that my daughter and I now had the tools to support her recovery. If she wasn't working her program, I did not have to go back to care taking, enabling, and so on. A key question I had was "What would I do if she relapsed and didn't take steps to regain recovery?" I got my answer from a local treatment professional: "Put her out, let her go. When she decides to stop using she can go to a halfway house." I shared this with my daughter. I am grateful this has not occurred, but I am prepared to follow through if it does. None of what I tried before had worked. I received support from a Twelve-step program for families and friends of people in recovery, and this group helped me during the discharge transition.

Daughter: By the time I was in treatment for 18 months, they decided that I had a good chance of surviving if I went home. I was scared, but I knew by that time I was willing to do anything to stay clean. Treatment wasn't comfortable, but I learned how important it was to stay away from old people, places, and things while I was in there. I now had to learn how to live in the "real world" and be responsible for myself. I knew that it was going to be a long scary process, but the only way to achieve it was to do it.

Mother: During the treatment program my daughter realized that she was the one ultimately responsible for doing the work in treatment and supporting her recovery when she came home. She makes choices everyday, and experiencing the consequences of those choices (good or bad) is important to staying in recovery. As her mother I had other supporting responsibilities, including: not enabling, not shielding her from consequences, not anticipating what she needed, not helping her unless she asked for assistance, and not doing things for her that she could do for herself.

Where We Are Today

Mother: Today we live pretty average lives of work, school, and play. My daughter lives in the college dormitory, and I live a half hour away and provide support when she asks for it.

When my daughter came home things were a little tense and artificial for a while. However, we have stronger communication skills and have been able to talk through difficulties as they arise. We also have a family therapist to facilitate when needed. My biggest challenge is to not help her unless she asks for help, and I'm getting better at it. Our relationship is much more relaxed now. I'm surprised how similar it is to our relationship before treatment, but now it is healthier because we have better boundaries. I continue to attend a Twelve-step program for families and friends of people in recovery and have found my work in this program invaluable in terms of peace of mind and guidance for day-to-day healthy living.

My daughter has my financial support as long as she continues to follow a plan we've agreed on. This plan currently includes attending daily meetings, school, working and living in the dorm at college (rather than an apartment). She is free to make different choices, but if I don't support them I don't help pay the bills. Now the problems she deals with are good ones because they are normal teenage problems like time management, getting enough sleep, eating right, and getting her homework finished

on time. I am grateful every day for her continued recovery, and we remember to say "I love you" everyday. I make suggestions, but I am much less involved in how she lives.

Daughter: When I came home I was able to stay clean thanks to a Twelve-step program I attend daily, my Higher power, and women I met through that program. I got a sponsor, started working the steps, and am going to school as well as keeping a job. I have become more comfortable at home and have built a recovery network that I can use to stay clean. Many people in my support network are older then me, but I have found the only way to stay in recovery is to look at our similarities instead of our differences. My mother and I have a healthier relationship now that we are taking care of ourselves.

I recognize today that I am responsible for my recovery and that I will never be cured. My mood is significantly better now that I cope with my feelings in a healthy way. I am blessed for the opportunities I have laid in front of me, but most of all for being taught how to recover at such an early age.

Conclusion

Mother: As stated at the beginning, hindsight would indicate that we could have handled things differently. Maybe so; maybe not. I now believe that wherever we are is where we are supposed to be. On one hand, I believe that my daughter's earlier treatment professionals and I could have helped her get the help she needed earlier if we had identified her potential for addiction sooner. On the other hand, hindsight is 20-20. It's possible all our collective experiences were necessary to get us to where we are today.

The following suggestions may be helpful for parents of troubled adolescents. The HBO Addiction Program (www.hbo.com/addiction/) and Drug Strategies (www.drugstrategies.org) provide families with current, unbiased information to find the help they need for troubled adolescents with addictions. There are many programs out there. It's confusing and baffling for a parent trying to choose a good one. Some programs are so bad they are dangerous; and some are mediocre, some are good, and some are great. Match is critical; even the best program may not help if the program is not designed to treat adolescents. I asked my daughter if the treatment program she attended would have helped if she had only had the depression and cutting issues and was not an addict. Her answer was "yes, a good program will help adolescents with many different issues because the root of their problems is the same and the coping strategies are the same." My daughter recommends that parents visit the program in person and spend as much time as possible on-site observing what it will be like for their son or daughter. She advises, "Don't take the therapist's word for what the program will be like." Parents should also ask for the names and numbers of parents and alumni of the program and call them. HBO Addiction recommends five questions parents should ask a treatment program:

1. Is your treatment program specifically designed for teens? If so, how?
2. What questions do your staff members ask to determine the seriousness of the teen's substance use problem and whether the teen will benefit for this particular program?
3. How does the program involve the family in the teen's treatment?
4. How does the program provide continuing care after treatment is completed?
5. What evidence do you have that your program is effective? (www.hbo.com/addiction)

While it is beyond the scope of this article to provide details about these questions, the resources listed at the end of this article provide additional information. In my experience, all these questions were important, but I want to place special emphasis on Question #5 regarding evidence. In cases where family members don't have the skills to critically scrutinize the evidence a program provides (if any), I suggest seeking an unbiased expert (e.g. therapist, social worker, researcher) to assist you. During my investigation I located one promising program via the Internet. Upon closer scrutiny of this particular

program, I discovered the evidence of success they provided actually came from a different program. In short their website looked great, but they lied to me. Please do your research, look for a good match, and make use of the information in the resources below if your family has a loved one facing similar problems.

In closing, I'd like to share my daughter's wise observation that this isn't a story with a happy ending because the story isn't over. Our lives are both immeasurably better now than if this crisis had never happened. We have both grown mentally, spiritually, and emotionally. However, there are no guarantees of what tomorrow will bring. It's best for us to take life one day at a time and be grateful everyday for what we have.

Resources

HBO Addiction can be accessed at http://www.hbo.com/addiction/

This web site contains current information on adolescent addiction and has specific recommendations for treatment of adolescents. The section on "Drug Treatment for Adolescents" contains five key questions parents should ask about a treatment program.

Drug Strategies, a non-profit research institute, developed Treating Teens: A Guide to Adolescent Drug Programs. This guide describes nine key elements that are important in successful teen drug treatment and provides reliable information on 144 adolescent drug programs.

Go to the Drug Strategies website at www.drugstrategies.org for more information on teen treatment.

Treating Depression and Somatic Symptoms: An Experiential Journey from Eeyore to Piglet

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Abstract

This case presents the treatment of a nineteen-year old female treated at a Therapeutic Boarding School (TBS) following seven weeks of intensive treatment at wilderness treatment program. Her presenting diagnoses were Major Depressive Disorder, Recurrent, Severe and Somatic Symptom Disorder.

Introduction

Joanne is a nineteen-year-old student from Oklahoma. She was referred to a Therapeutic Boarding School (TBS) following seven weeks of intensive treatment at wilderness treatment program (WTP). She is the only child of Bobby and Betty Hote (pseudonyms). Bobby reportedly struggled with anxiety and depression throughout much of his life. Betty has a significant history of multiple physical ailments and disorders (i.e. fibromyalgia, migraines, gastrointestinal distress). Joanne was the product of a normal pregnancy and met all developmental milestones. Betty suffered from exacerbated physical distress during Joanne's early childhood which limited her ability to fully attend to her daughter. In order to support the family, Bobby worked long hours and traveled frequently for business. Joanne's childhood household was self-described as one in which her father was generally absent, uninvolved, and quiet, while her mother was physically symptomatic and as a result, frequently unavailable to Joanne. Joanne had little opportunity to develop self-awareness and understanding because her parents infrequently reflected her experience and attended to her needs. The deficient sense of self that formed made social interactions, motivation, agency, and resilience difficult or unattainable elements of Joanne's world. In addition to the lack of physical attention, emotions were also generally ignored or dismissed by Joanne's parents. If Joanne did receive attention it was generally in the form of physical complaints, the language of her mother.

Throughout Joanne's childhood and into her adolescence, she began to experience a range of symptoms, including headaches, joint pain, and weakness. She was diagnosed with rheumatoid arthritis and migraines. In addition to the physical symptoms, which often precluded her school attendance, she also experienced significant social and school-related anxiety. Joanne missed at least one-third of the school days each year between sixth and tenth grade. During her junior year, at age 16, she also began to experience significant and untreated depression, suicidal ideations, and eating disordered behavior (restricting). During this time, Joanne did not receive psychiatric or psychological care due to the fact that much of her week was spent attending to her physical ailments and her parents did not wish to "overwhelm her with more doctors." Her migraines had become so intractable and problematic that she had a neural-stimulator installed to address her headaches. The operation was successful and after a significant recovery, she experienced some relief from the migraines. However, at that point her other symptoms increased. By the end of her junior year, Joanne asked to be admitted to a psychiatric hospital. After a short inpatient stay, Joanne attended WTP and was then transferred to TBS.

TREATING DEPRESSION AND SOMATIC SYMPTOMS

Conceptualization, Diagnosis, and Treatment Goals

The essence of Joanne's psychological/emotional disturbance seems to manifest in two ways – depressive behavior and thinking, and somatic symptoms. Some of her physical complaints could be explained by physiological etiologies, whereas others were presumably psychosomatic in origin. Joanne's constellation of symptoms is consistent with a diagnosis of Major Depressive Disorder, Recurrent, Severe as well as Somatic Symptom Disorder. At the WTP, Joanne participated in a psychological assessment, which yielded the aforementioned diagnosis. The psychological assessment was performed at the Psychiatric Hospital and consisted of the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A), the Personality Assessment Inventory-A (PAI-A), and the Thematic Apperceptions Test (TAT) The clinical team considered the possibility of Munchausen's by Proxy (called Factitious Disorder Imposed on Another in the DSM-5). In the end, this diagnosis was not given, because it was not believed that Joanne's mother was intentionally creating or reinforcing the symptoms in her daughter. Likewise, a Fictitious Disorder diagnosis implies a degree of intentionality that is not consistent with Joanne's presentation. Instead, it seemed likely that her somatic symptoms were a manifestation of psychological symptoms that, in turn, were a product of the unspoken rules of the family. The family's fundamental unspoken rule seemed to be that emotions were not to be shared and that physical complaints were an adaptive means to get attention and support.

Based on this conceptualization, a primary goal of treatment was for Joanne to express and process her emotions directly, without resorting to the somatic manifestations with which she is familiar. A related and secondary goal was to explore and perhaps unlock the origins of her physical distress. We hoped that Joanne could realize that some of her somatic complaints were largely the manifestation of her suppressed emotions. Regarding family therapy, the primary goal was for the family to create new, healthier rules that allowed for emotional expression – particularly for Joanne – so that emotions had a primary route of expression and therefore did not need to be transformed into somatic symptoms in order to be expressed, noticed, or treated.

Treatment

Joanne was enrolled at TBS, by chance, one week prior to a "Challenge Trip," which consisted of seven days of intensive hiking and camping in a front-country setting. The group was initially slated to backpack for the seven-day excursion but concerns about Joanne's physical limits (particularly regarding her neural-stimulator) prompted trip leaders to alter the plans. The trip provided Joanne an opportunity to bond with her group at TBS which included ten female students, four female staff, two direct care staff, and a team teacher). The trip also created an opportunity for her to heighten her awareness of her tendency to use physical symptoms to communicate her inner experience. She spent much of the trip, and a subsequent three-day biking excursion, reporting somatic complaints, which hindered or precluded her participation in activities. When prompted to share her feelings, she often responded with "I'm tired," or "My joints ache." Trip leaders, unknowingly engaging in Joanne's pattern of maladaptive coping, modified trip requirements based on her physical "limitations." Joanne's overall presentation was quickly dubbed, "Eeyore," referring to the invariably gloomy and pessimistic Winnie-the-Pooh character. The moniker seemed to fit Joanne whose depression seemed constant and self-limiting, much like the children's story donkey who is always upset but rarely communicates that sadness directly.

Soon after the Challenge Trip, the treatment team proposed that Joanne's group participate in a 5K race. The treatment team was guided by the belief that many of Joanne's symptoms were a physical manifestation of untreated, underlying psychological distress, and that the treatment called for

experiential activities which would challenge her long-standing beliefs about her physical limits as well as evoke emotional responses. In addition to weekly individual / family therapy, three-times-weekly group psychotherapy and therapeutic interventions in the milieu, the training for the race became a primary facet of Joanne's therapeutic work. Running, often with her therapist, Joanne was not only the slowest group member, but also the one most likely to stop mid-run – citing joint pain, headaches, or extreme fatigue. Whenever she reported such a complaint, her group-mates, therapist, or staff person would gently direct her back to her underlying emotion. Joanne's group mates were instrumental in the intervention – proving to be firm in their limits ("Joanne, you look sad, can you talk about feeling sad rather than your joints hurting you?") and tremendously supportive in their solidarity and care for Joanne. For example, one of the faster runners would consistently finish her training run and then return to accompany Joanne, cheering her on as she came in at her own pace. Overtime, Joanne began to complain less and a sense of self-efficacy emerged as well as feelings of pride and enjoyment. During individual therapy while Joanne was on a walk with her therapist, her therapist asked, "Joanne, do you believe you're actually sick?" Joanne responded, plainly, "No, I don't." She said, "I don't actually think I need my brain pump."

During the following weeks Joanne informed her family, group-mates, friends, and staff that she was not physically sick. She told them that her physical symptoms were manifestations of her unexpressed emotions. In many ways her process of disclosing this was much like that of an adolescent who is "coming out" about their sexual identity.

Over the coming months, Joanne's transformation was noticeable. She wore brightly colored clothes and a smile replaced the look of defeat that previously resided on her face. Her group-mates began to refer to her as "Piglet," another character from Winnie-the-Pooh, with a tremendous capacity for loyal friendship, tolerance, and kindness. Her peers began to see her as a leader – an individual who could "speak her truth" and offer empathic support and genuine care.

Joanne competed in the 5K. She finished the race with a personal best time and with all of her group-mates running over the finish line by her side, in solidarity. Tearfully, she remarked on her progress and asked to be considered for a student-leader position on the upcoming seven-day challenge trip.

Meanwhile, Joanne's family was working to keep stride with her in therapy. Her father experienced tremendous guilt and anger regarding the various treatments (including brain surgery) to which he had "subjected" his daughter, realizing he was sadly misguided. Her mother, using strategies similar to Joanne's regarding emotional-versus-somatic expression, began to understand how her daughter's somatic complaints could be linked to emotional distress. The family learned to listen to their daughter's feelings, acknowledge them as valid, and focus on her psychological health with the same energy they previously put toward physical health. Eventually, Joanne's mother sought her own psychotherapy to address her underlying "anxiety," which she reported suffering from for most of her life. Joanne's father engaged in his own psychotherapy to address unresolved issues from his childhood that made it difficult for him to engage in emotionally charged conversations.

Joanne began to regress while on the seven-day backpacking challenge trip for which she was a student-leader. Weighed down by a thirty-five pound pack, and the responsibilities of leadership, she resorted to old patterns of somatizing her feelings, and "Eeyore" re-emerged. Joanne, though deep in a regression, remained open to the feedback and support of her peer group and was able to, on day three of the journey, remember her newfound and began expressing her emotions directly. Joanne attributed her regression to stress about an upcoming transition from TBS campus to a transition house, run by TBS. There, she would be attending a public high school for her senior year and transferring to

an outpatient setting. During the transitional period, the pull to resort to somatizing was strong but Joanne, with the help of her treatment team and peers, continued to express her emotional experience directly. She left campus in good standing and was viewed as a leader and a "success story" by many of her peers.

Post-Treatment

Joanne's work at the transition house focused on solidifying the growth that she made on campus. Joanne was successful and recently informed her parents that she wished to undergo surgery to have her neural-stimulator removed. She disclosed that she had not been charging her battery for some months and had not experienced a re-emergence of headaches. Joanne received acceptance letters from universities across the country. She has renewed her interest in the cello and hopes to study music and education in college to pursue her dreams of teaching youngsters like herself, in the future.

Ironman: Treating a Young Man with Autistic Spectrum Disorder

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Abstract:

This case study follows the history, treatment process, and current status three years post treatment of a young man who wanted to be identified for the purpose of this case study, as Tony Stark from Malibu California. The diagnoses addressed include Autistic Spectrum Disorder (Level 1), Anxiety, and Parent Child Relational problem. Several modalities of treatment were described in residential, transitional, and post treatment settings. These included communication training, cognitive behavioral therapy, relational therapy, systems based family therapy, parent psycho-education and training, organizational support and tutoring, recreational therapy and sports. Tony is currently beginning his senior year in a top 20 university.

Case Study of Tony Stark

Upon admission to Telos Residential Treatment, Tony Stark, age 17, had started his senior year in high school and lived at home with his parents, James and Anne, and his 12 year old sister, Jasmine. Prior to entering treatment he played a high school sport and engaged in other social activities but frequently isolated in his basement where he would watch sports, play video games, spend time online and sleep. His primary access to socializing was through the internet.

He is intelligent with a full scale IQ of 135, in the superior range, but his processing subscale on the IQ testing was a 93 (more than two standard deviations below his full scale, indicating a significant relative difficulty in this area). He had also received the diagnosis of Autistic Spectrum Disorder (Level 1). He had low motivation in school, where he often became rigid in his approach and showed frustration toward his teachers and other authority figures. His parents worked to balance accountability with accommodations. They provided tutors and worked with schools to design support plans for Tony.

Tony presented with signs of Asperger's Disorder, which, under the Diagnostic and Statistical Manual of Mental Disorders – 5, is classified as Autistic Spectrum Disorder, Level 1. In addition to the classic symptoms such as flat affect, stiff posture and movement, and lack of reciprocal social interaction, he had a life-long history of difficulty with recognizing social cues and maintained only a few peer social relationships. Over a period of several years, he was teased and bullied. He tended to be more engaged with adults rather than same age peers, with whom he was often annoyed. He was rigid in his thinking and quickly became agitated by changes in structure and routine.

He was frequently oppositional with his parents. Conflict centered on his use of media and low motivation with academics and responsibilities. He responded to frustrations and stressors by becoming angry and argumentative. Tony received treatment for anxiety and often shut down when anxious, especially when his expectations were changed at the last minute. In regard to the decision to place Tony in residential treatment, his father James wrote the following:

"Tony was 17 when he decided to go to Telos. This was a decision everyone, including Tony, agreed was necessary but was nothing short of an act of family desperation. Tony was struggling in school and isolated socially. Even worse, our home dynamics were out of control. Everything at home was dictated by how Tony would react. We had failed at all "normal" parenting techniques. If we were

too loose, Tony acted without regard to anyone else. If we were too strict, Tony was disrespectful and disengaged totally. We had all lost any objectivity and our relationships were basically broken. Not only was this affecting Tony and us as Tony's parents, it was also greatly affecting Tony's younger sister, Jasmine. Something had to change. We all needed separation and objective intervention."
Tony's father, James, has made it clear that past attempts at outpatient therapy, medication (including antidepressants, mood stabilizers, and stimulants), and even short-term inpatient treatment (for up to four months in a specialized psychiatric hospital) were not effective at addressing these issues. He stated:

> There were so many positive elements to the Telos approach including the structured stages of progression, the books we were assigned, the family therapy, the triathlon training and the other recreational therapy, the rooming arrangements, the school, the service projects, etc. Every element of the program worked together and supported each other… this seemed to work especially because of how the Telos staff operated. They operated as a team. They were in constant communication on how Tony was doing and what he needed to work on and they all had a good sense of how to help Tony in ways that were productive and principled.

Treatment Objectives and Intervention

Tony's individualized treatment plan addressed the key issues that were preventing him and his family from being successful. The first goal was to help Tony to manage his emotions, anger and frustration in particular. The second goal was to build a positive and realistic sense of identity. We wanted to help Tony recognize his strengths which included intelligence, assertiveness, visual spatial processing, athletic ability and sense of humor. At the same time, it was important for him to appreciate his limitations, particularly those related to Autistic Spectrum Disorder. The hope was that doing so would enable him to improve his social functioning, reduce rigidity and frustration, and develop strategies for academic and relational success. The third goal was to help Tony and his parents improve their family dynamic by addressing his parents' expectations for social emotional experience, improved communication and structure for addressing problem solving, and finally to develop a positive and collaborative family identity.

The first treatment goal was to help Tony increase his emotional management skills. To promote this goal the treatment team provided him with opportunities to gain insight into the source of his emotions as well as improve his ability to cope with those emotions. The team's primary intervention was to teach him how to use "reflect and process" moments. This skill involved staff-prompted or self-initiated 10-15 minute breaks in which Tony used the ABC format from Rational Emotive Therapy (Ellis, 1991) to help him identify and challenge the beliefs that were generating and perpetuating his frustrations. After doing so he was encouraged to "process" with a staff member as well as discuss how he planned to approach things moving forward. Over time the team learned that Tony's most common maladaptive thought pattern was "black and white thinking" in which he viewed other's opinions or approaches as inferior or flawed.

At times, as with most other clients, Tony needed the structure of staff intervention or delineated consequences to motivate him in this process. During those times the treatment team used a relationship continuum approach. The primary goal of the relationship continuum is to minimize crisis while helping the client to problem solve effectively. There are three main pieces to this process. The first is the staff's "way of being" of a "heart at peace" (Arbinger, 2006). The second is a consulting approach that is based on the consulting parent role in the Love and Logic model (Cline & Fay, 1992). Finally, the staff are trained to adopt a processing approach developed by the team psychiatrist. This approach delineates small and concrete steps to use when problem solving

with clients. The approach provides support, sufficient time, and an attitude of collaboration. When these interventions, applied together, fail to elicit an adaptive response, students are reinforced by consequences such as activity restriction or incentives of phase advancement. Finally, in Tony's case, further therapeutic work was done to help him to learn how to compromise and recognize the validity of multiple perspectives.

The second treatment goal was to build a positive and realistic identity. To accomplish that goal, Tony needed resilience especially during his moments of frustration, and particularly in relation to academic achievements. He also needed to establish and maintain a positive and realistic view of himself. The first key was to build a milieu in which he could be successful, thereby motivating Tony.

Tony reports that the two things that helped him the most were having space from the dynamic in his home and building strong relationships with the staff:

> Telos worked for me because it got me away from my parents and into a new environment with a fresh start and a number of great staff members, some of whom I still stay in contact with, 4 years after graduating from Telos. Many of the residence staff members were college students or recent college graduates which made them easy to relate to and their advice was much more relevant than that of parents, who many teens believe grew up in the stone age.

A relationship based approach is a powerful ingredient in residential treatment. The therapeutic relationship has long been recognized as an integral factor in the success of therapy (Lambert, 2010). Starting with a positive, relationship based dynamic was a key factor in Tony's treatment. From this point he was encouraged to participate in a number of esteem building activities including recreational therapy, team sports such as flag football and basketball, triathlon training and competition, and completion of his Eagle Scout project and application.

In addition, Tony received academic support through his principles coach, who was the assistant academic director. Principles coaches are volunteer staff that dedicate time outside of their paid work to build relationships with the boys and help them work through their issues. In many cases the principles coaches are the people that the boys remain most connected to after treatment. In his case, Tony's principles coach was in a unique position to help him organize his academic assignments and work through frustrations he had with teachers (a role which would normally be played through additional academic and organizational tutoring).

There was a point in the process where Tony, who had recently turned 18, was frustrated and wanted to discharge himself. The joint work of the therapist, his principles coach and his parents helped him to see that by staying in the program he could complete his education thereby creating a solid platform from which to launch into life. One particularly critical session occurred when the therapist helped Tony recognize the difference of the world view that he had (as someone with Asperger's Disorder) in comparison to the world view of people who do not have Asperger's. This was done after Tony experienced a conflicted, rigid moment. The therapist took off his shoes and used the shoes to represent the two perspectives, and by moving them, demonstrated the gap in perception between the two groups. One of the most important aspects to this intervention was that correctness to either perspective was not ascribed; the focus was solely on the difference and validity of each perspective. Thereafter, Tony was able to stay on track during the program, with fewer rigid moments.

The final goal of treatment was to reduce conflict in the family system through parent education regarding Tony's differences and through communication training. One particular training was developed by the author, called "Round Table Negotiation" in which the family members were taught

to resolve conflicts while in a power neutral location. The first step involved validating each family member's perspectives about the nature of the problem. Each person's definition of the problem was considered equally valid (like the Knights of the Round Table) and was combined into the family's definition of the problem as a whole. The second step was determining a common goal around which the family will collaborate, rather than the more traditional process of compromising while maintaining competing goals. This was a critical step in that it unified the family around a common interest and helped them remove some of the suspicion, animosity, and defensiveness. It also increased the family's investment in solutions because the solution was not the spliced together amalgams with which no one was completely happy (common with a compromise based system). The next step was to brainstorm possible solutions to reaching the common goal. Finally, the family members "counted the cost" of the options by rating the cost benefit ratio of each and choosing the one that they agreed would be the most worthwhile and effective. Tony and his family were able to employ this technique on numerous occasions both in therapy and while on therapeutic home passes to solve issues ranging from expectations of balanced time (alone and with family), techniques for approaching teachers/professors, appropriate timing and venue for expressing frustration, to minor daily conflicts such as where to go to dinner or what recreational activity to participate in. This allowed them to significantly reduce conflict and enjoy their time together as a family without anyone feeling that their desires were marginalized.

Tony's family participated in "family day's seminars" which lasted for two days every ten weeks, which included parent support, in person family therapy, and parent training. Family days helped Tony's parents to make the necessary adjustments in their parenting to be synchronized with the growth that Tony is experiencing. In relation to these events, Tony's father commented:

> The family weekends were gut wrenching but life changing experiences. The weekends included educational topics, group sessions with other parents, family sessions, individual sessions and family activities. Beyond all the structured sessions, there was family time together which inevitably brought up issues from the past that we had to work through in the weeks that followed. These were vital in getting to a place where real change was achieved and sustained.
>
> Two tools from Telos stuck out to me. First, in one of our early family weekends, the Telos staff explained how parenting kids without processing challenges [that is, without Autism or the associated delays in executive function] was like aiming at a target that was 3 feet in diameter from about 10 feet away while parenting kids with processing challenges was like aiming at a target that was 1 foot in diameter from 100 feet away. This metaphor helped me to put in context and let go of my feelings of failure as a parent and move forward in a more positive place. The second tool was learning how to use the "Telos Way" of engaging my son. This was about putting myself fully in Tony's shoes and understanding how some seemingly easy things for others were exceptionally difficult for him, despite his incredible talents in other areas. This helped me develop compassion in areas where I had previously been angry or frustrated. It helped me connect with Tony in a way I had truly failed to do before then. It changed everything for me and my relationship with Tony.
>
> I think all parents pray that their children will inherit their strengths and not their weaknesses. In Tony's case, I hoped he would be a better, maybe even super human, version of me - not experiencing "normal" disappointment while accomplishing more with his life. No matter how unrealistic that was, it was my dream for Tony. While I never consciously did so, I am sure Tony sensed my unrealistic expectations and the resulting disappointment I felt when I realized that Tony had not only inherited my strengths but also my weaknesses. In fact, both those sets of traits were inherited in an amplified manner in the form of his Asperger's. Tony was, in fact, human. Amazingly, I had to learn to see and accept that.

Another important family intervention was to establish a common base of principles for decision-making. The therapist asked the family to create their own coat of arms to represent their core principles (Fulmer, 1983). The primary principles that Tony's family highlighted were virtue and compassion underscored by intelligence, responsibility, authenticity, and perseverance. This became a touch stone from which to consider the best course of action when decisions were to be made. It helped to reduce conflict and fostered a common language when considering options as individuals and as a family.

Finally, the family therapeutic process also created opportunities for his parents to make changes in their lives, to improve the family functioning and personal growth. When James and Anne sent Tony to treatment, there was no guarantee that he would respond. However, they chose to invest in it and gain from it themselves. Tony's father James commented on the overall process:

"The key to all of this working was the therapist. He served as the head coach and quarterback in making sure everything worked together. In this regard, we were particularly blessed. Our therapist had the experience and skill to connect with both our son and us. He spent countless hours helping us work through how to better understand each other and communicate in more constructive ways. He helped us all replace the anger and frustration with understanding and compassion. I don't think we ever could have gotten there in traditional therapy settings. We needed the intensity that could only be created in the kind of setting Telos provided.

To the point of Tony's humanity, I had to learn something even more important through the Telos experience. When we went to Telos, my objective was to "fix" Tony and his Aspergers. That was naïve and short-sighted. There was really nothing to fix about Tony. He was who he was - with his own set of strengths and weaknesses. Just like anyone, he had to learn to appreciate and leverage his strengths while understanding and managing his weaknesses. Telos gave Tony the tools to do that. Telos gave me the tools to see my son in his totality and to see that he and we have been blessed beyond measure just the way things are.

In the end, I have learned as much and been positively changed by Telos as Tony has. Telos forced me to see the world as it is and not just as I want it to be. It has helped me appreciate the good and bad and become more tolerant and accepting of myself and others. There is now way to place a value on such a gift."

Transitional Care

As a final stage of treatment, Tony was moved to our transition program where he could take college courses in a more "true to life" environment, with a step down in structure to help him to prepare for life at home and, more specifically, for dorm life when he went to college. Tony indicated: "Also, the Transition House [now called Anthem House] provided a good transition to living on my own in a college dorm upon leaving Telos since it allowed me to attend a local college and adjust to college classes while providing numerous resources to ease the transition without smothering me."

The transition phase was critical to Tony's treatment. It proved an excellent testing ground for the parent-to-son contract regarding expectations for level of effort in college and engagement in academic and therapeutic support. Through the process, Tony learned how to make adjustments in his communication with professors and in organizing his time.

Another challenge that Tony faced in transitional care was dealing with roommate issues in a less structured environment. He had to balance doing his own share of the household chores and responsibilities. He also had to work through interpersonal conflict successfully with less staff oversight. The balance of reduced supervision with ongoing support proved a successful opportunity

for Tony to step into adult responsibilities and freedoms. He managed this balance well and was prepared to move on to college.

After Treatment

Tony attended a top 20 university upon leaving the transitional care at Telos. It was important to ensure he continued to have support as he adjusted to this level of academic performance. There were several factors that led to a successful adjustment for Tony.

The first step was devising a family contract in which Tony was required to utilize the supports that his parents arranged for him. The contract also stipulated requirements for class attendance, communication with professors, and level of financial support based on grades. Tony was highly motivated by financial incentives.

It is critical to have a team in place to support young people when they leave residential treatment (Thayne, 2013). There were three primary support personnel that helped Tony during the transition to college. Each mirrored one of the supportive roles in residential treatment that supported Tony's success. He had a life coach who would follow up with Tony to ensure that he was utilizing all of his resources and help coordinate communication with parents, professors and dormitory staff and other authority figures regarding advocacy and troubleshooting. The second individual was a college senior from the psychology department who met with Tony a few times weekly to mentor him and help him organize his homework and with social integration. Tony worked with the on-campus student affairs office where he had access to testing and writing accommodations and academic tutoring as needed.

Finally, Tony took proactive measures to join the university athletic department where he managed one of the sports teams. Tony also participated in intramural sports and attended football games. He even hosted social gatherings. Through his own efforts, as well as those of his parents, and the supports offered, Tony is on a positive trajectory and enjoying a rich and successful life.

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A Case Study of Classroom Interactions as a Parallel to Therapy

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Abstract:

In this case study we provide a brief, but detailed description of an intervention by a classroom teacher that pushed the treatment forward and provides the basic elements of treatment that can change this young woman's sense of self and approach to the world. After describing the academic intervention we will reflect on how this intervention makes pedagogical and psychological sense.

Background:

Helen is a 19 year-old female with an African-American father, whom she never knew, and a Caucasian mother. She was raised primarily by her grandparents. Helen presented as intelligent, physically beautiful, and socially adept. She did adequately at school, earning mostly C and B grades. Generally, she had little motivation for school; she gave up quickly in the face of difficulty. She was outgoing, appearing confident but guarded, and somewhat aloof. At times, she came across to her peers as a "mean girl" no one wanted to cross.

Helen came to the program after being dismissed from a boarding high school. She was expelled for drinking alcohol which, combined with several earlier rule infractions including a defiant and remorseless attitude, led to her dismissal.

Her multi-generational family history was fundamental to her identity and its impact was evident throughout her treatment. Helen's mother, Mary, was adopted by parents who had two biological boys. As an adopted child in a high achieving family, Mary felt she did not belong. She handled her feelings of alienation by withdrawing and rebelling. As a teenager, she became heavily involved with drugs and promiscuity. Mary had two illegitimate children, one of which was Helen. Both children are of mixed race, with different, uninvolved, biological fathers. Helen's grandparents tried to help Mary with her children and finally took the responsibility of raising Helen. They found raising Helen to be difficult, given Mary's chaotic, irresponsible, and inconsistent role.

As Helen grew up in the same high achieving Caucasian family as did her mother, the pattern began to repeat. She also felt an outsider—perhaps even more than her mother. Like her mother, she was of mixed race, felt abandoned by her biological mother, and felt alienated and alone in her home environment.

Diagnosis at admission:

Depressive disorder NOS
Attention-Deficit/ Hyperactivity Combined type
Generalized Anxiety Disorder
Oppositional Defiant Disorder
Identity Problems

A Developmental and Relational Diagnosis:

Although the Axis I diagnoses capture a number of the symptoms that led to residential placement, they fail to describe the heart of the problem. One can understand virtually all of Helen's Axis I symptom diagnoses in terms of an underlying failure to achieve a resilient and accurate sense of self, along with a resultant defensive structure to protect herself from being vulnerable. Her symptoms appear to be the result of a basic insecurity and lack of trust undoubtedly produced by the instability of her relationship with her mother and the accompanying feelings of abandonment. This deep distrust and insecurity of attachment appears similar to what is observed in many adopted children. It is likely that this unresolved and inconclusive abandonment was even more painful than that produced by adoption, since she was a young mixed race child raised by older grandparents and experienced an on-going repetition of the abandonment as her mother sporadically appeared and disappeared from her life with no resolution. In addition, her entire family including her grandparents, and all of her mother's brothers and their families were exceptionally bright, high achieving, and successful. The only "failure" in this extended family was Helen's mother, who felt she did not belong in this family.

In this environment, Helen developed a guarded, aloof attitude. She did not trust, and did not want to reveal her feelings to anyone. As she became a teen she used her beauty and charm to latch onto boyfriends, but the relationships were constantly fraught with insecurity and fears of being abandoned. Such fears created push-pull relationships, filled with conflict, often ending abruptly only to be followed by a new relationship that followed the same pattern.

The Intervention in the Classroom Setting:

Dennis Hartzell is the Head of School at Montana Academy. In addition to overseeing the daily operations of the school, he also taught a course on Greek Mythology and Literature. The content of the course was structured around four units: 1) The Greek pantheon and world view; 2) The nature of heroism as defined by the narratives of Jason, Perseus, Theseus, and Hercules; 3) The Odyssey of Homer; 4) The tragic vision of experience as presented in Sophocles' Oedipus the King and Antigone. Helen was a student in all four of these units. Her trajectory in this class reflected struggle, perseverance, and personal transformation. In this case study, Dennis describes her journey in three episodes.

Episode One: Struggle

It was clear to me in the first weeks of our work together that Helen had issues with the academic dimension of her life at Montana Academy. A striking young woman, recently turned nineteen, she clearly calibrated the minimal level of engagement that would allow her to avoid unpleasant consequences. At first, I wondered if her barely adequate responses to the demands of our course reflected intellectual deficits as well as attitudinal issues. Indeed, I spent several weeks increasingly distressed by the possibility that I was imposing tasks on Helen that she truly couldn't manage. My concern grew primarily out of her written work, which was often shallow in substance and deeply flawed in syntax and organization.

CLASSROOM INTERACTIONS

A different sort of Helen began to emerge, however, as time went on. The first clue that my view of her capabilities was skewed came when she and her classmates prepared and delivered oral presentations on individual deities in the Greek pantheon. Helen had been randomly assigned Aphrodite (the goddess of love and beauty). Her presentation was a revelation for me. She had prepared carefully and she presented Power Point slides of considerable impact, combining text and images. Her presence and delivery were even more impressive. In front of the class that day was a poised, confident, engaged individual who knew what she was about. Her grade on this work was considerably higher than anything she had earned up to that point, and I could tell that she liked how that felt. In the next week or two, leading up to the final assessments of that unit, she was clearly spending more time on her assignments.

In that final week, however, she collapsed. Of the two final pieces she was assigned to write, the first was superficial and sloppy; the second didn't come in at all. Despite repeated reminders to her that she needed to submit that final essay, nothing appeared. Finally, after giving her a deadline by which her Incomplete would become an F grade, she handed me a woefully inadequate response to the assignment. After I had reviewed her work and written a frank comment, I asked her to meet with me. She saw that I had given her a failing grade on the essay, and she barely glanced at the comment I had written. We proceeded to have a fraught conversation, with my expressions of concern (framed by how encouraged I had been by how she had stepped up just weeks before) being met by her insistence that school was not important to her. Indeed, she looked me squarely in the eye and claimed that school had never been important to her and that nothing I could say was going to change that. I responded in part with what she would see as the usual platitudes about the excitement and fulfillment of learning; she dismissed those contemptuously. But I also told her, with a determination equal to her own, that I was not giving up on her. I knew she had signed up to continue in my course, and I assured her that I was going to continue to hold her to a set of expectations that she had proven she could meet.

I subsequently learned from Helen's therapist that this pattern of self-sabotaging collapse under the pressure of exams and final assessments had been evident since Helen's arrival at Montana Academy.

Episode Two: Perseverance

During the second unit of Greek Mythology and Literature, Helen got back to work. I was relieved to see that, despite her angry, painful claims that school didn't matter, she was once again behaving as if school did indeed matter. About mid-way through the unit, however, Helen found herself challenged again. This time, the challenge came in the form of a broken heart. A deep and sweet attachment that she had formed with another student came to an end under particularly difficult circumstances for her.

Helen arrived at class in a state of emotional turmoil. I asked her to step out to speak with me. When I acknowledged that I knew she was in the midst of a difficult time, she lashed out verbally at me. I made it clear to her that I never spoke to her in such a way and that I would not accept her speaking to me in that manner. This took her aback a bit, but she then insisted that she was not going into class. Once again, I told her very directly that she didn't have that choice. She was going to go back into class. Whether she chose to work or not would be her choice; I acknowledged that I could not make her do so. I also indicated that should she choose not to work, there would be consequences to that choice.

Back into the class we went. Helen threw herself into a chair and turned away from her classmates and me. For the next thirty minutes or so, Helen did her best to ignore the rest of us in a seething silence. We continued to work through an exercise on the nature of quest heroes. With about twenty minutes remaining in the period, Helen slipped out her notebook, turned back to the table, and began

to participate. When class ended, she waited for the other five students to depart and then asked if she could come to see me at lunch-time. I said that I would look forward to that.

Over lunch that day, Helen apologized for her behavior that morning. She was tearful, dignified, and authentic. After accepting her apology, I offered two observations. The first was that the morning's incident was over as far as I was concerned. The second was that I was deeply impressed by the resilience she had shown by resuming her work, even in the midst of her heartache and confusion.

As unpleasant as that confrontation had been, I felt that Helen had made an important step forward. She had persevered in a moment of great challenge, and she had then managed herself beautifully. She had gone back to work.

Episode Three: Transformation

During the third unit of our course, Helen and her three classmates undertook to read the 400+ pages of Robert Fagles' translation of The Odyssey. While I wondered again whether this was a reasonable expectation for me to have of them, I was soon reassured that they were as attracted to Homer's extraordinary epic as I have been for the past thirty-five years.

Early in the term, I shared with the class a poem by W. B. Yeats. "No Second Troy" is a complex work grounded in Yeats' allusion to one of the significant elements of the Trojan War. I regularly ask my students to explicate modern or contemporary poems that make use of Greek mythology. These exercises reinforce for them the relevance of this material to our own lives. Helen's explication of Yeats' poem was superb, easily the most insightful and fluent response that I received that day. (And this was a class with several very capable, highly motivated students.) I put an A- on the paper and wrote an extended comment detailing the ways in which Helen had unlocked and illuminated the meaning of a rich and sophisticated piece of poetry.

The next day, I stopped by Helen's study hall and asked her to join me for a moment. I passed the explication to her and asked her to read the comment I had written. This time she did, and she was thrilled. I then explained to her that one of the consequences of her success was that now we both knew what her best work looked like.

"And why," I said to her, "would I want to spend my living time and energy reading work from you that you weren't proud of? And why would you want to spend your living time and energy on work that didn't represent your best effort?"

We made a deal. She promised to sustain her commitment to her best work. I promised to sustain my commitment to expectations that prompted her best work. And we shook hands.

These days, Helen often arrives in class and immediately goes to the board to write a favorite passage from Oedipus the King. And I just discovered that she is actually reading ahead in Antigone.

A couple of weeks ago, Helen told one of my colleagues that she thinks she wants to become a teacher.

That feels like transformation to me.

Reflections:

Drs. John and Carol Santa are, respectively, the Co-Clinical Director and Director of Education as well as Co-Founders of Montana Academy. In this reflection, they offer their conceptualization of the process described in the classroom interventions described by Dennis Hartzell.

CLASSROOM INTERACTIONS

This intervention in a classroom is exactly what provides the basis for change and addresses the underlying failure to mature, not simply as a student but as a person. School is the job of adolescents and inadequate school performance, as in the case of Helen, is often not a reflection of an underlying disability or impairment, but is symptomatic of an underlying immaturity and attitude. In order for students to mature academically, they need an environment that promotes and relies on strong and honest relationships with teachers. Relationships are less important when a child is emotionally stable, secure, and mature enough to understand the value of school. Helen depended upon the holding context of her relationship with Dennis in order to begin performing in school. Helen did not want to disappoint him even when he held her to high standards.

Effective teaching includes accurate recognition as opposed to cheerleading. Dennis provided Helen with honest feedback within a demanding educational context and clear boundaries. He provided specific written and verbal comments indicating what she needed to do to improve and recognized specific accomplishments, including her resilience. He let her know he was not giving up on her, while not tolerating inappropriate behavior both socially and academically. Through all this, Helen knew that Dennis was not going to abandon her. They were going to stick through this together. Because of their relationship, Helen did not go back to old patterns of distancing and protecting herself by rejecting and pulling away from Dennis or by failing in his class. He also refused to engage in her power struggle, making it her problem within a context where she could begin to understand her previous maladaptive behavior of sabotaging herself and her relationships. She knew Dennis was not going to give up on her; consequently, she started to not give up on herself.

Dennis also held the bar high with realistic expectations. Growing up academically requires a student to be challenged with high expectations and rich curriculum. High educational standards are important but these standards cannot be measured by standardized tests. They must be built individually by understanding each student and engaging her/him personally. Students like Helen readily dismiss school as stupid when given insipid assignments such as reading a textbook and answering chapter questions. Curriculum must be serious in order for student to take it seriously. Dennis provided his students with rich curriculum engaging them with challenging reading that fostered insightful discussions and thoughtful writing. Because he knew Helen so well, he understood just how high to hold the bar. He recognized her capabilities and kept nudging her toward meeting them. Helen started taking his curriculum seriously and began to see herself as a student and as a competent and worthy person. Dennis allowed Helen to choose her level of performance, but at the same time provided an accurate mirror that gave her the confidence to continue and push herself to live up to what he so clearly saw.

To summarize, the series of classroom interactions in the case example are built around a set of elements that are fundamentally relational in nature:

1. Developing a respectful relationship
2. Persevering in the face of her rejection and a teacher consciously focusing on the process rather than simply the content of their interaction
3. Accurate recognition and mirroring of a student by a teacher
4. Limit setting in the form of high, but realistic expectations
5. Refusing to engage in a power struggle, but making this her problem
6. A corrective attachment experience with appropriate boundaries

These elements of the student–teacher interaction are a perfect parallel to the process of therapy, which requires exactly the same elements in order to produce change. When these interactions take place in many contexts, not just the therapeutic office, they provide experience that can become integrated into a changed perception of self and a changed approach to the world. The effectiveness

of longer term residential treatment depends not just on what takes place in formal therapy, but also on the interactions throughout the milieu. They provide a parallel to therapy and promote internal growth, as demonstrated so powerfully in this example of a classroom interaction.

It should also be noted that as Helen matured and developed a stronger internal sense of self and an increased ability to interact with others effectively, her psychiatric diagnoses and symptoms abated. The long term resolution of these symptomatic diagnoses seemed to rely more on the knowledge she acquired through relational interactions than it did on particular learned skills.

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