NATSAP

National Association of Therapeutic Schools & Programs
126 N. Marina St., Ste. 2
Prescott, AZ 86301

TO:

JTSP u Volume I u Number I

# JTSP
# Journal of Therapeutic Schools & Programs

NATSAP

2006 u VOLUME I u NUMBER I

JTSP
Journal of Therapeutic Schools & Programs
A Publication of the National Association of Therapeutic Schools and Programs

JTSP JOURNAL PRODUCTION STAFF

Director of Publications
Janice Moss
Executive Director, NATSAP
NATSAP Prescott, Arizona

Senior Editorial Specialist
Alicia Arteaga
Executive Assistant,
Prescott, Arizona

**JOURNAL OF THERAPEUTIC SCHOOLS AND PROGRAMS (JTSP)** is published two times 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. 

**PERMISSION TO QUOTE, REPRINT, PHOTOCOPY** It is the policy of NATSAP and the Editorial Board of JTSP that abstracts published with journal articles are indicative of, and not a substitute for, the work as a whole; therefore, access services are allowed free use of these abstracts without securing the permission of the JTSP. Enquiries about policy and procedures relating to permission to reproduce material published in the journal should be directed to: *Dr. Michael Gass, Editor, JTSP, NH Hall, 124 Main Street, University of New Hampshire, Durham, NH 03824, (603) 862-2024, mgass@unh.edu*

**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 sent to Dr. Michael Gass, Editor, JTSP, NH Hall, 124 Main Street, University of New Hampshire, Durham, NH 03824, mgass@unh.edu. Send six copies of the submission

**ABOUT THE NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS** The National Association of Therapeutic Schools and Programs is a non-profit member organization of schools and programs from around the country and was formed to serve as a national resource for its members. Through a dynamic process, the National Association of Therapeutic Schools and Programs develops and advocates ethical and practice standards designed to protect consumers while improving the effectiveness of programming within member programs

**MEMBERSHIP** Schools and Programs interested in membership the National Association of Therapeutic Schools and Programs are referred to their website, www.natsap.org or the Executive Director at (928) 443-9505.

**National Association of Therapeutic Schools and Programs**
Headquarters Office: 126 North Marina Prescott, Arizona 86301
Telephone: (928) 443-9505 • Fax: (928) 443-9507
info@natsap.org • www.natsap.org



JTSP
Journal of Therapeutic Schools & Programs
A Publication of the National Association of Therapeutic Schools and Programs

WE EXTEND OUR GRATITUDE TO THE FOLLOWING SPONSORS OF JTSP

CORPORATE SPONSOR

ASPEN EDUCATION GROUP

NATSAP MEMBER PROGRAM SPONSORS

ALLDREDGE ACADEMY
BENCHMARK YOUNG ADULT SCHOOL
DAYBREAK BEHAVIORAL RESOURCES
ECKERD YOUTH ALTERNATIVES: E-HOW-KEE
ECKERD YOUTH ALTERNATIVES: E-SUN-ALEE
FAMILY FOUNDATION SCHOOL
MISSION MOUNTAIN SCHOOL
MONTANA ACADEMY
NEW HORIZONS FOR YOUNG WOMEN
OPTIMUM PERFORMANCE INSTITUTE
SECOND NATURE ENTRADA
UINTA ACADEMY
WILDERNESS QUEST

**Dr. Jared Balmer, Ph.D**., is the co-founder of The Oakley School and Island View Residential Treatment Center. He currently functions as the Executive Director of Island View RTC. Dr. Balmer is a member of the Behavioral Health Advisory Board of the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). Dr. Balmer has taught at several Universities and has worked with adolescents and their families for over 30 years in a wide variety of settings. He can be reached at Island View RTC, 2650W.2700S. Syracuse, Utah 84075.

**Dr. Joanna E. Bettmann, Ph.D**. is Assistant Professor at the University of Utah College of Social Work and an adjunct faculty member of Smith College School for Social Work. Along-time clinician in the wilderness therapy field, she consults on and researches wilderness therapy. She can be reached at Joanna.bettmann@socwk.utah.edu

**Dr. Rob Cooley, Ph.D**., grew up in a logging community on the McKenzie River in Oregon, where he learned to row white water at age four, hiked with the Boy Scouts in the Three Sisters Wilderness area, and later set chokers for small logging outfits and built back country trails for the Forest Service. He earned a Ph.D. in counseling psychology from the University of Oregon in 1979. He specialized in family and adolescent therapy, at Oregon's child welfare agency and in private practice, while taking summers off to run a white-water rafting outfit for adolescent adventure camps. In 1988, he combined his outdoor and therapy interests in founding Catherine Freer Wilderness Therapy Expeditions, a three-and seven- week program with a strong therapy emphasis, which is licensed in Oregon for both chemical dependency and mental health treatment and is JCAHO accredited. Rob has been involved with the Outdoor Behavioral Health Industry Council (OBHIC) and with NATSAP since their inception. This article speaks to both his interest in using outcome research to improve and

validate NATSAP programs, and his hope that the innovative services developed by NATSAP programs will become available for all young Americans who need them.

**Troy J. Faddis** is the director of family services, assistant clinical director, and reunion family therapist at Aspen Achievement Academy. Troy supervises and runs the family reunions, doing family therapy with Aspen's adolescent clients and their families.

**Dr. Daniel Garvey, Ph.D**., is the President of Prescott College. Dr. Garvey was a faculty member at the University of New Hampshire, teaching and researching in the area of experiential education. Dr. Garvey is the former President and Executive Director of the Association of Experiential Education. He has authored more than 25 books and articles dealing with the broad topic of experiential education. He was appointed by Arizona Governor Janet Napolitano to the Arizona State Commission on Service and Volunteerism. Dr. Garvey can be reached at Prescott College 220 Grove Avenue, Prescott, Arizona 86301

**Nevin Harperisa Ph.D**. student in Outdoor Education and Experiential Learning at the University of Minnesota, Research Assistant in the Outdoor Behavioral Healthcare Research Cooperative, and past supervisor of a wilderness expedition treatment program or adjudicated youth in British Columbia, Canada.

**Dr. John A. McKinnon, MD,** is a founder and president of Montana Academy, a therapeutic boarding school for teen-agers in NW Montana. He was educated at Harvard College (BA English Lit), Cambridge University (MA Economics) Case Western Reserve School of Medicine (MD), Yale (Resident Training in Psychiatry) and Vermont College (MFA Fiction). In a former life he was Assistant Professor of Psychiatry at University of California (San Francisco) and Associate Director of Resident Training, and he directed the outpatient psychiatry services at the San Francisco V.A. Medical Center. He has practiced adolescent and adult psychiatry in Fort

Worth, TX and in Kalispell, MT, where he was Medical Director of psychiatric inpatient services at Kalispell Regional Medical Center.

**Janice K. Moss** is the Executive Director of the National Association of Therapeutic Schools and Programs and was a founding member of the Board of Directors. She was Executive Director of Spring Ridge Academy from 1998 – 2004. Ms. Moss spent 25 years in the semiconductor industry in the Information Technology field. She held the Chief Information officer position for SEMATECH, a semiconductor consortium established in 1988 prior to her transition to Spring Ridge Academy.

**Dr. Keith C. Russell, Ph.D**., is an Associate Professor in the Division of Recreation and Sport Studies and Youth Development Leadership at the University of Minnesota, Minneapolis, MN, USA. He is also the Director of the Outdoor Behavioral Healthcare Research Cooperative (OBHRC). His research emphasis includes program evaluation, the study of human-nature relationships ,the therapeutic values of natural environments, and international protected area management. He teaches courses in statistics, research methods, philosophy and theory of adventure education, and wilderness leadership for personal growth and therapy. He has been a wilderness educator for more than fifteen years in the US, Mexico, Costa Rica, and New Zealand.

**Dr. Carol Santa, Ph.D**., is currently Co-owner and Educational Director of Montana Academy, a private residential school for troubled teenagers. She has been an elementary teacher, reading specialist, Language Arts Coordinator and university professor. She currently is co-director of Project CRISS, a program which focuses on reading, writing, and studying across the curriculum. Carol has authored over 50 articles in professional journals and has either edited or authored a half dozen other professional books. In 1999 - 2000 she was President of the International Reading Association, a professional organization of 90,000 teachers, writers, and

authors whose goal is to improve literacy.

**Dr. John L. Santa, Ph.D**. is currently President of the National Association of Therapeutic Schools and Programs and has served on the Board of Directors since its inception. He is also a co-owner and Clinical Director of Montana Academy. Dr. Santa received a B.A. in psychology from Whitman College, followed by a masters and PhD in psychology from Purdue University. He has undertaken postdoctoral studies at Stanford University, the University of Montana, and the University of California San Diego Medical Center. Dr. Santa was a tenured faculty member in the department of psychology at Rutgers University and has published numerous articles in areas of psychology and education. He is also a licensed clinical psychologist.

**Dustin Tibbitts** is the Executive Director of New Haven, a residential treatment center and school for girls. Dustin's experience includes thirteen years working with intensive in-patient residential treatment settings, rape and suicide crisis lines, and raising foster teenagers in his home. He graduated from Brigham Young University with a bachelor's degree in Psychology and from Southern Christian University with a Masters in Marriage and Family Therapy. His clinical expertise is in the areas of healing trauma, attachment disorders, sexual abuse, personality disorders, eating disorders, and depression. Dustin and his wife have a daughter and two sons. He loves to snowmobile, hike, camp, garden, collect pocketknives, and wrestle with his kids.

# The "Miracles" of the Journal of Therapeutic Schools and Programs

**Dr. Michael Gass, Ph.D., LMFT**
*University of New Hampshire*

Welcome to the inaugural issue of the Journal for Therapeutic Schools and Programs (JTSP). The purpose of this Journal is to publish written work that will assist professionals in therapeutic schools and programs in providing comprehensive care for adolescents, young adults, and families. In approaching this task as Editor, I feel incredibly fortunate to be supported by such a strong combination of professionals in the roles of Associate Editor, Board of Directors, Journal Production Staff, Editorial Advisory and Review Board members, Editorial Assistants, as well as current and prospective authors. Such a strong base of support certainly makes the daunting task of facilitating the development of a new professional journal less ominous and more enjoyable.

But in undertaking such an endeavor, the proverbial question concerning the "why" or" purpose" of such a journal needs to be asked. Is it appropriate to invest all of these talented and dedicated human resources, let alone the financial resources, to this new undertaking? What will such a journal "do" and what difference will it make? Certainly if the development of such a journal does not lead to a positive outcome, we and the field would be better off investing our efforts and talents elsewhere.

When examining such a basic but critically fundamental question, several thoughts came to mind that have contributed to the conception and direction of the JTSP. In many ways and by many people, a "miracle question" strategy (e.g., de Shazer, 1988) was used to direct this process as well as to examine the potential outcomes of the Journal. Our miracle question went something like, "Say one night, while you are asleep, there was a miracle and a professional journal appeared that provided incredibly valuable information and direction to the field of therapeutic schools and programs? What would it look like? What would it do? What critical questions would it seek to answer and how would it accomplish it?

While I must admit there have been a few nightmares in the initial activities of the Journal's development, there have been several key visions

and positive directions that have been integral to its anticipated success. Several of these have revolved around these questions:
What is the profession of therapeutic schools and programs and how should NATSAP (as well as other therapeutic schools and programs) act and plan to constantly improve the profession?

What are the best and most effective practices and approaches used in therapeutic schools and programs for specific clients under specific circumstances?
What issues should be addressed regarding the training, competence, and best practices of therapeutic schools and programs?
How do the practices of therapeutic schools and programs interface with other mental health and educational practices?
What are the best administrative practices for therapeutic schools and programs?

The following is a wish list, authored in efforts toward realizing the "miracles" the JTSP seems poised to lead in the professional discourse. As you read them, imagine reading a future JTSP issue that not only answers these questions, but leads to the development of even more critical questions that benefit our field and create new miracles in the lives of the clients. It is that process and outcome that is worthy of the talented resources invested in the JTSP.

The Profession of Therapeutic Schools and Programs In looking at the qualities that constitute the body of a profession, Millerson (in Kultgen, 1988) identified 21 characteristics associated with a profession. The following characteristics were placed in the following rank order (with the number of sources that identified this quality listed in parentheses):

1. Integrity is maintained by adherence to a code of conduct (13).
2. The profession is organized and represented by associations of character (13).
3. A profession involves a skill based on theoretical knowledge (12).
4. The skill requires extensive and intensive training and education (9).

5. Professional service is altruistic (8).
6. The professional must demonstrate competence by passing a test (8).
7. The profession assumes responsibility for the affairs of others (5).
8. Professional service is indispensable for the public good (2).
9. Professionals are licensed, so their work is sanctioned by the community (2).
10. Professionals are independent practitioners, serving individual clients (2).
11. Professionals have a fiduciary relationship toward their clients (2).
12. Professionals do their best to serve their clients impartially without regard to any special relationship (2).
13. They are compensated by fee or fixed charge (2).
14. Professionals are highly loyal to their colleagues (1).
15. They regularly contribute to professional development (1).
16. Their prestige is based on guaranteed service (1).
17 .They use individual judgment in applying principles to concrete problems (1).
18. The work is not manual (1).
19. Profits do not depend on capital (1).
20. Professional status is widely recognized (1).

What is interesting to note about these qualities is how many of these are established requirements for NATSAP membership. For example, take a brief look at the requirements to just belong to NATSAP. NATSAP has three levels of membership: (1) Provisional, (2) Associate, and (3) Full. Full members are Programs/Schools who have served program participants for more than 2 years, agree to abide by and sign the Ethical Principles established by NATSAP, acknowledge and provide documentation that they are in full compliance with the NATSAP Principles of Good Practice, and are licensed or certified by a state licensing board or accredited by a regional accrediting body.

What a wonderful miracle it is to see how far NATSAP has come in the development of the profession in such a short period of time! Think about the other miracles that could arise in our future if the JTSP highlighted answers concerning:

(1) What professional structures should be in place to deliver the best practices and resulting services for clients? What would this look like at professional level? State or Provincial level? National Level?

(2) What form of professional interaction creates the most effective delivery of therapeutic schooling and programming for clients (e.g., the form of interaction between family, therapist, support staff, administrators, accrediting bodies and educational consultants)?

## Treatment Effectiveness with Therapeutic Schools and Programs

In determining the effectiveness of therapy approaches and educational practices, the miracle question might be stated as "what intervention, by whom, is the most effective, for this client with this specific issue, under which set of circumstances? (e.g. Kazdin, 1991)". Each of the five variables included in this question, along with the interaction of these variables, needs further examination for the validation and continuing development of therapeutic schools and programs. Some of the questions informing these analyses could include:

- Are there differences in the effectiveness between the types of therapeutic schools and programs (e.g., residential treatment centers, short-term programs, extended wilderness experiences)? If there are differences, does the effectiveness of a particular program depend upon certain population characteristics (e.g., adolescent with one set of specific needs is best suited for one type of treatment, where as another adolescent with different needs gains the most from

another treatment milieu)?

- Are there differences in the effectiveness of certain treatment approaches in therapeutic schools and programs? For example, does the manner in which therapeutic schools and programs staff process growth experiences for adolescents create meaningful differences? If so, how and when are these processes best implemented?
- What types of research designs would be most appropriate for studying specific types of issues? Alternative designs to traditional approaches to research also need to be explored—these types of designs could include single-subject designs, multiple baseline analyses, case study methods, and qualitative designs. Critical incidents in therapeutic schools and programs also need further exploration.
- What comparisons can be made between current programming other approaches used with clients seeking services from therapeutic schools and programs? When, and under what conditions, is it best to provide a particular form of educational or therapeutic practice?

## Issues of Training and Competence of Professionals in Therapeutic Schools and Programs

In the rapidly evolving fields of therapeutic schools and programs, questions have arisen about who is qualified to conduct therapeutic school and program experiences and how this should be regulated. Some of the questions associated with the training of professionals conducting therapeutic school and program experiences include:

- Who are the most appropriate professionals to lead therapeutic school and program experiences?
- How do we test different training models to prove program effectiveness? What would we find if we did?
- How do we accommodate different educational and therapeutic styles in

therapeutic schools and programs to obtain maximum client benefit?

- How are therapeutic school and program professionals best "trained?" Should programs become involved in the training of therapeutic school and program professionals?
- How do we assess/teach competence in developing professionals? Is there an appropriate way to conduct self-assessment for therapeutic school and program professionals? How does the field ensure that professional competence is kept up to date?
- What are the "best models" of supervising therapeutic school and program staff?

**Models of integration and use for effective therapeutic school and program experiences**

Many of the current models used in therapeutic schools and programs are an appropriate mix of a number of existing approaches to working with adolescents. As these models are used, a number of questions have arisen:

- What are the potential benefits, as well as concerns, of current models?
- Once clients leave therapeutic schools and programs, how do we plan for the most successful transition possible?
- How can therapeutic adventure programs best interact with insurance companies to acquire/maintain third-party payments?
- How do therapeutic school and program experiences meet/interact with specific diagnostic/symptom criteria (e.g., DSM IV)?
- Where do our various programs fit on the continuum of mental/behavioral health care? In what cases are we the most appropriate treatment option as clients move through that continuum?

## Treatment Issues

Certain issues concerning treatment have arisen in conducting therapeutic school and program experiences. Some of the areas needing further investigation include:

- What influence do certain medications have on the therapeutic school and program experiences for clients?
- How do therapeutic school and program experiences vary for clients with particular diagnoses?
- What are certain contraindications for therapeutic school and program experiences? Should there be identifiable and written "red flags" cautioning the use of certain therapeutic school and program experiences with certain populations?
- Should there be a database of information identifying certain therapeutic school and program experiences as being most effective with a particular client population?
- Do certain group compositions and individual characteristics influence the effectiveness of treatment during therapeutic school and program experiences?

## Clearer Definitions of Programs

As with any innovative educational or therapeutic practice, steps toward a vigilant state of professional examination need to be established. This examination may include some of these questions:

- What can reasonably and ethically be accomplished with our clients in a given length of treatment time?

- What similarities and differences exist between therapeutic schools and programs with the same treatment objectives (e.g., behavioral, psychosocial, cognitive)?

- Does the training background of a professional make a significant difference to the outcome of treatment? If so ,where ,how, and to what degree do these differences occur?

In seeking the "miracle" answers to these questions and others, the Journal staff will seek to find authors who use case studies, topical clinical articles, overview articles, professional opinion papers, book reviews, and research. Articles may address specific interventions for client populations, issues surrounding staff training and retention and general personnel management policies, management and leadership approaches, clinical practice issues, critical issues planning as well as governmental/regulatory relationships, funding issues and treatment models/strategies. Submissions relating relevant theory to the practice of youth care in our programs are encouraged as well. Original research of clinical relevance is welcomed, though it must be written in a manner that shares useful information to member programs. Let this initial commentary serve as an invitation to join in this discussion through the Journal's supportive submission process. We hope to hear from you!

In a final yet important comment, special recognition needs to be given to John Santa. It was his vision, strong advocacy, compassionate and professional service, high regard for quality, and tireless efforts that truly made the JTSP a reality. Thanks to John's efforts, our dreams of even better and more effective therapeutic schools and programs has just received a tremendous professional contribution.

## References

De Shazer, S. (1988). Clues: Investigating solutions in brief therapy. New Y Norton Company.

Kazdin, A. E. (1991). Effectiveness of psychotherapy with children and adolescents. *Journal of Consulting and Clinical Psychology*, 59(6), 785-798.

Kultgen, J. (1988) . Ethics and professionalism. Philadelphia, PA: University of Pennsylvania Press.

# A Brief History of the National Association of Therapeutic Schools and Programs, NATSAP

Dr. John L. Santa, Ph.D.
Jan Moss Montana Academy

Abstract

In this article we attempt to provide a personal account of the development of the National Association of Therapeutic Schools and Programs. Both of us were involved from the beginning and we have chosen to write this article from the perspective of our personal reflections, giving credit to some of the important individuals who have contributed to creating the current organization. This is a selective history rather than one that is authoritative and exhaustive.

## A Brief History of the National Association of Therapeutic Schools and Programs

In the fall of 1998 Montana Academy was in its infancy. My (John's) office was in a temporary trailer when my secretary introduced me to an energetic young man named John Reddan. He described his background working in admissions for a private school in Hawaii and for the National Association of Independent Schools (NAIS). He also passionately described the need for a professional association that could advocate for the rapidly growing industry of therapeutic schools and programs. He explained how he was visiting programs to determine the level of interest, purpose, and needs of such a national association. He described his personal commitment for creating an association and his need for sponsors to help with the start-up costs. He had already talked with Len Buccellato of Hidden Lake Academy who shared his enthusiasm, and who had generously provided several thousand dollars in seed money to help him launch the association.

Frankly, I was a bit skeptical at first. We were a new school with no money for extras. In fact we had barely begun to pay ourselves salaries. The idea of contributing seed money to a non-established national organization

sounded somewhat risky. While John seemed a bit like a polished salesman, I saw his focus and honesty. He had vision, and like most of us who have started our own programs, John was an entrepreneur with a dream. I liked his vision and felt that a national organization would serve many purposes. I also wanted a professional organization with colleagues to exchange information and ideas. The earlier history of therapeutic programs seemed more competitive and isolated. A professional organization could become an opportunity to develop colleagues and share information in a more professional manner.

As a psychologist, I was already participating in several professional organizations and found them immensely helpful. But none of these organizations was directly relevant to my current professional needs. Many of us possessed years of experience and training as psychologists, psychiatrists, social workers, teachers, or experiential educators, but what we were currently doing in therapeutic communities was different. In many ways we were forging a new and more effective continuum of care for troubled adolescents that extended far beyond the scope and vision of more traditional healthcare models. We needed our own forum, our own association.

John invited me to attend an organizational meeting hosted by himself and Len Buccelloto at an Independent Educational Consultants Association (IECA) conference in Atlanta. I felt honored to be invited, and when I attended the meeting I came away impressed and even more enthusiastic about the idea of a national association. Our school and five other organizations put up seed money that added to the donation of Len Buccellato to launch the organization. The founding programs included Hidden Lake, Cascade School, Spring Ridge Academy, Montana Academy, Aspen Youth Services, Three Springs, and Crater Lake. These six founding programs contained a mixture of both new and established programs. Most of us in the new group liked the idea of being included, and the opportunity to develop our profession, share information, and learn from others. Those from more established programs joined because it was time for a solid professional and trade association. We all shared John Reddan's well-articulated dream.

The next chapter in the evolution of NATSAP occurred when John Reddan announced an organizational meeting in true "field of dreams" fashion. The meeting occurred in January of 1999 in Albuquerque, New

Mexico. I was quite skeptical that anyone would come, but 66 individuals from forty-four different programs attended. John Reddan facilitated our discussions and the group concluded by forming an association, electing the first Board of Directors, and establishing consensus on priorities for the organization. Jan remembers her early contacts with John Reddan as follows:

> "In December of 1998, John Reddan contacted me at Spring Ridge Academy. Our Admission Director had attended the Atlanta organizational meeting and Jeannie Courtney, the founder and CEO of Spring Ridge Academy, had expressed interest in supporting John's vision. Jeannie felt that she could not spare the time from her relatively new program, but asked me as Executive Director to represent Spring Ridge at the New Mexico meeting.
>
> The night before the big meeting, the six sponsors sat around a large dinner table. John assigned us our tasks as facilitators of small group sessions to formulate the wants and needs of the various schools and programs in a professional organization. As I look back, I am amazed at John's vision and certainty that the organization already existed, and this meeting was simply a formality in establishing its direction. I found myself caught up with his enthusiasm and commitment and thus began my journey into the foundation and growth of NATSAP."

The first Board of Directors included: Michael Allgood (Cascade School), Tim Brace (Aspen Education Group), Len Buccellato (Hidden Lake Academy), Bobbi Christensen (Crater Lake School), Kimball DeLaMare (Island Lake RTC), John Mercer (Mission Mountain School), Jan Moss (Spring Ridge Academy), John Santa (Montana Academy), Rosemary Tippett (Three Springs) and Diane Albrecht was asked to join our board as an ex-officio representative from IECA.

At the first board meeting we elected a slate of officers—Kimball DeLaMare as President, Tim Brace -Vice-President, John Mercer - Treasurer, and Jan Moss - Secretary. Kimball was the perfect first President. He had tremendous credibility with vast experience as co-owner of a highly respected program. Even more important, he is a public relations genius. Kimball knew everyone in the therapeutic community—all of the consultants, and probably the

names of everyone's children. He has a terrific sense of humor, does stand up imitations (particularly of his business partner Jared), and a deep passion for helping adolescents and their families.

Under Kimball's capable charismatic leadership, our board began meeting regularly to flesh out the organizational structure and to envision how we might carry out the tasks of our new national association. We all paid our own travel expenses to meetings, met in a condominium generously donated by Jared Balmer and Kimball, and began talking. As with any group, the first few meetings were about establishing trust and a sense that we could work together.

As you might imagine, the idea of imposing order and structure on a group of individuals who were mostly therapists, as well as owners or leaders of their own programs, was a challenge. In a remarkably short time, however, we came to respect each other, enjoy one another's company, and saw how each of us could contribute to the group. Michael Allgood and Tim Brace brought a wealth of knowledge about the evolution of therapeutic schools, both tracing their roots in the field directly to Mel Wasserman who was the founder of the original CEDU schools. Both Rosemary Tippet and Tim Brace worked for large therapeutic program corporations, but made a point of being supportive and not insisting that the power flow only to the larger corporations. One had a sense that they would help marshal their company's resources to help all of us. Rosemary was particularly impressive in her ability to listen carefully and then share all that both she and her company had to offer in order to make the association more successful. John Mercer quickly emerged as an articulate and

Thoughtful professional with a background that was more experiential and educational in nature. He had served for many years on the Pacific Northwest Association of Accredited Schools (PNAIS) Board of Directors and readily shared his knowledge of effective non-profit boards. He helped establish a responsible financial structure. Jan Moss's strong background in business and organization helped keep us focused, organized, and on task. She made an extraordinary effort to produce coherent minutes from our early meetings (when it was rare that fewer than three people were talking at any one time!). Diane Albrecht was remarkably warm, encouraging, and supportive. She listened carefully, and if we strayed or were about to make a hasty decision she would interject with her Maine accent a gentle bit of

corrective advice. I am certain that John Reddan had no idea what he was getting into when he proposed an organization with such a strong willed and opinionated board.

We struggled to create order and process out of passion, enthusiasm, and good intention, and it quickly began to happen because everyone so willingly committed time and energy into the project. Special commendation must go to Kimball, who spent endless hours outside of our board meetings, promoting the association and providing leadership to establish NATSAP as a credible undertaking that deserved the support of all responsible programs.

The initial organizational meeting also established a set of priority projects including standards for ethical practice, an annual conference, employee referral service, public relations support, outcome studies, a directory, training workshops, statistics, lobbying support, and a purchasing consortium. These priorities reflected a mixture of goals to create more professionalism and collegiality coupled with the need for political voice, general marketing, resource pooling, and public relations support.

Over the last six years, members of NATSAP have made considerable progress on most of these goals. Within a year, we published a directory listing 66 programs and held our first national conference in Tampa, Florida with 230 individuals attending even though an impending hurricane forced a change in date and venue. Work on ethics and standards became the top priority and provided a model for engaging broad member input and consensus. The Ethics and Standards Committee conducted a series of retreats or "summits" to forge consensus on basic ethical and practice issues describing ethical, well-run programs. These meetings generated enthusiasm, commitment, and cohesion for the organization. John Reddan wisely chose wonderful sites for the retreats that led people to relax, become colleagues, walk on the beach, and at the same time work hard to develop and achieve consensus on ethical principles and practice standards. The first meeting was in a beautiful home overlooking the Pacific Ocean in Santa Barbara. We came away from this "West Coast meeting" committed, suntanned, and engaged in the process of establishing ethical principles.

A year later we had an "East Coast" ethics summit on Tybee Island, Georgia, with more walks on the beach coupled with serious discussion of ethics and standards and sprinkled with my first encounter with Crispy Creams enthusiastically pushed by Carol Thorne and John Reddan. That year we also had a Standards Committee meeting in Big fork, Montana overlooking Flathead Lake, resulting in a draft of practice standards for NATSAP member programs. We tediously developed consensus around practice standards endorsed by small programs, independent schools, and residential treatment centers. Obtaining a reasonable balance among the influence of wilderness programs, medical models of RTC's, schools, and experiential programs was no simple task. However, we emerged with a set of general guidelines that would tolerate diversity of approach while still insisting that all programs address basic safety, structural, and process issues necessary for any responsible program.

This committee represented a depth of experience and perspective. Sharon Laney from Three Springs and Donna Brundage from CEDU waded through the intimidating language of human resource, OSHA, and risk management issues, translating these concepts for those of us who have resisted bureaucracy. They cut through to the core concepts and made them accessible for all of us. Paul Smith and Penny James grasped the intent of the policies, generalizing them so that they applied to rural and wilderness settings while still allowing these very different approaches to contribute their own flavor. The process was stimulating and effective. While Jared Balmer could not attend the meeting, it is important to note he provided a working draft of standards as a framework to guide our discussion. With his work in hand, we discussed each proposed standard and achieved a workable consensus for all levels of our members. From the beginning, Jared provided tremendous support and "behind the scenes" guidance.

The work on ethics and practice standards was seen by most of us as our first priority for several reasons. First, establishing standards and creating opportunities to discuss ethical issues would raise the level of practice for all programs who participated. Second, having clear standards allowed members to set themselves apart from them any other programs who were not operating according to these basic standards of quality. Finally, the adoption of standards allowed us to advocate our unified positions to the public, legislative bodies, and regulatory agencies.

Parallel to this work on standards, John Reddan quickly produced the first NATSAP Directory in 2000, containing 66 member programs. This annual Directory grew to include over 100 in the 2001 and is approaching 150 member programs in 2005. The Directory has become widely circulated and used by all referring professionals. It continues to provide a major piece of public relations, awareness, and marketing for the entire industry with more than 10,000 copies distributed in 2005.

Another early goal was to establish a tradition of first-rate professional conferences. The first NATSAP Conference was scheduled in September 1999 in Tampa, Florida. However, a hurricane threatened to ruin the conference and John Reddan and Conference Chair Rosemary Tippett (Three Springs) made the difficult and frightening decision to cancel and reschedule the first conference in January 2000. Thus began the tradition of scheduling our annual conferences in the winter and in warmer climates.

The first conference was intimate with 230 attendees and set a tone of collegiality and professionalism. Most of the presentations were by our own members and were very well received. Talks by John McKinnon, M.D., Jared Balmer, Ph.D., and many others established the precedent of sharing information among professionals rather than pretending to have a special arcane knowledge known and closely guarded by the charismatic owner of a particular program. The openness of these presentations and the atmosphere of talking with each other as colleagues rather than competitors created new relationships, fostered the development of our profession, and promoted a high standard for all future conferences.

In 2001, we found ourselves in San Diego where we shared information on topics ranging from "How Horses Teach Non-Verbal Crisis Intervention" complete with horses on the Mission Bay beach, adoption, and dealing with the impact of suicide on a program in an informative presentation by Andy Anderson. The conference, under the leadership of John Reddan and Conference Chair, Bobbi Christensen (Crater Lake School), proved to be a huge success.

In 2002, Andy Anderson, the new Executive Director, and Conference Chair Jan Moss (Spring Ridge Academy) led us to Hutchinson Island near Stuart, Florida where the focus was "Facing the Future." David Brodzinsky, Ph.D.

provided a stimulating address on adoption and Gary Ferguson, author of Shouting at the Sky, gave us glimpses into the power of the human spirit and the healing that is possible when linked with the beauty and challenges of the wilderness.

We continued with our themed conferences in 2003 with "Focusing on Families" in beautiful Santa Barbara, California and chaired by Penny James (Explorations). NATSAP members and colleagues conducted breakout sessions, continuing in the standards of excellence for learning and collegiality. Michael Jenike, expert on Obsessive Compulsive Disorder and Claudia Black, Ph.D., author of It's Never Too Late to Have a Happy Childhood gave our keynote addresses. By this time, our conference had grown from 230 attendees a tour 2000 Conference to 363 attendees at this Conference.

In 2004 we found ourselves in Clearwater Beach, Florida as Conference Chair Will White (Summit Achievement) focused the conference on "Best Practices" where he provided 28 excellent breakout sessions and keynote addresses by Dr. Edward Hallowell, M.D., Michael Gass, Ph.D., and Carol Santa, Ph.D. A tradition was born when Kimball DeLaMare, the first President of the NATSAP Board of Directors, was presented the first NATSAP Leadership Award.

At the 2005 "Working Together" Conference held in Tucson, our attendance reached a new record of 636 attendees. Conference Chair James Meyer (Oakley School) began another tradition with "Community Gatherings," with topics ranging from lowering costs to working toward ethical relationships between programs and consultants. Throughout the planning and organization of all conferences, Rosemary Tippett, Jan Moss, Penny James, and Sarah Moir (Catherine Freer Wilderness) were invaluable resources to their success.

Finally, it is important to credit the direct leadership of NATSAP. Since its inception NATSAP, has benefited from having a succession of three full time executive directors each of whom brought energy and talent to the position. As mentioned earlier, our first Executive Director was John Reddan, a major visionary and founding influence. The next Executive Director, Andy Anderson, helped to build membership and offer support to the many smaller and beginning programs. Jan Moss, our current Executive

Director, has the benefit of years of history with the board and tremendous organizational skills. She is helping to make NATSAP a strong, well-run organization that can support a much broader range of activities. Jan has concentrated on expanding regional chapters and conferences to reach deeper into the membership base. She is also creating a central structure that can support all of the committees and help them to achieve their goals.

NATSAP has also benefited from the committed leadership of three Presidents. Kimball DeLaMare, Paul Smith, and John Santa have all provided support for the executive directors, leadership for the Board of Directors, and served as effective representatives and spokesmen for the entire industry. All three are dedicated not only to NATSAP but to helping adolescents and their families. All three are clinicians, program owners and developers, and strong advocates of responsible, ethical, residential treatment.

NATSAP has also grown through the effort and selfless commitment of an active Board of Directors. The following 26 individuals have served on the Board of Directors, representing the diversity in our membership:

| **Board Member** | **Program/School** | **Terms Served** | **Officer Position(s)** |
|---|---|---|---|
| Michael Allgood | Cascade School | *1999-2003 | Vice-President |
| Michel Berrett | Center for Change | 2005 - | |
| Tim Brace | Aspen Education Group | 1999-2000 | Vice President |
| Larry Brown | Peninsula Village | 2000-2001 | |
| Len Buccellato | Hidden Lake Academy | 1999-1999 | |
| Susan Burden | Aspen Education Group | 2002-2003 | |
| Bobbi Christensen | Crater Lake School | 1999-2001 | |
| Sue Crowell | Aspen Education Group | 2000-2001 | |
| Kimball DeLaMare | Island View | *1999-2002 | President |
| Gil Hallows | Aspen Achievement Academy | 2004 - | |
| Penny James | Explorations | 2000-2003, 2005 - | Secretary |

| | | | |
|---|---|---|---|
| Cheryl Kehl | Second Nature | 2003-2005 | Secretary |
| Craig LaMont | Telos Residential Treatment | 2002 - | Treasurer |
| Sharon Laney | Three Springs, Inc. | 2004 - | Vice-President |
| Greg Lindsey | Hidden Lake Academy | 2000 -2001 | |
| John Mercer | Mission Mountain School | *1999 - | Treasurer |
| James Meyer | Oakley School | 2003 - | |
| Jan Moss | Spring Ridge Academy | 1999 – 2001, 2003 - 2004 | Secretary Treasurer |
| John Powers | Aspen Education Group | 2003 - 2004 | |
| Craig Rodabough | Logan River Academy | 2005 - | |
| John Santa | Montana Academy | *1999 | Vice-President President |
| Paul Smith | Catherine Freer Wilderness | *2000 – 2004 | President |
| Gene Thorne | Discovery Academy | 2002 – 2003 | |
| Rosemary Tippett | Three Spring, Inc. | *1999 – 2005 | |
| Betsy Warren | Academy at Starters | 2002 - 2003 | |

Terms = Start year through ending year *Reelected and/or reappointed

As we enter 2006, we see that NATSAP has fulfilled the initial vision of creating a strong professional and trade association. Both NATSAP and the entire industry have grown rapidly in the past seven years. NATSAP has helped raise awareness of best practice standards and encouraged a lively professional exchange of ideas and information. By establishing a sense of professional collegiality, NATSAP has contributed to safer and more responsible programs available to serve troubled youth and their families.

In the next ten years we expect NATSAP to continue to grow in membership, visibility, and stature. NATSAP membership already establishes a standard of practice, quality, and professionalism that sets member programs apart from others who take a less professional and more market-oriented approach. Our programs must continue to offer high quality ethical practice and a willingness to constantly examine our profession to seek improvement.

We must be mindful and careful of competition and marketing as forces that can erode the development of our profession. We must guard the collegial professionalism and sharing that has developed at NATSAP, and in the next decade we must expand our professionalism to offer

genuine research and exploration of what we do, of what is effective, and what are the limits of our work. NATSAP members must go beyond customer satisfaction surveys and simple outcome measures to explore across programs what we are doing, and determine the basis of effective intervention. Such exploration requires openness, collaboration, and sharing of information. This will require developing data banks that will make possible to study the long-term effects of our work.

As a trade association we envision NATSAP developing more clout and presence as the advocate and spokesperson for our industry. We are already contacted on a regular basis for commentary and information releases, but we need a larger national presence to represent our industry proactively as opposed to in defense from attacks aimed largely at programs who fail to meet NATSAP standards. All of us as members must work to establish NATSAP as our public advocate and representative in order to protect us from potentially harmful legislation and spurious attacks that damage all programs. In summary, we expect NATSAP to grow markedly in importance as both a professional and trade association in the next decade.

# NATSAP LEADER OF THE YEAR AWARD: Dr. Rob Cooley, Ph.D.

Keynote Acceptance Speech
January 2005

Thank you, Kimball, for your introduction. I want to thank the NATSAP Board, not only for this honor, but much more for the hard work you have done, and the values and passion you have brought to your board work, in creating this amazing organization which has so much to offer all the children of our country.

I am more honored than I can express to have been chosen for this award. It is a great pleasure—and pretty scary, for I'm not an experienced or easy public speaker!—to have this opportunity to share some of my thoughts about our common endeavor with you, my fellows in this new profession, so many of whom are my mentors and my friends. About two years after I started Freer, a good friend, who was running a complicated big- city engineering company, said of my endeavor, "There have to be easier ways to make a living." Boy was he right! I've pondered ever since why I persevered anyway, and why, as I came to realize, so many other people—not all of whom were anyway near as obviously crazy as I was—were doing the same thing.

As I suppose is normal for this kind of award, it isn't really about me. In this case I imagine that what has been created, and is being recognized, is a certain kind of spirit which infuses our common endeavor, and in which I have been fortunate enough to be involved. It's about all the people who have worked alongside of, and often ahead of, me, to create something we all care deeply about. So I want to dedicate this award to all of us who have persevered in this very hard, not especially remunerative or status-promoting, work of our hearts.

The spirit we share at NATSAP is a spirit of being willing to bring our personal lives and issues and passions to work and deal with them honestly as part of our growing and our work. It's a spirit of open, warm cooperation and genuine friendship among colleagues who are often significant competitors; "teamwork for the common good." It's a spirit of sincere

search for the public good, through on-going discussion and research. It's a spirit of real desire for excellence, for trying, as Freer phrases it in our mission statement but as I believe is true for all of us, "to develop and provide the best possible adolescent treatment." It's a spirit of always putting our clients' best interests ahead of everything else.

**Personal.**

I want to say a little about Catherine. She was a climber who worked with me as a river guide, eventually becoming my guiding partner in our adolescent summer whitewater rafting business. She became one of my best friends, and was the most awesome person I have known well. Survivor of a difficult childhood and the rigors of her climbing expeditions, she was tough as nails and completely sensitive and tender: the ideal wilderness therapist. She and I envisioned the Freer program together. She died on Mt. Logan, doing one of those ultimately dangerous climbs that world-class climbers do, before we could start the program. So it is named in her honor, and modeled on her character. It put together, for both of us, a way to combine our careers (climbing, psychotherapy/ family therapy) with other needs (working with kids and a winter job for Catherine; for me, getting outdoors more, and integrating my river guiding into my therapy work).

I grew up on the McKenzie River in Oregon, rowing in white water by age 4 (a s my 4 children have done in their turn.) I paid for college and grad school with summers of logging, Forest Service trail work in the backcountry, and river guiding. Outdoors was where I went to be safe, to get over grief or illness, to try to understand myself and my world. For Catherine, living outdoors and climbing and working with kids were not just a refuge, but her life. How I wish she were here in more than spirit to share this podium with me.

**Teamwork.**

I've been a member and attender of a lot of industry/professional associations, from service groups to guiding to therapy and banking, but none of them have been much like the Outdoor Behavioral Healthcare Industry Council. I believe this Leadership Award is, as much as anything, an award to OBHIC: for the great work it has done, and for the model it provides for some of

what NATSAP is doing and hopes to do.

Our first meeting was dreamed up and organized by Mark Hobbins (Aspen) and Mike Merchant, (Anasazi) "way back" in 1997. Paul Smith and I attended from Freer, and Steve and Scottie Peterson from Red Cliff. Gil Hallows (Aspen Achievement) and Sue Crowell (SUWS) joined us.

We stared at each other across the table, and on our side of it, at least, formed conspiracy theories. How had Mike and Mark even heard of us, let alone invited us to such a meeting? Was Aspen trying to buy us? Was Mike trying to convert us? (Actually, Paul and I were the only non-Mormons there at first, so it could have been any or all of them on that one!) Was Red Cliff trying to steal our "secrets"? No shrinking violets, Paul & I decided we might as well as at least find out. (We did take the precaution of checking first with our good friends Jared Balmer and Kimball DeLaMare, who said we were reasonably safe in that company.) Within a year we had visited Aspen, Anasazi and SUWS, and spent a lot of talking time with the Petersons. Soon, Hans Toeker (Three Springs) and Andy Anderson (Eckerd) joined us, and we visited their programs too. At all those programs we were welcomed openly and warmly, and critical program and marketing information were shared with little reserve.

Uncertainty and suspicion gave way to respect and warmth, and we began a remarkable endeavor: working together to improve ALL of our programs: recognizing that in doing so each of us was giving up some competitive advantage, but believing that "a rising tide floats all boats." That we would all benefit more from sharing to improve the whole industry than by hanging onto our own little corners of it.

We dove into making that happen, with an early statement of principles and a more extended "Best Practices" developed by Paul and Sue. We wrestled with the membership issue: open to all, or only to those genuinely making an effort to adhere to those principles and practices? Then we tackled Risk Management. In a public environment that suspected outdoor treatment was far too risky for problem kids, we decided to find ways to find out just how risky our programs were, and to live with the answers. Amazingly (at the time), we were able to agree on early definitions and each program sent to me their annual reports on client and staff injuries and illnesses; I compiled

them and, as agreed, published the collective figures in the University of Idaho's Journal of Wilderness. (There was some precedent for this in the non- traditional outdoor guiding industry, and in sports; but this was several years before hospitals began to collect, compile and open for public examination their risk incident rates. As far as I am able to determine, neither public nor private residential or psychiatric programs do so yet, except for critical incidents compiled by JCAHO.) Happily, the facts were favorable: our programs' incident rates were lower than those for outdoor adventure programs. Even better, as we all began to examine our incidents and compare our programs' rates with our collective rate, our rates began a downward trend which, in most respects, continues into the present.

Then, through Keith Russell, who visited a "wilderness practitioner training" at Freer and was soon looking for dissertation topic, we began to study our collective processes and outcomes in other ways. Keith grew up in the Northwest, living half outdoors like a lot of us do, and had run, and studied, outdoor training programs for the Job Corps; and his mentor at the Univ. of Idaho, Dr. John Hendy, who in his earlier life was a Forest Service manager, was intensely interested in the interface between therapy work and wild, public lands. Dr. Hendy published an article I wrote on the value of doing therapy in the wilderness, and then, with much coaching and editing and patience with me, turned our OBHIC risk incident study into a seminal article and published that, too.

For his dissertation, Keith visited four of our program fields for a week at a time, did endless interviews with clients, guides and program managers, and, with Dr. Hendy's guidance, turned it into an amazing doctoral dissertation which accurately and sensitively described our industry, our clients, our work. (I want to note that Dr. Hendy has now retired, and Keith has moved to the University of New Hampshire where he and OBHIC are enjoying the benefits of being associated with one of the best Outdoor Education departments in the U.S. and the visionary leadership of Dr. Mike Gass, who gave a fine keynote address here at NATSAP last year and is again on our program this year. Indeed, he and Keith have agreed to publish our new NATSAP journal.) From there, it was a short jump to OBHIC's forming, with the University of Idaho, a Research Cooperative with Keith as a half-time researcher (and half-time teaching professor) and beginning to study the next most important question: where our programs providing effective treatment?

A short jump, but a hard one to make. It took a lot of money relative to our means—the $50,000/year cost was split among seven programs, and was matched by almost as much contribution of management and staff time to collect and organize our research. That meant Catherine Freer, at least, was putting about 20 percent of its profits at the time into the research effort. It took a lot of trust among ourselves and Keith and John Hendy. And it took a real belief that, as Carl Rogers, an early psychotherapy researcher said, "the facts are always friendly." Finally, it took having program decision makers at all of our three- times-a-year OBHIC meetings. Programs that were interested but weren't willing to provide that eventually dropped out of the research and out of OBHIC. We made major decisions at every meeting in our early days, and moved fast; programs whose OBHIC representatives had to check back through other management layers back home couldn't keep up, and didn't understand what we were really up to and why it was so important. Fortunately, enough of us had by then developed real trust with one another, and a good sense of camaraderie and fun, that it hung together and worked.

We've met in some pretty nice places, too, as we try to do most of our meetings at member programs so we can all visit those programs: McKenzie River cabins and raft trips, Frenchy's Clearwater Beach café (that was to be in town with NATSAP), UNH for New England fall leaves and fresh lobster, northern Idaho, Loa, Utah. Denmark, where my wife's Danish family has a cabin on an island, is a future hope!

**The Public Good.**

That brings me to my third topic: what has this research accomplished for the public good? I believe it is, as so far accomplished and as planned, showing the way toward "the best possible adolescent treatment." OBHIC has a good ways to go yet with this huge project, and for it to really work, it will need the other kinds of alternative programs represented in NATSAP to dig in and do their own data collection and research. Here's what we've accomplished so far:

> Most important, we have proved that a small organization of small programs, working hard together and with an excellent researcher, can produce solid, meaningful research that has the

power to chance the way adolescent treatment in our time is conceived and delivered.

We know now that OBHIC programs deliver effective treatment. Our first outcome study used the Youth Outcome Questionnaire with a sample of 858 families spread across 7 programs and a full year. The YOQ is a simple but well-researched and solid outcome protocol on which higher scores indicate greater behavioral/mental health disorder. Average adolescent in patient admission scores are 100; average outpatient scores 78; average community adolescent score is 23. The upper limit of the normal community range is 46.

Our results showed that kids enter our programs with behavioral disturbance scores of about 100, similar to those kids entering psychiatric hospitals, as rated by their parents. At discharge, three to eight weeks later, the parents scored their kids at about 49, just outside the normal range.

At three and six months after discharge, kids' scores rose slightly–to 56 and 57– but not statistically significantly, before trending backdown to 49 again at 12 months. In other works, contrary to a common opinion about brief, intense treatments, the therapeutic and behavioral gains of OBHIC treatment were sustained over 12 months.

Our most recent completed study, published in April 2004, called an 88-client sample from this study at 2 to 3 years after discharge to get qualitative data from parents and kids. Some of the important results:

- 83% were doing better, and 58% were doing well or very well. 17% were "struggling."
- 81% rated OBHIC treatment as effective; 10% split between "not effective" and "not sure" or "partially effective."
- 86% were in high school or college, or had graduated from high school and were working. 6 had graduated from H.S. but were living at home and "doing nothing;" only 5 had not graduated from H.S., and these were living at home and working or "doing nothing," and one was in prison.

- Substance abuse/dependence was a treatment issue for 75 of these kids (81%). In the two to three years since discharge, 27% of these had abstained entirely, 73% had used or were still using at the time of the follow-up interview. Among this group, 15% of those who entered with CD problems (12 families) reported substance abuse as a "significant problem" still.
- 34% went on to therapeutic boarding schools or NATSAP residential treatment programs; 47% got out-patient after care; only16% got no after care treatment.
- Parents and kids reported that getting through school and finding new, healthier friends was a long, tough process.
- From this study and others, we know that family issues go much better for almost all kids, though again they are not easy.

Here's what's on our future research table:

- What kinds of problems does wilderness treatment work for? This is crucial if we are going to get past being a stepchild to the traditional residential and psychiatric treatment network, where we are dismissed as working only with/for minor substance abuse and behavioral problems of Oppositional Defiance and adolescent Conduct Disorder.
- OBHIC is wrapping up data collection on an in-depth study of substance use patterns and attitudes before and after treatment and at six months post-treatment. We expect this will show that our clients have substance abuse involvement similar to kids treated in traditional bricks-and-mortar residential settings; and we hope it will show that more of them get better, and that they stay better longer.
- The same OBHIC study is doing a brief pilot on depression and anxiety. Two Freer outcome studies have shown outdoor treatment to have about the same amount of effect on depression as do anti-depressant drugs. Other research on depression treatment would suggest that outdoor treatment effects are longer lasting, but that surmise has not been tested so far.
- Dr. Jeff Clark's doctoral dissertation research on incipient adolescent personality disorders showed that Freer treatment is effective for these serious disorders, and that the effect sizes are moderate to large. This was an excellent piece of research, and its

conclusion should be astounding to all those not familiar with wilderness therapy: no other kind of brief treatment has, according to Dr. Clark's dissertation, ever been shown to be effective for these disorders.

- While the pilot anxiety data are not yet compiled on our current OBHIC study, I suspect they will be powerful; and that other anxiety-related disorders, such as OCD, PTSD, shyness, and minor to moderate eating disorders, will also be shown in the future to be effectively treated by wilderness therapy.
- ADHD is an obvious winner for wilderness treatment; we need to research it.
- Schizophrenia. I believe, based on two minor published studies, scattered experiences over the years at Freer, and my own experience with a large Oregon State Hospital month-long camp for mostly back-ward, long-term psychotics for which I was the head river guide in 1972 (and, yes, that's the full-page Life Magazine picture you remember of one of my river clients flipping his raft in Grasshopper Rapids), that wilderness therapy may be the behavioral treatment of choice for schizophrenia. No, it won't fix it; but it may make it manageable, for clients and their families, and could return many chronic schizophrenics to productive lives given adequate follow-up supports.
- What kinds of clients do OBHIC programs work best for, or not work for at all? Out of the 200 or so Freer clients who were in the OBHIC YOQ study, Freer has pulled the files for 14 kids whose scores suggest they failed to improve or, indeed, got worse as a result of going through Freer. We will be analyzing our file information, and then calling those families and kids, to try to learn whether there are some kinds of kids or problems (that we don't already know about) that we should not be treating. This is pretty avant-garde stuff in the traditional treatment community—I have heard near-gasps when I talked about it in that community—but it is just the kind of thing I find OBHIC and NATSAP programs doing all the time.
- Freer hopes to begin studying one sub-population, with SAMSHA assistance, to compare its success rates with rates for our other clients and their success rates in other treatments.
- Soon, Freer and OBHIC will begin taking a look at family change as a result of wilderness treatment.

- We will also be starting to study "Positive Psychology," strength-based outcome results. Logically, wilderness programs, and other NATSAP programs, should do even better, compared to traditional "fixit," "medical model" programs, in this arena than in the area of improving functioning in the DSM categories.

**Desire for Excellence.**

Not excellence for its own sake, or to make our companies more competitive or profitable. We are not making lightbulbs and jet engines; we are trying to give the gift of successful, fulfilling, meaningful lives to our clients' kids and their families.

There is a shared sense among us, I think, that the medical and residential childcare models we worked for in our early years were not very good. Psych hospitals, indoor residential CD treatment, state-run residential programs: these kinds of programs served medical, basic treatment and government child management needs pretty well, but did not primarily serve either their adolescent clients or their parents and families, and did not serve them very well. We knew, intuitively, that kids needed more individualized and respectful care, more physical activity, better and more individualized teaching, and (in my case) it was obvious at that time, living and adventuring outdoors would also be healing. Families needed to be included in the treatment. Careful planning and direction for the next steps after intensive residential treatments (by another name, quality casework), and transitional/halfway programs of many different kinds.

Now we're doing that and have been for 20 years or more; a growing collective effort. Creative, high quality programs abound in the NATSAP universe and beyond; and the striving for excellence, for developing new and better models and making them as high quality as we can, is a thread that runs through our programs.

Some of the important components of this effort:

- Sharing with each other, and referring to each other. The visits, the mentoring. How unique this is–and fragile, too, and not

quite universally practiced among us. We can be good, but not great, if we lose this.

- The consultant network. Unlike state caseworkers, our consultants have the time and resources to become thoroughly knowledgeable about their sources, and about the clients. They stay with the clients overtime, like the Danes do, instead of getting a new case worker every couple of months. And families can choose their own consultant, and change them!
- Individualizing programs and treatment. They don't all "look the same" in our network.
- I worry about programs getting too big, and being careful as larger groups are built to hold onto the client orientation as primary. Community and regional banks both have their functions, but it is the community banks that do best at individual client service, and that's a focus we need to keep.
- Choosing to be, for the most part, "for profit." Important, because we are getting paid by our client families, not by government and donor grants. Non-profits too often serve grantees, government needs and bureaucracies ahead of their family and adolescent clients. And because the discipline of keeping the bottom line at least somewhat positive constantly brings efficiencies into our work which benefit both the families who are paying, and the quality of service they and their children are getting.
- Making sure that our own staffs feel inclusion and buy-in, experience personal growth and satisfaction at work and in their lives. Through staff-friendly policies; perhaps through ESOPs, as Freer has done recently. One of the reasons NATSAP programs are so often excellent is the sense of ownership by staff, responsibility and excitement and passion about our programs and our industry. And they pass that onto our clients; "what goes around comes around," more in service than anywhere else.
- Helping outside agencies we work with regularly, such as local schools, the Forest Service and Bureau of Land Management, JCAHO, insurance companies and state regulating agencies, to improve their processes. We know a lot about how to restructure traditional ways creatively to help them become more effective, and we share this at times.

**Clients First.**

In the end, the biggest question we could ask, one that may be beyond the scope of OBHIC alone, is this: are our alternative network treatments and case management not just effective for individuals, but SO effective that society is, given their cost, better served by our programs than by traditional programs or by no treatment at all?

I believe the answer is "yes" or I wouldn't be giving this talk, and I probably wouldn't still be in this business. A primary motivator for me has been the belief that in creating and developing Freer as we Freer folks have, and being a contributing part of the whole alternative treatment network, we are together building a better treatment structure which can, in time, provide a model for, and bring better treatment to, all American children.

Our programs are expensive. 7 weeks in a good wilderness program, consultant fees and a year in a good therapeutic boarding school or NATSAP-style residential treatment program will cost $60,000 to $100,000 or more: the cost of a high-quality four-year college education. Is the cost worth it? Of course it's worth it-if they can afford it-to the individual families and kids that go through our programs. The odds are good, and their children are the most precious part of their lives. And we can look at individual programs and come to a quick "yes" answer. We have a pretty good state-contract residential treatment program in our area; it costs almost twice as much as Island View, and is much less effective in its treatment. We can look at the large-scale DATOS outcome studies for publicly funded adolescent residential CD treatment and see that, allowing for client differences, they appear to be substantially less effective than our data indicates for OBHIC programs. But if you were the National Behavioral Health Care Czar, how would you decide this issue, balancing all the costs–out-of-pocket family expenditure, insurance company payments, and public agency costs–against effectiveness? It's very difficult, probably impossible, to have true random-assignment, long-term outcome studies in a field involving lives and souls.

There may be away. I happened across a study, only because I was a student of his in graduate school and his name in a journal caught my eye, by Dr. Pete Lewinsohn, a Univ. of Oregon psychology who has made

the behavioral study and treatment of depression his life work. In 1987 to '89, he got a random sample of 1,700 high school students from throughout Oregon, and tested and interviewed them twice at one-year intervals to study depression. You will not be as surprised as I imagine. Dr. Lewinsohn was to discover that 417 of these students were diagnosable as having substance abuse problems. Between 1993 and 1999, as these students turned 24, he re-interviewed them and their families to explore the development of their substance abuse and related issues. He found that, at age 24, 35 percent of the students diagnosed with Alcohol Use Disorder or Problematic Use still had diagnosable substance abuse problems. And they still had, in very large measure, the problems that we know go along with that: depression, anxiety, and personality disorders, especially borderline and conduct disorders.

If our OBHIC failure rate in treating substance abuse/dependence, as reported in our latest published study at 2 to 3 years after treatment, is fairly accurate at 15%, might this mean that we are "saving" an extra 20% or so of the youth population from failing lives due to substance abuse? Who knows? Our data are at ages 17 to 20 or so, not age 24, and our sample is far from random, our research protocols much less thorough than Dr. Lewinsohn's. On the other hand, some of his random sample no doubt did get treatment for their substance abuse, behavioral and mental health problems; it's not a "no treatment" sample.

But let's just run a couple of numbers. If 417 kids each got $20,000 worth of OBHIC treatment, that's $8.3million. As a result of that treatment, only 15% of those young people, instead of 35 percent, suffer more or less permanent substance abuse disorder. That's 82 extra kids "saved" (20 percent). Allocating the costs among those extra "saved" kids only, that comes to $102,000 apiece. We, and they, and their families, wouldn't have too much trouble concluding that was money well spent. What would our National Behavioral Health Care Czar think? Just looking at the money, not the more human issues, is it likely that those young people, no longer abusing chemicals, would earn at least an extra $50,000 in their lives, and incur, for themselves and their children and spouses, at least $50,000 less in medical and other treatment expenses? Accident expenses? Welfare and prison expenses? I think so. And if we added in our complete array of consultant and NATSAP programs, how many kids might we then save from failed lives?

But I'm not the Czar, and none of us is likely to be. So we need to convince them: by the quality of our programs and the overall system we create, by the power of our research, by our willingness to build and share beyond our own system. If we could be sufficiently convincing, we may have the opportunity to assist, and in some cases truly to save, many lives and souls, far beyond the scope of the professional field we now work in.

If we are to come anywhere near such a sweeping goal for benefits to future clients, we need to take care of a couple of things here at home. Most important, the common theme among us of putting our clients first, both our adolescents and their families; and making every reasonable effort to do the best we can for them, rather than just doing what has been done in the past, or works for most. Individualizing treatment. Including families. Referring unselfishly.

The downside of being for-profit: just as dependence on the dole of grants and government programs can lead to mediocrity, so can pursuing money in the for-profit sector. A good therapist told me, "always live on less than 2/3 of your income; then you are free." For programs, the rule is perhaps, "never take money seriously beyond a decent living for staff and break even for the company." Being for-profit is a good discipline, requiring attention to client service and efficiency; but it cannot be a priority if program quality and client interests are to be best served.

Avoiding dual relationships involving self-interest. This is getting better at NATSAP but remains a problem. Enron/Merrill Lynch, Marsh & McClennan, mutual fund companies offering timed trades, drug company research, physicians and therapists having other relationships with clients: when we make decisions about what is best for our clients against a backdrop of valuable favors or cozy relationships, we put our clients and our industry at risk. In the case of licensed psychologists, social workers, and family therapists, some of our common practices could lose them their licenses and for good reason. We need to continue to work together to change this.

So here's my hope: an America in which any child or young adult who needs behavioral health care and is not critically dangerous to self or

others is referred to a therapeutic consultant who guides child and family as appropriate through wilderness treatment, modern NATSAP-style residential treatment and therapeutic boarding schools, and special schooling for Learning Disabilities and special long-term living situations for young schizophrenics (we have Spruce Mountain already, and need more of them!)Vouchers will eventually pay for those services, as long as they remain excellent and client centered. Let's do it right, and go for it: the best possible adolescent treatment for ALL our children who need it.

I wouldn't be here if it weren't for Catherine, who wanted to be one of the best rock and mountain climbers in the world (which she did become), to open the door to that world for other women, and very much to improve the world: by developing and teaching climbing techniques that would, through an invisible infrastructure of knowledge, enable human beings to achieve things a previous generation did not believe possible; and to bring her understanding of the hard physical and emotional challenges of world class climbing to ordinary adolescents on river trips and in wilderness therapy. Very much what we are all doing, in a different dimension.

And I would not be here without my partner and friend Paul Smith and my wife Ingrid, who have persevered through all the tribulations of starting a business and doing it in a new industry, constantly teaching me crucial life lessons and building a values-based company.

Nor without the many mentors and friends among you who have helped me in so many ways, with such generosity and such gentle high standards: idealism and optimism, tempered by realism; cooperation and openness, transparency with our relationships, family values, fair prices, and a primary concern for our individual and family clients. "Trustworthy, loyal, helpful, friendly, courteous, kind…." Sounds a little corny here in the boomer generation, but it's the core of what we try to teach and give to our clients and it must be the core of what we are and do as well. That's why we do this: to help ourselves, our clients, staff and friends become better human beings, and to make this world a better place.

# Teaching for Executive Functioning

**Dr. Carol M. Santa, Ph.D.**

## Introduction

Poor school performance characterizes many students entering therapeutic boarding schools. They have shut down and are functioning far below their intellectual potential. By high school, they appear anxious, withdrawn, inattentive, disruptive, distractible, or at times sullen, angry and oppositional. Such students are generally disengaged and bored in school.

They enter our schools with a myriad of diagnoses such as Asperger's, bipolar disorders, and depression. Many are classified as dyslexic, as learning disabled, or diagnosed with attention deficit disorders. They have received a plethora of diverse treatments. They have been subject to stimulants, anti-depressants, mood stabilizers, school IEP's, special education classes, tutors, and therapy. Despite these interventions, these students continue not to perform in school.

While these disorders are at times real and some even biologically based, classifying students by psychological or educational labels is not particularly useful for understanding the underlying reasons for the child's difficulties and for developing a treatment plan. Solutions to a child's problems are not best thought of as primarily an educational or psychological issue. Both are completely intertwined and should be considered as dimensions of the same problem. Rather than focusing on specific symptoms, it makes sense to view them as symptom clusters stemming from a more global developmental failure, a general immaturity that extends along multiple dimensions-emotional/social, cognitive/academic, and even moral.

## The Immature Adolescent

As Director of Education and Co-owner of Montana Academy, I find that most of our students function at a level of maturity much younger than expected for their chronological ages. By less mature, I

mean they have failed to develop frustration tolerance and an ability to delay gratification. They have little persistence to complete tasks; they are impulsive and self-centered. Moral issues of right and wrong are a matter of whether or not they will get caught or offend a primitive loyalty to friends even though such friendships are superficial and ever-changing. The world revolves around them.

They also have a child-like sense of the future reflecting a quality of magical thinking. They talk about far flung goals– "I wanna be a physicist or a rock star"– without any thought to the steps or means to get there. In other words, they think and act more like four-year-olds than adolescents.

Their approach to school also lacks maturity. If they don't like their teacher, they won't try. If an assignment appears difficult, they give up without putting any effort into succeeding with the task. They have difficulty turning in assignments and tend to blame others for their lack of success. These dysfunctional behaviors camouflage the underlying problem of cognitive immaturity manifested in deficiencies of executive functioning such as planning, organizing, and self-monitoring. They do not know how to be successful in school. More specifically, they don't know how to learn.

Casting our troubled teens as developmentally young has some support from neuropsychology. Increasing evidence suggests that adolescents who begin to fail at the level of our students may have a biological immaturity of brain structure. More specifically, the immaturity occurs in the frontal lobes, which often don't mature in humans until late adolescence and early adulthood. The frontal lobes, identified as the part of the brain necessary for executive functioning, are critical for higher-order purposeful behavior. They act as the brain's CEO, responsible for orchestrating higher- order purposeful behavior leading other neural structures in a concerted effort. Damage to the frontal lobes produces indifference, apathy of judgment and lack of planning. The frontal lobes are critical for every learning process. Immaturity of the frontal lobes can lead to deficiencies in developing priorities, organization, self-monitoring and inhibitions–the very skills necessary for mature behavior and for success in school.

Equally intriguing is the potential link between immaturity of the frontal lobes, executive functioning, and learning disabilities. Students identified with learning disabilities have the cognitive capacity to learn, but for a variety of reasons are not doing well in school as shown by a discrepancy between their intellectual capacity and academic achievement. Most learning-disabled students also show a breakdown in the domain of executive functioning. Consequently, they appear far younger than they are.

This breakdown in executive functioning for the learning-disabled child often becomes most obvious with reading comprehension. Gersten, Fuchs, Williams and Baker (2001), in a comprehensive review of research on students with learning disabilities, concluded that most learning-disabled students have comprehension problems related to strategic processing of text. For example, learning disabled students have limited knowledge of text structure. They are unaware of how text is organized and don't know how to organize information while reading. In addition, they have difficulty distinguishing essential from non-essential information. Moreover, they seem unaware of their inability to comprehend, and lack a repertoire of strategies for fixing up any perceived comprehension problems. These readers typically become frustrated and simply give up. Their lack of task persistence and knowledge about how to go about reading and learning correspond to the psycho-neurological descriptions of individuals with immature frontal lobe development. The learning behaviors of our immature 15 and 16-year-olds are more typical of 3rd and 4th graders displaying a younger child's non-strategic approach to reading and learning.

Difficulties with executive functioning are exacerbated by traditional education. Immature teenagers become easily overwhelmed in large schools with 30 students in a class. They have difficulties with 6 or 7 different courses and have few opportunities for building relationships with teachers. The escalating content demands of secondary school also compound the problem of immaturity and executive functioning. Many students attending therapeutic boarding schools did reasonably well in elementary school when the instructional focus was on learning how to read and write. They begin to have more difficulty in the middle grades as the emphasis shifts to learning content with the assumption that the basic skills of learning are firmly in place.

To compound the problem, few secondary teachers are prepared to help students become learners of content. Most teachers have little background in teaching executive functioning and consider themselves content specialists rather than learning specialists. Secondary teachers often assign, lecture, and test without ever stopping to show their students how to read and take notes from their chemistry text, or how to listen and organize information from a history lecture. This approach works if a student has already acquired the ability to form abstractions, relate new information to previous knowledge, organize, and communicate effectively. When a student is immature and has a long history of school failure, he/she must be explicitly taught the skills that facilitate learning. Acquisition of these skills and an understanding of why and how learning strategies work are essential steps in developing a new concept of oneself as a competent learner. Teaching the process skills of executive functioning is in many ways more important than teaching a particular content. If we can teach students how to learn, they will become better learners for their entire lives. Students will forget content details in their physics class, but they won't forget how to learn physics.

Students' lack of executive functioning is not just an issue for students attending our schools. The Alliance for Excellent Education, a national policy, research, and advocacy organization, published a comprehensive report from the Carnegie Corporation on the state of adolescent literacy in United States (Biancarosa & Snow, 2004). The report, Reading Next: A Vision for Action and Research in Middle and High School Literacy places the problem of poor executive functioning and adolescent literacy into a national perspective.

It begins with some alarming statistics. More than eight million students in grades 4-12 are struggling readers; every school day more than three thousand students drop out high school; only 70 percent of high school students graduate on time with a regular diploma; 53 percent of high school graduates enroll in remedial courses in post-secondary schools. The authors conclude that the heart of the problem has to do with poor reading comprehension. Most older struggling readers can read words accurately, but they cannot comprehend what they read. The central conclusion of the report is that students "lack the strategies necessary for comprehending what they read."

The authors of Reading Next recommend explicit instruction in

reading comprehension and intensive writing not just in language arts classes but in the content subjects as well. They advocate for the integration of instruction which facilitates not only comprehension, but learning from texts—in other words, they recommend teaching the skills of executive functioning. They also describe the need for greater student engagement and motivation as well as more opportunities for students to work together in small collaborative groups interacting with one another around a text. In order for this emphasis to occur in middle and secondary schools, students need more time in school to learn how to read and write effectively. For this to happen, teachers must have long-term professional development focusing on teaching strategic learning and reading comprehension.

Given the challenges students face in secondary school, mature students somehow survive, figuring out on their own how to succeed in school. Those having difficulties fall further and further behind. School becomes harder; it takes more effort, and students become less tolerant of the struggle. They save face by not trying. It becomes easier to not try and then to fail. Most don't read their assignments, and become more inattentive and progressively more detached from school. They cluster with like-minded peers, further aggravating their detachment.

**Meeting the Needs of the Immature Adolescent**

The clients attending therapeutic boarding schools are generally collapsed, non-functioning teenagers, who have tremendous difficulties coping with school and life. Yet many of these same students start becoming functioning young adults once they are placed in therapeutic boarding schools. Why is this the case? What is it about therapeutic boarding school that helps immature adolescents grow up?

Therapeutic boarding schools are-by design-laboratories for helping collapsed teens resolve in effective ways of dealing with their world, their families, and school. These design elements fall into four overlapping categories:

1. Content and Process embedded in significant relationships
2. School problems treated in context
3. Clear Accountability

4. Direct teaching of the processes of executive functioning

Further exploration of these design elements will follow; our hope is to promote a greater understanding of the links between these structural characteristics of learning in therapeutic boarding schools and student success.

**Significant Relationships.**

In well-designed therapeutic schools, the focus is on the whole child, both academically and therapeutically. In both therapy and in education, we teach a combination of content and process. In therapy, we instruct students on skills for dealing and managing emotions, with direct instruction in practical coping skills. Therapy depends not only on specific ideas and issues that are uncovered, but also engaging students in a relationship. Therapy is a process that involves teaching skills but also creates a laboratory for exploring oneself. Students discover new concepts about themselves and apply these new emotional skills in the context of this relationship, a relationship based on accurate recognition and unconditional acceptance.

School, particularly in therapeutic schools, involves the same mixture as therapy. We recognize the importance of a relationship model in education as well as in therapy. The student learns specific content and processes in the context of a relationship with a teacher. The relationship with the teacher is less important when a child is emotionally stable, secure, and mature enough to understand the need to acquire present knowledge for future purposes. Most adolescents are expected to go to college at age 18, sit in a lecture hall with several hundred students, take notes and learn a vast amount of information. Many of our students lack the maturity and executive functioning capabilities to perform these sorts of learning tasks. They depend more on the holding context of a personal relationship with a teacher and explicit teaching of executive functioning strategies along with the content.

Part of the process of growing up is to perform in order to please others. As children develop a more sophisticated self, they perform for their own self-satisfaction. Initially they perform to please others and get recognition from therapists and teachers. Recognition must be accurate as opposed to

cheerleading. An example of what I mean happened recently at Montana Academy in Phil Jones's Writing Workshop class. Students do formal presentations of their weekly writing assignments. Lila never felt comfortable presenting her ideas. Each week Phil invited her to present, but she always refused. At the beginning of class, Phil decided to read excerpts of two student papers displaying exceptional imagery. Lila's paper was one of them.

When she realized that Phil was reading her work, she pulled her sweatshirt up over her head. Phil read her paper aloud, talked about why the imagery worked chuckling at the humorous content. He recognized her work specifically and honestly. He didn't cheerlead with global statements about doing a nice job. The next week Lila stepped to the front of the class and presented her own work. Instead of making a big deal out of it, Phil quietly nodded his head, listened and again commented on specifics in her paper that worked. His recognition was honest. He doesn't do "back flips" over third rate papers, or when a students that finally turns in a late assignment. Instead, he notes the specific accomplishments and also gives gentle, clear feedback on specific ways to improve. Arresting school failure begins by establishing relationships with teachers who in turn allow students to imagine themselves in different ways–as successful and competent.

**School problems treated in context.**

School problems must not be treated in isolation, but rather recognized as complex symptoms that are integrated into a student's overall treatment plan Teachers should be included on each treatment team. This approach requires a constant flow of information between members of the treatment team. The therapist and daily life staff should know on a daily basis how each student on the team is behaving and performing in school; similarly, teachers must know the underlying emotional issues each student faces.

**Accountability.**

Schools should provide accountability for each student. If a student is not turning in homework or performing below expectations, they might be assigned additional tutorial classes during the week instead of taking more interesting classes such as horseback riding or fly fishing. Students might be required to stay on campus during the weekends or not be allowed to move

forward in the program until they begin to put in effort on academics. Along with accountability, a quality therapeutic boarding school succeeds by increasing structure for all students-especially those who are struggling. Simplifying and structuring a student's life helps them to practice staying focused, organized, and prioritized. Struggling students with poor executive functioning have difficulty organizing themselves in complicated, unstructured situations. As they learn basic organizational skills, they can begin to apply them to more complex situations.

**Directly teaching processes of executive functioning.**

For the past twenty years I have worked with a number of talented secondary teachers to develop a program (Project CRISS) for helping students become better readers, writers and learners (Santa, Havens, &Valdes, 2004). Project CRISS is a staff development program for helping middle school and high school teachers take on a broader definition of what it means to teach content. The research documenting the project's effectiveness indicates that if teachers incorporate direct instruction in executive functioning as part of their classes, students perform better in their classes and demonstrate gains in reading comprehension. The theoretical principles and the executive learning strategies contained in Project CRISS are particularly relevant for students in therapeutic boarding schools. Many of our students exhibit significant failure in schools as one manifestation of their general immaturity and social-emotional collapse. When school failure persists for several years, students fall behind in specific content areas and in acquisition of necessary learning strategies.

With the help of Project CRISS methods, teachers learn how to teach strategies essential for executive functioning by showing students how to read an assignment, or write a paper. Project CRISS methods help teachers to accomplish this through direct, explicit instruction embedded within the content they want students to learn. For example, when assigning students to take notes on a reading assignment, they demonstrate how they read and take notes on the assignment. After demonstrating, teachers monitor students practicing the note-taking procedure on their own. They provide feedback and further modeling as needed.

Teachers also learn that effective strategic teaching is more than showing students how to take notes or develop a concept map. For students to become

proficient learners, they must also understand how principles of learning derived from cognitive psychology operate for them as learners.

Thus, a combination of factors unique to therapeutic boarding schools help collapsed teens gain maturity. Students have rich opportunities to build significant relationships. School problems are not treated in isolation, but as part of a student's over all treatment plan. Moreover, therapeutic schools by design provide students with consistent accountability and structure. Our schools can also become laboratories for directly teaching students executive functioning skills necessary for academic success.

## Teaching for Executive Functioning

In our school, we take a two-pronged approach to teaching executive functioning skills. First, students learn these skills as part of regular classroom instruction, with teachers incorporating learning strategies as part of all content instruction. Second, students participate in a learning strategies seminar. In my seminar, students learn key principles from cognitive psychology that become the backdrop for the "why" of strategic instruction. Knowledge of the science behind strategic instruction helps convince students about why it is so important to examine themselves as learners. Students must see that executive functioning skills have value to themselves as learners. Knowing the scientific basis of strategic learning also helps students understand why and how their teachers incorporate executive functioning strategies as part of their content instruction.

## Practical Applications of Cognitive Theory.

I begin the learning strategies seminar by first teaching our students about the concept of metacognition because it is not only central to executive functioning, but it is one of the most researched concepts in cognitive psychology (Baker, 2002). Researchers have also clearly shown that metacognition is essential to school success.

Metacognition refers to the knowledge and control we have over our own cognitive processes. The knowledge component of metacognition is concerned with the ability to reflect about our own cognitive processes in relationship to a learning task. It also includes knowledge of learning strategies that one might use for accomplishing a particular learning event. The control component

deals with self-regulation or one's cognitive efforts. It includes planning our actions, checking the outcomes of our efforts, evaluating our progress, remediating difficulties that arise and revising our strategies for learning.

Many immature students generally lack the necessary metacognitive skills necessary for being successful in school. Research has consistently shown that younger children and poorer readers have less knowledge and control of their comprehension processes than do older children or better readers (Baker, 2002).

I introduce metacognition to students with a brief lecture. I talk about good readers as being in control, figuring out what makes sense in their reading. Competent readers sift through the author's meaning to connect the author's message with their own background knowledge. They know how to use a variety of strategies to meet their goals, and they can revise their learning plans to gain meaning. Successful learners make connections, ask questions, re-read, and organize information to represent the meaning of a selection.

While lecturing, I simultaneously model on a transparency how to take notes on my own presentation. Students use my modeling as a guide for recording their own notes. I also break up my lecture with paired discussions. After about ten minutes, I stop and ask students to talk and ask questions about what they have learned so far.

Upon completing my lecture, I have students review their notes and when they think they are ready, put their notes aside and convert their understanding of metacognition into picture notes. "What does metacognition mean to you? Transform your understanding to pictures." The next day, students explain their picture notes to the class. Afterwards, I lead a process conversation. "What did I do as a teacher to help you know if you understood the concept of metacognition? I go on questioning. "How did taking notes from my lecture help? What about paired discussions during my lecture? How did talking about what you were learning with a partner help you gain deeper understanding? In what way did transforming your understanding to picture notes and presenting them to the class help you be metacognitive?"

I also lead discussions about what it means not to be metacognitive. Our conversation might go something like this: Struggling students aren't in control of their reading and learning and don't have a clue about how to gain control. They don't see the need to set goals or to make plans for comprehending. During reading, they don't check whether or not they are getting anything out of their reading. While good readers find the struggle to gain meaning a challenge, poor readers simply give up. They quit trying, blaming their own stupidity and lapsing into their familiar sense of being incompetent in school. In most cases, it is not the student's fault. The problem is that no one has ever taught them how to learn. Holding conversations about metacognitive differences helps students become more introspective about their own learning. Students also begin to realize that their difficulties in school may relate more to lack of knowledge than to some innate learning disability.

Similar metacognitive explanations and discussions also occur in the students' academic classes. After teachers demonstrate a particular learning approach, they ask students to examine how it worked for their own learning. Learning starts to become more than a magical, random event as students start realizing being successful academically takes planning. Teachers also remind students to think about whether or not they understand the content, and to take more responsibility for asking for help if they aren't getting it. After all, the teacher is not the "mother" of your mind. You are!

The remaining principles which I teach in the seminar and teachers apply in their classrooms are really components of metacognition, but important enough in their own right to talk about separately. For example, to be metacognitive, learners need to know about the link between background knowledge and their own comprehension. They need to understand why they have to become more active and do more than simply read an assignment. They need to organize, talk, and write about what they are learning.

**Background knowledge and reading purposefully.**

I give a brief lecture about schema theory or the relationship of one's background knowledge to understanding. Comprehension is the integration of new information with one's prior knowledge; the more we know about a topic, the easier it will be for us to understand information. To help

students understand the power of background knowledge I do demonstrations. One of my favorites is to reenact a study conducted by Dooling and Lachman (1971). I send half of the students outside. For those remaining, I might do a Think-Pair- Share pre-reading activity (Kagan,1989). Students think and write down what they know about Christopher Columbus, pair with a partner to gather additional information, and then share their knowledge with the whole class. Then we invite the students sent outside to rejoin the group and listen to the following selection:

With Hocked Gems
Financing Him
Our hero bravely defined
all scornful laughter
that tried to deceive his scheme.
An egg, not a table typify
this unexplored planet.
Now three sturdy sister sought proof
forging sometimes through calm vastness
Yet, more often over turbulent peaks and valleys
Days become weeks as many doubters spread fearful
rumors about the edge.
At last welcome winged created appeared
signifying momentous success.

After listening students write down what they remember. Of course, the half of the class involved in the pre-reading activity always recalls far more than the "controls." After informing the "controls" about the topic of the selection, and reading it again, they too can fit the pieces into a coherent representation.

The results of this demonstration always lead to a lively discussion about how background knowledge influences learning and about what learners can do to prepare themselves for reading and listening. "Don't just start reading. Take time to think about what you might already know about a topic? Preview the assignment. Start by asking yourself questions about what you think you might learn" Doing mini-studies help students understand strategic learning as practical cognitive science and helps them buy-in to examining themselves as learners.

As part of our conversations, we also have students explore the effects of purpose setting on their comprehension. We might ask them to read a couple of short passages with and without specific purposes. Then we talk about comprehension differences. "How did purpose setting help you comprehend? What happened to your comprehension when you had no purpose for reading?" We explain that effective teachers usually guide their students to set purposes for their reading. If teachers forget to help you set purposes, what should you do?"

In the classroom, teachers warn students, "Don't just start reading. Take time to 'prime' your background knowledge." Teachers frequently list several topics from an upcoming reading assignment on the overhead and ask students to talk or write about what they might already know about them. They also remind students to preview the assignment and develop several purposes for reading. Frequently, they have to be quite directive with purpose setting—After reading this selection, you should be able to...; After viewing the video, you should be able to identify... .

## Organization and Learning.

In the seminar, I also teach students about the effects of organization on human memory. The past thirty years of research in cognitive psychology as well as more recent research about brain physiology, has demonstrated that learning and memory depend upon transforming and organizing information (Glass, Holyoak & Santa, 1979; Jensen, 1998). I talk about how our short-term memories have limitations. In fact, the average adult can only remember from five to nine discrete units of new information at once (Miller, 1956). However, our ability to remember increases dramatically when we transform and organize information by developing hierarchical relationships, creating categories, using charts, or creating mental pictures.

I impress on our students the benefits of supplying organization to information with some simple demonstrations based on a series of classic experiments by Bower et al., 1969. Figure 1 contains an example. I let half of the class see LIST A and the other half LIST B. I set a timer for one minute and ask them to memorize their lists. Then they write down the words they remember without referring to the list. Next, we compare class results and show everyone both lists. "Why did half of the class learning LIST A remember more than those studying LIST B?"

*Figure 1.*

| List A | List B |
|---|---|
| Skiing | Squirrel |
| Soccer | October |
| Hockey | March |
| Baseball | Norway |
| | Denmark |
| | Elephant |
| Norway | Soccer |
| Finland | Wolf |
| Denmark | Skiing |
| Sweden | August |
| | Finland |
| Elephant | Hockey |
| Squirrel | Sweden |
| Wolf | Horse |
| Horse | Baseball |
| | December |
| March | |
| August | |
| October | |
| December | |

Afterwards, I lead a process conversation about the importance for organizing information for learning.

In their science, social studies, math, science and English classes, students begin to understand why their teachers model different ways to transform information. Teachers show them how to underline selectively, to take notes, to develop charts and concept maps. Teachers also lead discussions about why organizing information is so important. Their conversations may go something like this: To learn, you have to do more than just read. None of us learn much this way. Think about the different ways you might organize this information. How are you going to transform it so that it becomes meaningful to you?

## Active Persistence.

I also explain to students about the necessity of active persistence. Learning takes work. We learn by putting effort into activities that require us to write, talk, and transform the information. Most don't understand what it means to work, to be actively persistent. They think that learning means glossing through a text or listening passively to a lecture. Somehow, learning is supposed to happen magically with a quick read, with cursory effort.

Teachers guide students in understanding what active engagement and learning effort looks and feels like. They might say, read this page, then stop and respond in your journals. During a lecture, they stop and ask students and to summarize what they have heard to a partner. Students might read and respond by drawing, making a concept map, taking notes or by asking questions. Throughout teachers engage their students in conversations: How are you going to persist actively in learning this information? What active strategies did you use to grapple with meaning? Why does learning take work?

Active persistence also relates to our previous discussion about teacher student relationships. Students tend to work harder for teachers they like, and often put little effort into classes where they feel disconnected and misunderstood. Strategic instruction within classroom context where students feel they belong plays an integral role in learning. Students put more effort into learning when they have a relationship with their teachers; they don't want to let their teacher down.

## Writing.

In the seminar, I speak frequently about why writing is integral to all learning. We discuss how writing in school is not just about writing answers to questions or writing essays. It has to do with learning. Everyone learns with a pencil in hand. Writing lets us rehearse what we known. It forces us to structure and organize ideas and provides away to self-check understanding. It helps us be metacognitive. Our students have multiple opportunities to write both formally and informally. For example, Rick Stern, a social studies teacher, begins each day with a writing activity.

These "quick-writes" might be about a previous day's reading or a background knowledge question about a topic they are about to study. Jack Ceserone's biology students write descriptions about specimens viewed through a microscope. Writing about what they see helps them observe more closely. Phil Jones has his composition students write about how they compose a poem or essay. Jenny Stone's art students write critiques of famous paintings. Jason Roscoe's drama class writes and performs original plays. Tim Price has his math students write about how to solve challenging problems and then asks them to create their own. Lya Hardwicke's Spanish students write lessons in Spanish which they then teach to the class. When writing and talking about writing become daily occurrences in every aspect of the curriculum, students start realizing why writing leads to understanding.

**Discussion.**

Adolescents already reside in a social world, so it is easy for them to extend this natural talent to their own learning. In the learning seminar and in the classroom, we help students internalize the value of discussion through demonstrations. They might read a short selection and then stop and say something about the reading to a partner. On other occasions, they read and ask questions, or summarize what they have read. They prepare for discussions by using sticky notes to mark places where they have questions or have made connections. Their notes then become the focus of small student-led discussion groups.

Students begin to see how much learning occurs when they have opportunities to explore their ideas through talk. They understand why this view of discussion is quite different from situations where the teacher remains the authority figure, with students reciting answers to teacher-directed questions. When discussion is viewed as recitation, little interaction occurs among students, little learning takes place. It is their talking, their oral grappling with meaning, that leads to deeper understanding. They-not the teacher-do the processing.

**Helping students put it all together.**

Once our students have an understanding of metacognition and its theoretical ingredients (background knowledge, organization, active persistence, discussion and writing) and feel competent in variety of learning strategies,

teachers start challenging them to make their own plans for succeeding with their assignments. Teachers have the following questions posted in their classrooms and ask students to consider each one as they begin to tackle an assignment:

1. How are you going to get in touch with your background knowledge before starting to read this assignment? (Write down what you know, preview the assignment, develop a couple of questions or predictions, etc.?)
2. How are you going to figure out the purpose for reading? (Ask your teacher, preview the assignment)
3. What active strategies are you going to use during reading to let you know whether or not you are understanding? (Generate questions as you read, stop and rehearse what you have just read, place sticky notes by information to bring to discussion groups)
4. After reading, how are you going to structure and transform key information? What are some of your organizing options? (Selective underlining, two column notes, charts, picture notes, concept map)
5. How might you use writing and discussion to help you "get it".
6. How will you know if you are understanding? How will you test yourself over the important information?

After students have completed their assignments and the assessments, teachers challenge them with some additional reflections:

1. How persistent were you? Did you put enough effort into this assignment?
2. What worked well in your Learning Plan?
3. How would you change your plan to do even better next time?

When students understand the theoretical principles underlying particular ways of learning and know how to do a variety of learning strategies within their content classes, they start changing their sense of themselves as students. Executive functioning becomes their mission - not ours.

## Conclusion

Poor school performance characterizes many students entering therapeutic schools. They arrive not knowing how to learn and with emotional blockades that prevent them from succeeding. School failure changes and damages one's sense of self. School is the job of children between the age of six and eighteen in our society. There are often underlying emotional, and neurological, and at times, behavioral difficulties that begin to create problems with school success.

The various symptoms adolescents exhibit appears related to a broader immaturity, or an inability to delay gratification, control impulses, and have a future orientation. In short, these children lack the executive function required of a successful adolescent. The lack of executive function may have a biological substrate in the delay of development of the front and pre-frontal lobes of the cortex. The problem then can become circular in that school failure itself alters the child's concept of who they are. Such children often become overwhelmed, helpless, and detached from school as a task that they cannot do. Frequently students use school failure to punish parents.

Our job is to create an environment that allows students to change their sense of themselves and begin to feel competent and empowered. Students begin to feel competent as they start producing real achievements such as charcoal drawings, poems, or essays that are accurately recognized and encouraged.

Our approach does not treat school failure as a primary underlying problem, but rather as a complex symptom that requires an integrated approach by the entire treatment team. A student must have a sense of one's self as capable and competent in order to succeed in school. Emotional difficulties and needs must be addressed, and supportive relationships must be established. A predictable structure and system of accountability and communication must be in place. Finally, we can improve academic

competence and build a new sense of capability by teaching directly executive functioning skills for learning throughout our curriculum. Such an integrated approach helps treat not only the individual problems and symptom clusters of our students, but addresses the needs of the whole child.

## References


Baker, L. (2002). Metacognition in comprehension instruction. In C. Block & M. Pressley (Eds). Comprehension Instruction: Research-based practices (pp.77-95), New York, NY: Guildford Press.

Biancarosa, G. & Snow, C. (2004). Reading Next: A vision for action and research in middle school and high school literacy. Washington DC: Alliance for Excellent Education

Bower, G. H., Clark, M. C., Lesgold, A. M. & Winzense, E. (1969). Hierarchical retrieval schemes in recall of categorized wordlists. *Journal of Verbal Learning and Verbal Behavior*, 8(3), 323-43.

Dooling, J & R. Lachman, R. (1971). Effects of comprehension on retention, of prose. *Journal of Experimental Psychology*, 88(2), 216-222.

Gersten, R.; Fuchs, L, Williams, J. & Baker, S. (2001). Teaching reading comprehension strategies to students with learning disabilities. *Review of Educational Research*, 71(2), 279-320.

Glass A., Holyaok, K. & Santa, J. (1979). Cognition. Reading, MA: Addison-Wesley Publishing Co.

Jensen, E. (1998). Teaching with the Brain in Mind. Alexandria, VA: Association for Supervision and Curriculum Development.

Kagan, S. (1989). The structured approach to cooperative learning. *Educational Leadership*, 40 (4), 12-13.

Miller, G. A. (1956). The magical number seven, plus or minus two: Some limits on our capacity for processing information. *Psychological Review*, 63, 81-97

Santa, C.; Havens, L. & Valdes, B. (2004). Project CRISS: Creating Independence through Student-owned Strategies. Dubuque, IA: Kendall-Hunt Co.

# What Organization Leaders Can Do for Therapists Who Are Victims of Vicarious Trauma

**Dustin Tibbitts, MFTI,**
*Executive Director New Haven, Inc.*

## Abstract

Organizations across the country spend many hours and dollars of their resources treating people who have been physically or emotionally abused. Many of the clients that these organizations treat have suffered some form of abuse or neglect. Day after day, the therapists and staff are bombarded with stories of horrific rape, unfathomable neglect, and other traumas. Overtime, many employees burn-out after experiencing these traumas vicariously. As employers, it is imperative to anticipate vicarious trauma, heading it off when possible, or providing assistance to employees in the event that they become traumatized themselves. This article defines vicarious trauma and suggests practical ways organization leaders can help prevent it. It also addresses the kinds of support leaders can offer their employees in the event that their employees become victims of vicarious trauma.

## Introduction

Counselors in virtually all settings work with clients who are survivors of trauma. Trauma is generally defined as an exposure to a situation in which a person is confronted with an event that involves actual or threatened death or serious injury, or a threat to self or others' physical well-being (American Psychiatric Association, 1999). Client traumas which therapists and other mental health workers frequently encounter in clinical practice include childhood sexual abuse, physical or sexual assault, natural disasters such as earthquakes or tornadoes, domestic violence, and school and work-related violence (James & Gilliland, 2001).

Although the media has obsessively focused on the new population of

traumatized clients resulting from the recent terrorist attacks on the United States and natural disasters such as hurricanes Katrina and Rita, sexual abuse issues are far more rampant. With estimates indicating that 1 in 6 women (Ratna & Mukergee, 1998) and 1 in 10 men will experience sexual abuse during childhood, and FBI estimates indicating that 1 in 4 women will be victims of sexual assault in their lifetime (Heppner et al., 1995), sexual victimization is one of the most commonly presented client traumas. Typical client reactions to traumas include intense fear, helplessness, or horror. As a result of trauma, a person may experiences every anxiety or arousal that was not present prior to the trauma (American Psychiatric Association, 1999).

In the residential treatment center which I direct, our therapists working with victims of sexual abuse are repeatedly exposed to traumatic images and the after-effects and consequences of trauma. These images can remain with the counselor long after the therapy session has ended; in some severe cases exposure to trauma can lead to induced trauma in the counselor. Astin (1997), for example, wrote a personal account describing that she would imagine a rapist coming toward her–in the same manner as therapist had approached her victimized client. I have heard leaders of organizations unfamiliar with the grueling work of therapy criticize therapists who are personally affected by a client's horrific experiences. They insinuate that a therapist is not resilient enough, is somehow lacking in skills, or has poor boundaries if he/she becomes emotionally influenced by a client's story. Therapists who express emotional and mental exhaustion after working for months with a client who has experienced severe sexual abuse often feel shameful that they are not strong enough to "hold the client's pain". This shame is often exacerbated by the ignorance of the therapist's leader to the realities of vicarious trauma. Such suppression of emotion and feeling misunderstood and undervalued by one's superiors can quickly lead to burnout.

## Research and Discussion

As Figley (1995, p.1) noted, "There is cost to caring." There are various names for this cost: countertransference (Hesse,2002), compassion fatigue (Figley, 1995), burnout (Rosenbloom, Pratt, & Pearlman, 1995), and vicarious trauma (Pearlman & Saakvitne, 1995).

## Countertransference

Experts traditionally view countertransference as the therapist's reaction to, or distortion of, client material based on unconscious or unresolved conflicts from the therapist's own life experiences (Hesse, 2002). "Reactions to secondary trauma that are manifested in sessions as countertransference pose a serious ethical dilemma for therapists, as clients can actually be harmed or possibly even re-traumatized by such reactions" (Hesse, 2002, p.303).

## Burnout

Burnout, on the other hand, may result in physical symptoms, emotional symptoms, behavioral symptoms, work-related issues, interpersonal problems, a decrease in concern for clients, and (sometimes) a lower quality of client care (Raquepaw & Miller, 1989). Burnout can result in a "loss of energy, commitment and optimism among staff generally, with a consequent depressing effect on organizational [original spelling] climate and culture" (Sexton, 1999, p. 398). Maslach (1976) described burnout as having three dimensions: (a) emotional exhaustion; (b) depersonalization (defined as a negative attitude towards clients, a personal detachment, or loss of ideals); and (c) reduced personal accomplishment and commitment to the profession.

## Vicarious Trauma

The construct of vicarious trauma (VT), however, provides a more complex and sophisticated explanation of counselors' reactions to client trauma and has implications for preventing counselors VT reactions (McCann & Pearlman, 1990). For example, Schauben and Frazier (1995) found that clinicians working with victims of sexual assault reported effects on the vicarious traumatization measure they employed, but not on the burnout measure. It is important to note that vicarious traumatization occurs only among those who work specifically with trauma survivors (e.g., trauma counselors, emergency medical workers, rescue workers, crisis intervention volunteers), whereas burnout occurs in any profession (McCann & Pearlman, 1990) and is often a result of simple exhaustion. VT is more often the result of a therapist working with a client's chronic, complex issues related to specific traumatic experiences. VT can lead to the changes in trust, feelings of being out of control, avoiding intimacy, damaged self-esteem, concerns for one's safety, and intrusive

negative imagery (Rosenbloom, Pratt, & Pearlman, 1995).

The consequences to organizations which employ therapists who work with these traumatized populations are varied. Neumann and Gamble (1995) and Pearlman and MacIan (1995) list a few of the most serious: More disruption of their empathic abilities resulting in therapeutic impasses and more frequent incomplete therapies. Greater trouble maintaining a therapeutic stance, which can lead to engaging in more boundary violations. High staff turn-over. Additional costs of employing and training new staff. Inexperienced trauma therapists are more likely to suffer from vicarious traumatization than their more seasoned counterparts. Higher costs for supervision of novice therapists.

**Suggested Solutions**

In order to help those who are at risk, organizations which employ therapists have a particular responsibility. Unfortunately, it can be the administration of a particular company that accidentally encourages burnout. Unsupportive administration, lack of professional challenge, low salaries, and difficulties encountered in providing client services are predictive of higher burnout rates (Arches,1991, Beck, 1987; Himle, Jayaratne, & Thyness, 1986). Unfortunately, anyone who has been in this industry for more than a decade has likely experienced these frustrations. "Individual staff members suffer, and the resulting loss of experienced staff can diminish the quality of client services" (Bell, Kulkarni, & Dalton, 2003, p.466).

**Who is Susceptible**

As I begin to discuss what to do about helping those who have fallen victims to VT, it is wise to first identify who is most susceptible to contracting it. Cunningham's (2003) study of VT brings up an interesting question: When a counselor encounters a victim of trauma, what kinds of trauma put that counselor at the most risk to develop VT? The answer: Clinicians who work with victims of sexual abuse are more likely to contract VT than even those counselors who work with cancer patients! Also, vicarious traumatization seems more likely to occur in clinicians new to trauma work, those who work primarily with sexual abuse clients, and those with a personal history of sexual abuse (Cunningham, 2003). This last finding was

confirmed by Pearlman and MacIan (1995) who noted significantly more vicarious trauma symptoms in 60% of the therapists they surveyed who had reported a personal history of trauma.

## Organizational Support

No therapist can work effectively with trauma survivors without support, just as no trauma survivor can heal alone (Herman, 1992). Organizations can ensure that adequate resources are made available to help therapists process disturbing clinical material (Figley, 1995). Examples of this support include (a) clinical supervision or consultation (preferably in session with the therapist and the trauma survivor), (b) peer process groups immediately after sessions, (c) Milan-style therapy "behind the glass" with a clinical team lending support, (d) wisdom and impartiality, and (e) company-sponsored trauma therapy training.

Regularly scheduled clinical meetings are an informal way to allow therapists to cathart with peers, plan possible solutions with the company's approval, and have access in a non-threatening way to company leaders. Attendance to personal therapy can also be a great source of release for a struggling therapist (Neumann & Gamble, 1995). "Sometimes it is useful to engage external consultants in order to provide objectivity in dealing with vicarious traumatization [original spelling] issues where the organisational [original spelling] dynamics may be part of the problem" (Sexton, 1999, p.399).

## Supervision

Proper supervision is vital. It is widely debated in our field whether or not supervisors should address their supervisees' personal issues during supervision, when those issues may be better suited for a therapy session. I have found that, when handled sensitively and with the permission of the supervisee, in-depth discussion of personal reactions to client's issues is very healing for the therapist involved. Sexton places high priority on such close supervision of therapists dealing particularly with clientele who are trauma survivors: "A key component of this curriculum is training in the identification and working through of intense countertransference experiences" (Sexton, 1999, p.399).

The implication is not that the therapist is weak and needs to be spoon-fed. How ironic and ignorant it is to assume that a therapist who needs therapy is weak! On the contrary, wise organizations view VT as a system-wide problem. The whole point is to avoid attributing blame to the therapist who is attempting to help a client heal. Rather, leaders should express support and encouragement to the struggling therapist (Catherall, 1995).

**Peer Support**

A little peer support goes a long way. In our facility, we encourage therapists to "team up" with each other spontaneously when conducting group therapy. Obviously, this means our therapists' caseloads have to be small enough to allow flexibility in their schedules, and the requirement for numbers of hours of therapy per client have to be manageable. We have found through trial and error that if a therapist carries a caseload of no more than five to seven clients and two groups (meaning weekly ninety minute sessions of individual therapy per each client, weekly ninety minute sessions of family therapy per each client, and two ninety minute groups per week), it helps curb burnout and allows for collaboration among peers, greatly reducing the chances that the eventual VT experience will go unnoticed and untreated.

**Education**

Critical to combating VT is the facility's instruction of its therapists. Goldblatt & Buchbinder (2003) suggest, "In preparing to intervene with family violence we recommend implementation of anticipatory workshops where the students can (1) clarify their attitudes toward abusers and victims; (2) reflect on personal experiences of abuse in the family of origin and in intimate or other relationships; (3) become more aware of personal background factors leading them to choose family violence as a preferred field of social work intervention; and (4) learn what to expect and how this work may influence their personal relationships" (p.271).

As mentioned above, although many supervisors of new therapists hesitate to use supervision time as "therapy" time for the supervisee, not doing so deprives the inexperienced therapist of a great resource in thwarting VT: self-awareness. It is crucial to maintain a culture that does not punish therapists for minor boundary mistakes or for minor misjudgments. There

must be an open-door policy between a therapist and his/her supervisor so the therapist at risk can discuss feelings and concerns freely and the supervisor can sense the onslaught of VT and proactively take action to prevent harm to the therapist.

**Building Therapist Competencies**

Bell (2003) suggests that therapists need five strengths: (1) competence about coping, (2) maintaining objective motivation, (3) resolving personal traumas, (4) drawing on personal role models of coping, and (5) having buffering personal beliefs. Organizations can help therapists develop these strengths. "To foster strengths, settings need to embody the philosophical framework of the strengths perspective: that people have strengths, that they are the experts about their own experience, and that relationships of collaboration, rather than hierarchical power, assist in identifying and building on those strengths" (Bell, 2003, p.522).

The upper hierarchy of an organization, therefore, has a responsibility in this process. An intervention on the part of an administrator or supervisor to enter the realm of the therapist and assist that therapist in a particularly difficult session or group is a powerful tool to support therapists in the workplace. When the administrator is not a licensed therapist, the gap between employer and employee can still be reduced by the administrator attending a group session periodically, or otherwise involving him/herself in the day-to-day experiences of the therapist such as eating lunch together, participating in after-hours activities, hosting company parties, or other informal situations.

**Resiliency**

Even with support, however, therapists should build resilience on their own. Sexton (1999) states, "Therapists need to learn to: (a) identify their own reactions and those salient themes that elicit strong countertransference reactions; (b) develop awareness of their own specific somatic signals of distress; (c) understand early warning signs of vicarious traumatisation [original spelling] in themselves; and (d) accurately name and articulate their own trauma-related inner experience and feelings" (p.400). Dane's research (2000) uncovered the coping skills that therapists use to keep from experiencing VT: (1) appropriate detachment,

(2) staying busy at work and after hours, (3) accepting one's limitations with the help of a wise supervisor, (4) setting limits for self and clients, and (5) "cutting off", meaning applying responsibility for healing to the client and not taking it upon oneself.

In a more pragmatic systematized approach, Kernberg, Clarkin, & Yeomans (1999) concretely proposes what they call a "pilot's list" of priorities for treatment. Obstacles to therapy are addressed first. These include suicide or homicide threats, threats to treatment continuity, dishonesty or withholding in session, contract breaches, in-session acting out, and between-session acting out. Next, the therapist addresses overt transferences such as verbal references to the therapist, and "acting-in" (e.g., seductive body posture). Finally, therapists address nontransferential affect-laden encounters. This "pilot's list" of priorities helps therapists keep control of their exposure to "charged" emotional reactions from their clients' traumas and provides a framework for supervisor and therapist discussion post-session. With a plan, a therapist dramatically increases his/her own feelings of preparedness, and preparedness engenders feelings of competence and resiliency.

**Spirituality**

Interestingly, spiritual beliefs play an integral part in the life experiences of most workers. In Dane's (2000) research, spirituality was often described as reinforcing that each therapist's work has meaning. One woman described praying before she would go on a field visit or reading a passage in the Bible to give her strength. "Before going to work, or during lunch time, I stop in a nearby church and ask God to give me strength," she said (Dane, 2000, p.35).

If the word "spirituality" doesn't fit in your organization, Wasco, Campbell, & Clark (2002) highly recommend that "facilities (a) allow their therapists a personal cathartic releasing of traumatic material and (b) help therapists to improve their capacity to integrate the traumatic material into [their lives]" (p.731). One therapist said, "There were a few of us that would meet after work and give each other support in the process. And it was a weekly thing, so it didn't build up. So we do it on our own....As needed" (Wasco et al., 2002, p.740). The key is for employers to be flexible enough to allow employee catharsis "as needed", not being so focused on efficiency that leaders forget what is good and sacrifice it for what they perceive as "right".

## Conclusion

In closing, it is every mental health organization's responsibility to be constantly aware of its employees' mental health, particularly if its clientele includes sexual or physical trauma survivors. In my experience, the more attention paid to my employees' needs through hiring good managers, creating a supportive corporate culture, and allowing flexible schedules, the less sick leave is used, the less turnover I have, the happier my clients are, and the more positive the company culture becomes. The mere process of allowing a therapist to vent his/her feelings about a particularly heart-wrenching or otherwise emotionally difficult case is sometimes all it takes. However, when more serious interventions are required, organization leaders can utilize the suggestions listed in this paper to treat and prevent vicarious trauma among their employees. As leaders watch over their therapists more sympathetically, educate them, encourage their therapists' personal spirituality, foster effective supervision of therapy, engender peer-to-peer support, and build therapist competencies and resiliency, organizations will flourish, and clients will directly benefit.

## References

American Psychiatric Association (1999). Diagnostic and Statistical Manual of Mental Disorders. Washington, D.C.: American Psychiatric Association.

Arches, J. (1991). Social structure, burnout, and job satisfaction. *Social Work*, 36, 202-206.

Astin, M. C. (1997). Traumatic therapy: How helping rape victims affects me as a therapist. In M. Hill (Ed.), More than a mirror: How clients influence therapists' (pp. 101-109). Binghamton, NY: Haworth.

Beck, D. F. (1987). Counselor burnout in family service agencies. *Social Casework*, 68, 3-15.

Bell, H. (2003, October). Organizational Prevention of Vicarious Trauma. *Social Work*, 48 (4), 513-523.

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational Prevention of Vicarious Trauma. *Families in Society*, 84(4), 463-481.

Catherall, D. (1995). Coping with secondary traumatic stress: The importance of the professional peer group. In B. H. Stamm (Ed.), Secondary traumatic stress: Self- care issues for clinicians, researchers, and educators (pp. 80-92). Lutherville, MD: Sidran.

Cunningham, M. (2003). Impact of Trauma Work on Social Work Clinicians: Empirical Findings. *Social Work*, 48(4), 451-460.

Dane, B. (2000). Child Welfare Workers: An Innovative Approach for Interacting with Secondary Trauma. *Journal of Social Work Education*, 36(1), 27-38.

Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley (Ed.), Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized (pp.1-19). New York: Brunner/Mazel.

Goldblatt, H., Buchbinder, E. (2003). Challenging Gender Roles: The Impact on Female Social Work Students of Working with Abused Women. *Journal of Social Work Education*, 39(2), 255-272.

Heppner, M. J., Good, G. E., Hillenbrand-Gunn, T. L., Hawkins, A. K., Hacquard, L. L., Nichols, R. K. (1995). Examining sex differences in altering attitudes about rape: A test of the elaboration likelihood model. *Journal of Counseling & Development*, 73, 640-747.

Herman, J.L. (1992). Trauma and recovery. New York: Basic Books

Hesse, A. R. (2002). Secondary Trauma: How Working with Trauma Survivors Affects Therapists. *Clinical Social Work Journal*, 30(3), 293-311.

Himle, D. P., Jayaratne, S. D., & Thyness, P. A. (1986). Predictors of job satisfaction, burnout and turnover among social workers in Norway and the USA: Across cultural study. *International Social Work*, 29, 323-334.

James, R. K., & Gilliland, B. E. (2001). Crisis intervention strategies. Belmont, CA: Brooks/Cole.

Kernberg, O. F., Clarkin, J. F., Yeomans, F. E. (1999). Psychotherapy for Borderline Personality. New York: Wiley.

McCann, I. L. & Pearlman, L. A. (1990). Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.

Maslach, C. (1976). Burn-out. *Human Behaviour*, 5(9), 16-22.

Neumann, D. A., & Gamble, S. J. (1995). Issues in the professional development of psychotherapists: Countertransference and vicarious traumatization in the new trauma therapist. *Psychotherapy*, 32, 341-347.

Pearlman, L. A., & MacIan, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558-565.

Pearlman, L. A. & Saakvitne, K. W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W.W. Norton.

Raquepaw, J. M., & Miller, R. S. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research*

*and Practice*, 20, 32-36.

Ratna, L., & Mukergee, S. (1998). The long-term effects of childhood sexual abuse: Rationale for and experience of pharmacotherapy with nefazodone. *International Journal of Psychiatry in Clinical Practice*, 2, 83-95.

Rosenbloom, D. J., Pratt, A. C., & Pearlman, L. A. (1995). Helpers' responses to trauma work: Understanding and intervening in an organization. In B. H. Stamm (Ed.), Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators (pp. 65-79). Lutherville, MD: Sidran.

Schauben, L. J., & Frazier, P. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*,19, 49-64.

Sexton, L. (1999). Vicarious Traumatisation of Counsellors and Effects on Their Workplaces. *British Journal of Guidance & Counselling*, 27(3), 393-404.

Wasco, S. M., Campbell, R., & Clark, M. (2002). *American Journal of Community Psychology*, 30(5), 731-761.

# Reflecting Teams and Other Innovative Family Therapy Techniques Adapted for Outdoor Behavioral Healthcare

**Troy J. Faddis, LMFT, CFLE**
*Aspen Achievement Academy*

**Dr. Joanna E. Bettmann, Ph.D., LCSW**
*University of Utah College of Social Work*

## Abstract

This article demonstrates the effectiveness of using traditional family therapy techniques to enhance wilderness therapy, also known as outdoor behavioral healthcare. This article presents the practice of utilizing the narrative family therapy technique of reflecting teams in combination with the experiential family therapy technique of family sculptures. This article discusses the combination of these theoretical models and techniques and introduces a practical approach to the integration of models and theories in an outdoor behavioral healthcare setting.

## Introduction

A marriage and family therapist first entering the field of wilderness therapy from other mental health professions finds some very unique challenges. One of the most pressing: learning how to apply traditional family therapy techniques into the unique setting of the wilderness. The learning process is not easy, and is made more difficult by the historically eclectic and poorly articulated approach to wilderness therapy (Russell, 2003). Understanding how the wilderness surrounding us impacts the therapeutic process is an integral part of this learning.

The theories and practices explored in this article are a result of that ongoing integration. This article will present one practical approach to family therapy in the wilderness using a unique fusion of narrative therapy techniques, experiential family therapy techniques, and wilderness therapy milieu.

This article will outline basic theoretical concepts from each of the above areas, integrating them to describe a practical approach to family therapy in the wilderness.

## Concepts and Definitions

Wilderness Therapy. Wilderness therapy historically has not been a well-defined term (Bandoroff, 1989; Kimball & Bacon, 1993; McFee & Gass, 1993; Powch, 1994; Russell & Farnum 2004). Russell (2001) states, "Despite a growing number of programs operating in the United States under the guise of 'wilderness therapy,' a consistent and accepted definition is lacking" (p.70). Russell (2003) defines a specific form of wilderness therapy known as outdoor behavioral healthcare, as a "type of program that works to address problem behaviors and attitudes through a variety of therapeutic and educational curricula and outdoor environments. Processes [are] facilitated by unlicensed professionals" (Russell, 2003, p.3). Russell further defines outdoor behavioral healthcare as group living with peers, including the use of interventions such as natural consequences, mentors, use of metaphor, physical exercise, and challenge. Defining theoretical models for wilderness therapy as well as integrative approaches to wilderness therapy is seriously needed within the industry (Russell, 2003). Below, we detail some of the family therapy theoretical models used in wilderness therapy settings, and then describe the application of these models to one wilderness therapy program.

## Family Therapy.

Early in the family therapy movement, the concept of cybernetics was integrated into theoretical and practical models. The notion of cybernetics, developed within technological industries, lent some legitimacy to the field of family therapy by treating clients from a systems perspective. In the 1980's, theorists developed the idea of second order cybernetics, which stressed that the therapist was an integral part of the family system, and therefore did not maneuver outside the family. Second order cybernetics also stressed that the therapists were not more of an authority than the families they treated. As this shift occurred, many therapists further developed the concept that therapists should not be in the expert role. Some of these therapists developed the postmodern therapy movement, which is referred to by Anderson, Goolishian, and Hoffman as a collaborative language systems approach (Nichols & Schwartz, 1998).

**Experiential Family Therapy.**

Developed principally by Carl Whitaker and Virginia Satir, experiential family therapy is based in a "here-and-now" approach. Its main axiom is that problem behaviors area result of unexpressed affect. Its techniques are dynamic, as exemplified by exercises such as family sculpting. Family sculpting is an exercise often used by experiential family therapist to vividly portray the roles which family members act out. In the family sculpting intervention, a therapist asks one family member to arrange the others in a literal sculpture which portrays his/her perception of family members' roles and actions. This intervention can be useful in heightening family members' awareness to each other's behaviors (Nichols & Schwartz, 1998).

Ever since David Kantor and Fred Duhl first developed the family sculpture exercise (Nichols & Schwartz, 1998), family sculptures have been applied to a variety of settings, ranging from choreography to family art therapy. The basic family sculpture exercise at Aspen Achievement Academy involves one member of the family arranging people and props (trees, rocks, cordage, streams, firewood, etc.) to create a meaningful tableau. The richer the metaphor created in the family member's sculpture, the better the reflection from the team. The facilitator asks adolescents to create a still picture of their choosing, emphasizing that an appropriate choice would illustrate an event, scenario, or dynamic that powerfully characterizes the adolescents perspective. Many adolescents find that they have an immediate image of what they want to sculpt; some do not. For those who do not, we suggest a few options, including creating a sculpture of the space where the problem story started, creating a sculpture of a climax that holds unexpressed stories, or creating a sculpture of changing points that offer a new perspective. This family sculptures exercise plays a critical role in the model we use with families at Aspen Achievement Academy, and its role will be explained further below.

**Narrative Family Therapy: A Postmodernist Theory.**

Narrative family therapy has its origins with Michael White, David Epston, Lynn Hoffman, Harlene Anderson, Harry Goolishian, and others, and grew out of post-modernist and deconstructivist thinking. Many postmodernists describe their approach to therapy as one based in principles and no tin methods (Nichols & Schwartz, 1998). The following four axioms outline the basic principles of narrative therapy: (1) realities are socially constructed; (2)

realities are constructed through language; (3) realities are organized and maintained through narrative; and (4) there are no essential truths, however, not all narratives are equal (Freedman & Combs, 1996).

Other important concepts within narrative therapy include: (1) the notion of a dominant story which is the overriding story one uses to define himself; (2) the problem- saturated story, which occurs when one dominant story is based on negative perceptions and cognitions; (3) the process of deconstruction, which occurs as the therapist asks questions to help clients more deeply understand their own stories; (4) an alternative story, which is introduced through therapy and offers new and different perspectives on old problem-saturated stories, giving the client the chance to see alternative perspectives; and (5) an audience, who witnesses the alternative stories, giving them strength (Freedman and Combs, 1996; Freeman, Epston, & Lobovits 1997; Nichols & Schwartz, 1998; White & Epston 1990).

Since the emphasis in postmodern therapy is placed on attitude and caring rather than on technique, there is a lack of various formal practice techniques in this model. One of the only techniques which emerged from narrative therapy is the "reflecting team" described below.

## Reflecting Teams

### A Brief History of Reflecting Teams.

Reflecting team techniques were created by Tom Anderson (Anderson, 1987). Influenced by the Milan therapy movement, Anderson was tired of the hierarchical nature of the Milan and other family therapy models, and accordingly sought to create non-hierarchical approaches to family therapy (Nichols & Schwartz, 1998; White, 1995). Composed of professionals, the reflecting team traditionally operates behind a one-way-mirror and observes a family being treated by a therapist. After the team observes, they switch locations with the family, and the family observes the team having a professional discussion of the therapy. Then, the family switches locations again, and each family member has the opportunity to respond to the comments made by the reflecting team. Lastly, the team shares back with the family a reflection of the families' responses (Freedman & Combs, 1996; White, 1995).

### Basic Concepts and Principles from a Narrative Perspective.

As used at Aspen Achievement Academy, the reflecting team is a definitional ceremony. One author states, "Definitional ceremonies deal with the problems of invisibility and marginality; they are strategies that provide opportunities for being seen and in one's own terms, garnering witnesses to one's worth, vitality and being" (Myerhoff as cited in White, 1995, p.267).The definitional ceremony helps to establish for the adolescent and family an audience that gives and receives, contributing to the expansion of viewpoints and the validation of family stories. For this reason, the reflecting team requires more in terms of attitude than a specific technique. Hoffman (1992) asserts that reflecting team participants should take an affirmative and affiliative stance with "'relentless optimism"' (Hoffman as cited in Freedman & Combs, 1996). As we work with families in the reflecting team format, we acknowledge that not all stories are equal. So as we work to strengthen some stories and identities, we also challenge faulty cognitions that promote poor story formation.

At Aspen Achievement Academy, our assignment to reflecting team members is to join with the family, to support and help in developing a new story about the family, and to help deconstruct the problem-saturated stories. These tasks are accomplished by having the team, particularly the therapist and therapeutic staff: (1) pay attention and build understanding first, encouraging participants to let go of preconceived ideas; (2) look for evidence that support the problem-saturated story so that those can be deconstructed and new stories developed; (3) look for differences and other aspects of the family sculpture that do not fit with the family's or adolescent's problem-saturated story; (4) offer to the adolescent and family alterative perspectives on their problem-saturated story; and (5) utilize peer- based support as an audience whose witnessing can shift cognitive perspective and reinforce alterative perspective (Freedman & Combs, 1996).

**The Family Sculpture and Reflecting Team Group**.

At Aspen Achievement Academy, multi-family group therapy sessions are run by a Masters-level therapist at the end of adolescents' time in the program. These multi-family groups normally culminate with a particularly powerful group exercise: the family sculpture and reflecting team group which is described below. Prior to this group, there are several days of therapeutic activities that establish the families' familiarity with each other. Familiarity

andrapportamongallgroupparticipantsisimportanttoachievebeforethisgroupbegins, in large part because families will serve as members of each other's reflecting teams, a process which will be further explicated below.

At Aspen Achievement Academy, facilitators always take the entire group of families and reflecting team members through a detailed example of the group process to provide them with the opportunity for a full informed consent to this exercise. The following description of the four interviews of a reflecting team have been adapted to work within the Aspen Achievement Academy wilderness setting from the work of Michael White (1995, 2000). The family sculpture and reflecting team group is split into four different sections, which are called interviews.

**The First Interview**.

In Anderson's model of reflecting teams, the first interview is conducted by a therapist who has been working with the family for some time. This therapist conducts a "typical" session discussing core family issues. At Aspen Achievement Academy, this first interview is dramatically changed. In place of the typical therapy session, the adolescent creates a family sculpture of his/her family. The family sculpture represents a dominant story that still shapes how the adolescent sees himself. The adolescent tries to capture basic family therapy components such as: cohesion, adaptability, roles, rules, collusions, triangles, etc. Most times, these dominant stories are problem saturated. Then the reflecting team, made up of other families and therapeutic staff, is asked to observe the sculpture as if they were at an art gallery. Reflecting team members are given three questions to answer as they observe the sculpture. The three questions are: (1) What is the meaning of the sculpture, and do I perceive any metaphors; (2) what similarities do I share with the story being told in this sculpture; and (3) what emotions do I experience as I observe this sculpture?

After reflecting team members have had a chance to observe the sculpture and internally answer the three questions, the adolescent who created the family sculpture then narrates and explains his sculpture to the reflecting team. The adolescent's family members are asked to observe silently as the adolescent explains his sculpture. This family sculpture exercise has a powerful impact in that it can demonstrate multiple facets of the family system in a short period of time. It also incorporates many traditional experiential family therapy

elements by creating clear opportunity for the display of unexpressed affect. This display of affect often elicits empathy and understanding from family members instead of defensiveness and resentment.

**The Second Interview.**

During the second interview, reflecting team members sit in a circle and talk, while the family whose adolescent created the sculpture sits outside the circle. Reflecting team members discuss their ideas about the sculpture, as well as the answers to the three questions mentioned earlier. For the family, whose sculpture was created, this is a time to hear feedback as it is given from the team. The family, sitting outside the reflecting team circle, is asked not to respond in any way to what is being said. They sit outside the reflecting team, yet close enough to hear what is being said. To help create a feeling of separateness from the family, the reflecting team forms a tight circle as they discuss.

The family members outside the circle are advised not to discuss comments being made by the reflecting team. During this interview, it may be difficult for family members to remember all of the comments being made by the team; it can be much like trying to drink from a firehose. In light of this, the facilitating therapist can encourage family members to take notes during this process. Family members can be asked to keep notes and to write things that are: (1) validating, (2) challenging to hear, and (3) help them to have new or better understanding of their family. Challenging comments may include things that are true, but the individual is not yet prepared to face, or comments that do not seem to fit the individual's experience. New understanding comments are those which help them to explain dynamics they knew but did not know how to describe, or comments that bring new insight and understanding.

The reflecting team as utilized at Aspen Achievement Academy is made up of all of the adolescents and parents not in the sculptured family, therapeutic staff, and a therapist. This peer-based team can have many benefits, as well as risks. Most of the benefits come from the strength the reflecting team creates as an audience. As discussed earlier, the narrative perspective attempts to draw away from the "therapist as expert" idea, and places equal expert status on family members. The peer-based reflecting team supports this concept by having other families who share many dynamics with the family act as

experts in their own experiences, offering rich perspectives to their peers. An additional benefit can be the breaking down of prejudices against therapy activities, changing participants' notions about what is therapy. It can create particular impact, for example, for a father to hear comments about his unflattering position in the sculpture from a fellow father who is very similar. Similar comments from the facilitating therapist might well provoke a more defensive response.

The risk of the peer-based reflecting team is the unpredictable nature of the team's comments, created in part by the often-intense feelings generated in team members after viewing the sculpture. While such feelings of team members can often be useful, they may have more personal application than direct relevance to the family who is the focus of the team. These feelings can be noted by the therapist and addressed in other therapy sessions. It is suggested that, in setting up the reflecting team, the facilitating therapist establish some ground rules for reflecting team members, such as no advice-giving, no judgment- making, and no problem-fixing in other families' sculptures. Facilitating therapists should be confident in anticipating team members' strong feelings, and should be assertive in redirecting inappropriate comments that are best saved for later. It is crucial, given the intense nature of this exercise, that the family sculpture exercise and reflecting team technique only be conducted by a qualified therapist.

Family sculpture groups also run the risk of generating team member comments that are not accurate or rich enough. White (2000) details this problem:

> One of these potential hazards is that reflecting team-members can find their lives thinly described by the persons who are at the centre of the definitional ceremony–team members can experience a lessening of their personhood as a result of people's responses to the outsider-witness retelling, and, needless to say, this is not a good outcome. As contemporary western culture is a culture of normalizing judgment, if attention is not given to the potential for people to reproduce these practices of judgment in their responses to the outsider-witness retellings, then team members are engaging in a context that could be significantly disqualifying not just of their efforts, but also of their very personhood (p. 13).

To avoid this concern, the facilitating therapist can ask team members to be brief in their sharing of comments and to keep their energy focused on the family's sculpture. The therapist should also encourage team members to stay on the task of answering the three questions mentioned earlier. These three questions help keep the untrained team members focused on important and useful material. The therapist can help team members stay focused by facilitating the answering of these three questions.

The first of the three questions focus on metaphors. Metaphors address the mystery of the family and their stories. Metaphors can also expand the alternative stories. Many of the new perspectives offered by reflecting team members regarding these metaphors add depth that the family may not have considered. Focusing on metaphors in the sculptures also enhances a deconstruction of the old stories for the family and helps keep them open to new stories.

The second question asked of team members focuses on similarities. Exploring responses to this question help the reflecting team and family to join together, promoting an emotionally safe environment.

The third question asked of team members focuses on their emotional reactions to the sculpture. This question assists in the process by offering a place for validation and acknowledgement of team members' experiences. The question can also normalize for the family their experiences, as they hear other team members expressing many of the same emotions that they themselves felt during the time that the family sculpture represented. The expression of affect can also reveal previously unexpressed or hidden affect for the student who created the sculpture and his/her family. The therapist plays a critical role here as the facilitator by keeping energy focused on those reflecting team responses which expand the family's stories.

**The Third Interview.**

In the third interview, reflecting team members sit on the outside of the circle, while the adolescent, his/her family, and the facilitating therapists it inside of it and talk. The third interview allows the reflecting team now to be the audience and hear the family's conversation regarding the team's comments. During this process, the facilitating therapist plays dual roles. In traditional reflecting teams, there is a different therapist who sits with the family during this

interview. This is not the case with the technique as utilized at Aspen Achievement Academy. As we have adapted the technique, the facilitating therapist is free to add comments during this interview, but reflecting team members are not.

As the adolescent and his/her family respond to the reflecting team's comments, they are asked not to tell their own dominant story as a response, but to share how the sculpture and comments from the reflecting team affected them emotionally, physically, cognitively, or spiritually. The family is asked to comment on several specific elements of the process. First, the family is asked to share their personal responses to the second interview, which was the reflecting team's discussion of the sculpture. This sharing constitutes the majority of the third interview. Family members are asked to reflect on the most meaningful comments made. They are asked to consider comments which were validating, challenging, supportive, or expanding. It is also helpful to have family members answer which comments taught them the most about themselves or about the family. Typically, the first person to share is the adolescent who created the sculpture. Then, each family member of the adolescent is asked to share. After every family member has spoken, the adolescent is asked to reflect on the comments made by his family members, essentially creating a mini-reflecting team within the process. Some students find it helpful to focus on reflecting comments made by parents which the student had not noticed before.

In the third interview, family members are also asked to share their experiences of the first interview, which was the sculpture creation and subsequent viewing by team members. This processing component of the reflecting team interview is not given a great deal of time, as there is a risk of family members attacking or invalidating the adolescent's sculpture, rather than simply being reflective on it. However, family reactions to the sculpture can be very powerful. The facilitating therapist is advised to redirect reactive comments, asking family members not to justify, rationalize, or re-explain.

Finally in the third interview, the therapist comments on both the family's reflection and the family sculpture. Here, the therapist can ask future-oriented or opening space questions and can point out important comments that were made earlier but ignored by the family. The therapist here can investigate how the comments impacted the family, and what the family might predict are the results of these new realizations.

## The Fourth Interview.

In the fourth interview, the family and the reflecting team discuss the previous interviews as one big group. During this interview, reflecting team members can ask new questions, as well as make strengthening comments which may add reinforcement to new story formation. Team members are advised by the facilitator to avoid loaded questions that carry value judgments towards the family or other team members.

## The Utility of Having an Audience.

From the perspective of narrative theory, having an audience is critical in achieving new story formation. This audience should be made up of those whose views keep the old story alive, as well as peers who have the influence to give validity to a new story or narrative. In this exercise at Aspen Achievement Academy, three audiences are in place.

One audience is family. Involving family members in the process of new story formation is important. Family includes any siblings and extended family members who play a significant role in the adolescent's life. These audience members are invaluable as they often can help challenge old stories and may support new narratives that demonstrate growth and healing.

Another audience is composed of peers. Peers, including the Aspen peers who have spent many weeks in treatment together, are also crucial audience members. Developmentally, adolescents are seeking connection and prioritizing approval from their peers. Thus, peers can play an important role by offering reinforcement for new stories and providing empathy and concern. Peers back home also play a major role in most problem-saturated stories. Having new peers talk about alternative stories in this group exercise is a powerful reinforcement.

A third audience is therapeutic staff and the facilitating therapist. Most adolescents in our program develop strong rapport with therapeutic staff through daily interactions and experiences. From the vantage point of strong relationships built through daily interaction, therapeutic staff can offer comments which may have dramatic impact. Thus, it is important for the facilitating therapist to train therapeutic staff on how to be most effective in this group process. It is recommended that staff meet with the facilitating therapist for

training prior to the conducting of the group. Such training may involve reviewing the staff's own family sculpture, which could then be used as an exemplar for the group. Staff are instructed to prepare a family sculpture which connects with the issues facing the students and has dynamic and descriptive parts (i.e. pulling, pushing, defiance, faulty cognitions, family homeostatic patterns, etc.). Adolescents often pull many of their dynamics from the example of the staff. The staff is asked to make a true sculpture and to not makeup a family for the sake of the exercise. The staff also needs to understand that this is an example only and to be prepared for the transference that may be placed on them during the reflecting team process. Being prepared to reflect in the third interview without re-explaining or justifying will model the safety needed for the rest of the group. Lastly, the staff should be clear that if unexpected issues are brought up, or if the process opens areas that need personal work, that they have the resources to do their personal work away from the context of this work. Readings are also often assigned to staff to prepare them for this work.

### The Role of Artwork in Creating Audience.

In narrative family therapy, the audience plays a crucial role by witnessing new stories and providing support for them. In the group exercise described above, the audience of the reflecting team is only one audience. Creating artwork can provide the opportunity for other audiences. Creating artwork as a family, after the family sculpture and reflecting team exercise, can strengthen alternative family stories and provide the opportunity for another audience.

Michael White and David Epston (1990) invite their clients to record their new stories in a way that they can then reflect back during moments when problem stories resurface. This recording can be done in many different forms, including artwork, journaling, letter-writing, or group-formation. For example, in Australia and Canada, there are many anti-anorexia/ bulimia groups who form a commitment to each other to better manage their self-image and drive for control (White & Epston, 1990). At Aspen Achievement Academy, we ask families to self-record using artwork. At the conclusion of the family sculptures and reflecting team group, we ask each family to take art supplies and draw their family sculpture as it was seen in the group. This project should be done by the family alone, without outside assistance, but using the gifts and talents of each family member. On the back of the artwork, we ask families to record

additional memories. We ask each family member to recall at least two or three meaningful comments or lessons they received from the family sculpture and reflecting team process. The comments should help them remember statements which gave them hope or statements which may stimulate change. The family is asked to record the comments using as many quotes from the team as they can remember. They are then asked to share the comments and artwork with each other, and commit to remembering them in the family by keeping their artwork in a place so that it gets shared often. This process, the creation of artwork along with the recording of the team members' comments, offers families an opportunity to develop a ritual for remembering (Doherty, 1999).

## Implications for Research and Evaluation

Our personal observations of participants' spoken and written feedback demonstrate high satisfaction with this integrative group technique of family sculpture with reflective team. However, these findings are not empirically validated and need testing. The authors have not seen any study in the literature which defines or tests this particular integrative model, and thus clearly there is a need for research here.

There is also a need to find a more complete theoretical model that defines wilderness therapy. As noted above, a theoretical model for wilderness therapy is in its early stages, drawing upon many disciplines. However, this model is yet to be rigorously tested. We advocate here for the empirical and rigorous testing of all theoretical models and integrative techniques used in wilderness therapy and outdoor behavioral healthcare settings. In its description of theories and techniques utilized in a wilderness therapy setting, this article attempts to contribute to this dialogue.

We believe research is needed to establish empirically what is working within wilderness therapy and which factors can account for its impact. For example, Russell (2003) suggests that in outdoor behavioral healthcare settings, therapeutic alliance is more important than which the theoretical model is used by the therapist. The notion that therapeutic alliance being of more importance to outcome than any particular theoretical model is supported by others in the mental health field (Miller, Duncan & Hubble, 1997, 1999). Establishing empirically what works in wilderness therapy is essential in creating an integrative model for wilderness therapy.

## Conclusion

This article outlines one integrative approach to family therapy in an outdoor behavioral healthcare setting. It describes a practical application of narrative reflecting teams in combination with the family sculpture exercise used in a wilderness therapy setting. It is our hope that this article outlines for others, through a combination of theory and practice, some ideas on how to create and utilize an integrative approach in the particular field of wilderness therapy.

## References


Anderson, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process*, 26, 415-428.

Doherty, W. (1999). The intentional family: Simple rituals to strengthen family ties. New York, NY: Avon.

Freedman, J. & Combs, G. (1996). Narrative therapy: The social construction of preferred realities. New York, NY: W.W. Norton & Company.

Freedman, J., Epston, D. & Lobovits, D. (1997). Playful approaches to serious problems: Narrative therapy with children and their families. New York, NY: W. W. Norton & Company.

Miller, S., Duncan, B. & Hubble, M. (1997). Escape from Babel: Towards a unifying language for psychotherapy practice. New York, NY: W. W. Norton & Company.

Miller, S., Duncan, B. & Hubble, M. (1999). The heart and soul of change: What works in therapy. New York, NY: American Psychological Association.

Nichols, M. & Schwartz, R. (1998). Family therapy: Concepts and methods. Boston, MA: Allyn & Bacon.

Russell, K. (2003, September). Definitions, models, and assessing outcomes in outdoor behavioral healthcare. Paper presented at the Naropa University Wilderness Therapy Symposium, Boulder, CO.

Russell, K. (2003). An assessment of outcomes in outdoor behavioral healthcare treatment. *Child and Youth Care Forum*, 32(6), 355-381.

Russell, K. (2001). What is wilderness therapy? *The Journal of Experiential Education*, 24(2), 70-79.

Russell, K. (2004). Two years later: A qualitative assessment of youth well-being and the role of after care in outdoor behavioral healthcare treatment. Technical Report: 1 Outdoor Behavioral Healthcare Research Cooperative School of Health and Human Services. University of New Hampshire, Durham, NH

Russell, K. & Farnum, J. (2004). A concurrent model of the wilderness therapy process. *Journal of Adventure Education and Outdoor Learning*, 4(1), 39-55.

Sexton, T. Ridley, C. & Kleiner, A. (2004). Beyond common factors: Multi level-process models of therapeutic change in marriage and family therapy. *Journal of Marital and Family Therapy*, 30(2), 131–149.

White, M. (2000). Reflecting teamwork as definitional ceremony revisited. Adelaide: Dulwich Centre Publication. Retrieved November 10, 2003 from http://www.dulwichcentre.com.au/reflectingarticle2.html

White, M. (1995). Reflecting teamwork as definitional ceremony. Adelaide: Dulwich Centre Publications. Retrieved November 10, 2003, from http://www.dulwichcentre.com.au/reflectingarticle.html

White, M. & Epston, D. (1990). Narrative Means to Therapeutic Ends. New York: W. W. Norton & Company.

## Authors' Note

This article is the result of a presentation given during the 2004 NATSAP Conference: Best Practices, in Clearwater, FL. I would like to thank my wife Christina and my four & ½ children, Charity, Saren, Andrew, and Tanner who supported me in writing this article. I would also like to thank Gil Hallows, Pam Parsons and all at Aspen Achievement Academy. Without your support and contributing resources, this type of work would not be possible.
---Troy Faddis

# Incident Monitoring in Outdoor Behavioral Healthcare Programs: A Four-year Summary of Restraint, Runaway, Injury, and Illness Rates.

**Dr. Keith C. Russell, Ph.D., Director,**
*Outdoor Behavioral Healthcare Research Cooperative, University of Minnesota*

**Nevin Harper, M.A., Research Assistant,**
*Outdoor Behavioral Healthcare Research Cooperative, University of Minnesota*

**Abstract**

The monitoring of risk-related incidents in residential treatment programs for adolescents with behavioral and emotional disorders is important in light of increased oversight of service delivery by state and national agencies charged with their licensure and accreditation. The goal of any monitoring program is to reduce the rate of injury or incident, which improves service delivery, in turn making the program safer and more effective. This paper provides an overview of the process and results of a risk-related incident monitoring program developed by members of the Outdoor Behavioral Healthcare Industry Council (OBHIC). Outdoor behavioral healthcare (OBH) programs engage resistant adolescents in inherently risk-related outdoor activities during the course of treatment, which averages upwards of 50 days living and traveling in wilderness environments. A risk-related incident monitoring program was developed and utilized to track, report, and analyze incident sat approximately ten OBH programs between the years 2001 and 2004. Specific incidents monitored during this time period include therapeutic holds and restraints, runaways, injuries, and illnesses. The percentage of clients that complete their treatment and graduate was also tracked.

Results show that during the years 2001-2004 the rate of therapeutic holds, runaways, injuries, and illnesses steadily declined. Restraints showed a steady rate of use by program staff; occurring approximately once per 3000 days that clients spent in wilderness

environments. Since incident monitoring of field days began in 1996, three fatalities have occurred in OBHIC member programs after approximately 1 million client field days. This equates to approximately 3.0 fatalities for every one million user days in the field. These rates will be compared, where possible, with other outdoor program rates and other therapeutic interventions for troubled adolescents. Recommendations include the importance of developing and maintaining consistent patterns of risk incident monitoring programs for similar programs, and the importance of consistent training and discourse around managing risk-related incidents for residential programs that work with adolescents.

## Introduction

This paper will describe the definitions, process, reporting, and analysis of a risk-related incident monitoring program employed by the Outdoor Behavioral Healthcare Industry Council (OBHIC). OBHIC was formed in 1996 to set standards for outdoor programs that utilize backcountry environments to treat adolescents with behavioral problems and addictions. Incidents that are annually monitored at each program include therapeutic holds, restraints, runaways, injuries, illnesses, and fatalities for adolescent clients and field staff. Results are reported from incident monitoring conducted between 2001 and 2004 for ten programs belonging to OBHIC. Also included are data from the years 1998-2001, outlining incidents that were tracked by OBHIC but were not gathered, analyzed, and interpreted by the authors of this report. The results will be discussed in the context of outdoor programming and behavioral healthcare services and recommendations will be made for practice and research.

A brief overview of the risks associated with outdoor program management in general will first be presented, followed by background information on outdoor behavioral healthcare (OBH) programs and their unique characteristics in terms of clientele and practice. Outdoor programming is used in this paper to refer to programs that utilize outdoor and wilderness environments in conducting therapeutic and educational programming to facilitate intentional outcomes for participants. Well known outdoor programs include Outward Bound (OB) and the National Outdoor Leadership School (NOLS), which take thousands of participants annually on guided excursions that are 4-to8-weeks in length. This will provide context to interpret the results of incidents monitored from OBHIC programs. Findings are presented with graphic figures and

descriptive passages to clarify incident occurrences, identify trends, and make brief comparisons of related incident data and research. Questions and suggestions regarding further evaluation and incident tracking for related programs are proposed, and finally, the author's conclusions are shared to encourage discussion of best- practice in OBH service delivery, with the goal of improved safety and treatment effectiveness for clients and their families.

## Outdoor Program Risk Management

Risk is an inherent element of outdoor program activities, intentionally used by providers of educational and therapeutic programs to develop a sense of stress in the individual and group, which in turn is reasoned to facilitate positive outcomes. One of the central roles of outdoor programs is to minimize the levels of actual risk in an activity, and to manipulate the levels of perceived risk to maximize learning for participants (Ewert, 1989; Priest & Gass, 1997). The type and difficulty of activities undertaken, program philosophy, and staff and participant competencies all influence risk assessment and avoidance in effort to reach specific program outcomes (Cloutier & Valade, 2003).

The inherent risks of outdoor programs and the legal expectations of the service provider to address them are critical considerations in outdoor program management (Brown, 1998; Cloutier, 2000; Hanna, 1991; vanderSmissen, 1997). Outdoor programs need to examine and identify what risks they are managing, implement the policies and procedures needed to reduce risks, then write and implement risk management plans. A risk management plan is defined as a "systematic analysis of one's operation for potential risk exposures and then set forth a plan to reduce the severity and frequency of such exposure" (vanderSmissen, 1997, p.1). Risk management plans need to be flexible enough to accommodate variations in staff training levels with use of equipment, understanding of policies and procedures (Ewert, 1987), as well as the type of participant being served. For example, in the provision of OBH programs for adolescents with behavioral, emotional, or psychiatric disorders, programs need to employ staff who are licensed and capable of dealing with potential crisis situations related to a clinical client group (Davis-Berman & Berman,1994; Russell, 2003).

While limited reporting exists on restraint in outdoor programming, injury and illness rates have been examined and reported in the literature at length

(Boulware, Forgey, & Martin, 2003; Gentile, Morris, Schimelpfenig, Bass, & Auerbach, 1992). The National Outdoor Leadership School (NOLS), in collaboration with other outdoor organizations, has been collecting and reporting injury, illness, and fatality data since 1995 in the published proceedings of the Wilderness Risk Managers Conference. NOLS co-hosts this annual risk management conference with the Student Conservation Association (SCA) and Outward Bound (OB) USA, which is dedicated to developing standards of practice for the wilderness education industry. Specifically, the goals of the conference are to a) educate wilderness practitioners on risk management and practical skills; b) share field and administrative techniques in risk management; c) influence risk management standards in the wilderness adventure and education industry; and d) provide a networking and professional development forum with today's leaders in the field (NOLS, 2005).

These outdoor programs provide valuable reference points for OBH providers because they involve clients that spend extended time in wilderness and outdoor environments engaged in similar activities. OBH program clients are predominantly adolescents while the outdoor programs are most typically young adults, course offerings range from 14-40+. Despite the similarities, OBH programs differ in two significant ways :a) the clientele in OBH programs are predominantly considered at-risk and are generally in treatment against their own free will, and b) high-risk adventure pursuits are not the primary activity in the field. OBH programs typically involve extended backpacking trips, with little or no use of high-risk activities such as mountaineering and rock climbing. Because of these differences, OBH programs also track other forms of data to manage the risk of their programs.

## Therapeutic Hold or Restraint?

Because OBH programs are working with resistant youth in therapeutic and clinical settings, it is sometimes necessary to utilize what has been defined in the literature as a therapeutic hold or restraint. There are three types of therapeutic holds that are based on the degree to which a staff member at a program physically moves or restrains the youth. As the therapeutic hold becomes more serious and longer in duration, it becomes a restraint. They are defined[1] as: a) physical assist, where a client passively resists staff making physical contact but complies with movement requested; b) therapeutic hold, which occurs when the client actively resists and is then propelled or held against

that resistance by a staff member in a standing, sitting, or prone position; and c) restraint, which occurs when a therapeutic hold mentioned above exceeds 30 minutes. This leads to confusion when reporting occurrences to outside agencies, as restraint is not so clearly defined in related literature and may therefore be inclusive of all physical contact restricting a client.

Therapeutic holds have long been utilized as a means of controlling aggressive and unpredictable behaviors of clients in numerous medical, judicial, residential, and healthcare settings. The practice continues to be used and is critical in some circumstances to minimize harm to clients, staff, and physical property. However, emphasis must be placed on awareness and understanding of the potential physical and emotional adverse consequences of holding clients against their will (Mohr, Petti, & Mohr, 2003; Paterson et al., 2003). Accrediting bodies of medical and behavioral health organizations have weighed into the discussion of potential adverse effects of restraint when national attention was peeked in 1998 following a feature article from the Hartford Courant titled "Deadly Restraint" (Weiss, 1998). The Joint Commission of Accreditation for Healthcare Organizations (JCAHO) stated in 1998 that restraint would be considered as an acceptable behavior management practice for maladaptive and problem behaviors only when accredited organizations can demonstrate: a) they have initiated a multi-disciplinary team to review, monitor and consult on restraint practices and patient outcomes, and b) that restraint is only used as the last available option to maintain the safety of the client/patient, staff and others.

Effective strategies to reduce therapeutic hold occurrences described in literature include the following: a) the use of a restraint committee, multi-disciplinary approach, and organizational policy changes; b) minimization vs. abolition: a harm reduction approach; c) advanced training for some staff in crisis prevention and response; d) patient and resident assessment and education practices that establish clear guidelines and understanding for restraint incidents; e) family participation that educates and involves family members in treatment process; f) tracking client characteristics identified at intake and through on-going assessments that help flag clients prone to restraint; and f) on-going communication with colleagues to help avoid power struggles and shows of force.

Though not the intention of this paper, results reported here may trigger increased interest in the development of training programs to heighten

awareness of the proper management of restraint-related issues. For example, Luiselli, Kane, Treml, & Young (2000) found significant clinical reductions in restraint of adolescents with developmental disabilities when specific behavioral criteria for restraints were utilized by staff. The results of these case studies included the use of restraint as a procedural intervention that would occur in a planned (i.e., when specific criteria were met) rather than an emergency (i.e., crisis) manner. More importantly, this research demonstrated that non-aversive treatment approaches such as cueing clients on their behavior, changing both physical and psychological environmental factors, allowing time away from activities causing agitation, and adding novelty to the intervention drastically reduced the need for restraint.

The issues surrounding risk management in OBH treatment and the use of therapeutic holds and restraints helps frame the need and importance of the monitoring program employed by OBHIC. The goal is to track the number of incidences that occur in the field, better understand why they occur, and to communicate with staff and professionals about the most effective way to minimize these risks. Below is a description of the monitoring program and process, which are followed by results from four years of data gathering.

## OBHIC Risk Incident Tracking

OBH programs use extended wilderness expeditions that average over 50 days in Wilderness and which are integrated with a clinical treatment model. Common program elements include healthy exercise and diet through hiking and physical activity, psycho- educational curricula, solo and reflection, and individual and group therapy sessions that facilitate a form of therapeutic alliance among adolescent clients, therapists and wilderness leaders that is unique in mental health practice (Russell & Phillips-Miller, 2002). OBH programs practice what has been termed wilderness therapy, which has been defined within a larger collective of alternate treatment modalities referred to as adventure therapy (Bandoroff & Newes, 2004; Gass, 1993; Gillen, 2003). OBH programs utilize one of the five following expeditionary program models :a) contained, b) continuous flow, c) basecamp, d) residential or e) outpatient. These classifications denote the length of time adolescents spend in a particular program, length of field or wilderness exposure, and the clinical aspects of programming including time spent with therapists and level of involvement with parents and families.

The typical adolescent client (age 14-17) is resistant to treatment, has tried other forms of counseling, and is usually in treatment because a parent, school official or judicial system has encouraged them, though some clients do enroll voluntarily. For example, in an outcome evaluation that assessed over 800 adolescents in OBH treatment, 74% had tried either outpatient or inpatient treatment services, and almost 80% had presenting symptoms that warranted a primary diagnosis of a mood, behavior, or substance use disorder (K. C. Russell, 2003). Most have failed in school and/or gotten into trouble with the law. Also important in the discussion of risk related incidences is that the majority of clients are entering the programs mentally unprepared and often physically out-of-shape.

## Defining Incidents

Members of the Outdoor Behavioral Healthcare Industry Council (OBHIC) developed definitions of incidents through working discussions and subcommittees beginning in 1998[1]. These definitions are also the result of consultation and discussion with several state agencies charged with licensing programs, as well as national accreditation agencies like the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) who accredit OBHIC programs. The definitions that follow are presented here to capture the essence of the type of incidents being monitored.

Therapeutic Holds and Restraints (Level I, Level II, and Restraint). Two categories of therapeutic holds (TH) are described: a) Level I-TH, and b) Level II-TH. A therapeutic hold (TH) occurs when "a client's freedom of movement is physically restricted." A Level I TH occurs when a client passively resists staff making physical contact but complies with the movement requested. This would be the case when a client is led along the trail, or moved to his/her campsite, by a hand pulling gently on a backpack strap or guiding her/him by the elbow. The client in such a case may not "want" to go in the direction encouraged, but is "willing to go" when urged along; any resistance is passive. A Level II hold occurs when the client actively resists, and is propelled or held still against that resistance. The hand on the pack strap or the upper arm may still be all that is used, but now it is strongly pulling or pushing a client who is actively resisting. Immobilizing a client against his/her resistance in a standing, sitting, or prone position is a more common type of therapeutic hold. Finally, a restraint occurs when a Level II TH exceeds 30 minutes. This leads to confusion when reporting these

results to outside agencies, as restraint is not so clearly defined in related literature and may therefore be inclusive of all physical contact restricting client or patient movement.

### Runaways.

Two categories of runaways are monitored. A Level I run away is defined as an instance when a client leaves a programming are a without permission and is out of staff oversight for more than 60 minutes. A Level II runaway occurs when a client is away from programming are a without permission and out of staff oversight for more than 24 hours. Reporting for runaways is also based on the seriousness of risk to the client. For example, a client may be away from staff oversight for only 10 minutes, but may be in an unsafe environment (e.g. a river area) which may constitute a runaway report.

### Injuries and Illness.

Illnesses and injuries are routinely monitored but are reported only if the incident (injury or illness) takes the client out of regular programming for more than 12 hours. These are reported for both client and guides in charge of client primary care.

## Training and Certification for Staff

Qualifications for primary care staff vary with each organization and with each member of what has been defined as the "treatment team." The treatment team consists of key staff a teach program that works with the adolescent to help effectuate change. When discussing monitoring incidents in OBH treatment, each team member plays a role. However, it is apparent that the majority of this responsibility falls on the wilderness leaders, who live and work with the clients out in the field. Also of note is that wilderness leaders are typically younger and more inexperienced than the clinical team, necessitating specialized training and on-program supervision. The following brief overview of the team approach highlights each staff member's contribution to the treatment program.

A treatment team often consists of: a) a clinical supervisor, responsible for the clinical care of the adolescent and oversees the clinical operations of

the program. Duties include regular meetings with therapists and wilderness leaders in the field and with the clients, and periodic contact with the family of the adolescent in treatment. Clinical supervisors possess doctoral degrees in psychology, counseling, family therapy or a related field, or are master's level therapists, counselors, or social workers; b) medical supervisor, responsible for the medical care and treatment of the adolescent. Duties include regular medical check-ups on the adolescent's medical conditions in the field, care for adolescents when an accident, injury or illness occurs, and regular meetings with staff on the status of clients in the field. Medical supervisors are medical doctors (MDs) or licensed registered nurses (RNs); c) field therapist, responsible for the development, implementation and follow-up of the individual treatment plan guiding the care and treatment of the client.

Duties depends on each program's treatment model, but may include daily or weekly contact with the client, carrying out of individual and group counseling sessions, weekly contact with parents of the client, routine meetings and contact with the clinical supervisor, and routine meetings with wilderness leaders in charge of the day-to-day living of the client while on expedition. Field therapists are licensed therapists, family therapists, or counselors, masters level social workers, and have training in drug and alcohol treatment, and other specialty areas; and d) wilderness leaders, responsible for the day-to-day care of the client while on expedition. Duties include leading the expedition of up to 12 people in a variety of wilderness environments, including alpine and desert, communicating with the base camp area, and managing day-to-day living.

Wilderness leaders are required to be trained in first aid, typically as a Wilderness First Responder (WFR) or a certified Emergency Medical Technician (EMT). It is also crucial that wilderness staff are trained in de-escalation techniques. Examples include the non-violent crisis intervention (NVCI), a nationally recognized training offered by Crisis Prevention Institute, and Positive Control Systems, recognized by the State of Utah as the training of choice for de-escalation issues. The theory behind these trainings is that to de-escalate and redirect a client's anger, rather than challenge and/or intimidate the client in crisis, reduces the frequency and intensity of physical intervention. Though the treatment team is responsible for the care of the client, it is the primary responsibility of wilderness leaders to manage the day-to-day behavior of the client while in treatment. Therefore, the majority of the

discussion and reporting on incidents centers around wilderness leaders and their day-to-day work with adolescent clients in the field.

## Incident Monitoring System

An incident tracking system was implemented by the Outdoor Behavioral Healthcare Industry Council (OBHIC) in 1998 to develop a systematic process to define, record, assimilate, and report incidents at participating member programs. Each program is responsible for day- to-day tracking of incidents using similar forms and reporting methods. Trip leaders submit these forms to the field supervisor responsible for the day-to-day field management of groups. These are then reviewed internally at each program. Programs annually summarize the incidents according to the definitions and submit them to the Outdoor Behavioral Healthcare Research Cooperative (OBHRC), now at the University of Minnesota.

The incidents are then aggregated and analyzed according to various metrics that illustrate rates and trends in the data. Definitions and tracking metrics were pilot tested in 1999 and 2000 and finalized in 2001. Ten member programs adhere to incident tracking procedures and routinely submit data to OBHRC for inclusion in this manner. One of the important metrics used to illustrate rates and trends in incidents is the field-day. A field day is defined as one client or guide remaining in the field for a 24-hour period. Another metric used is the number of total clients who participated in treatment for that program in a calendar year. The figure that is used is the number of incidents per 1000 clients served. Incidents described in the results include therapeutic holds (i.e., forms of restraint), runaways, illness and injury, and fatality rates of clients. Additionally, injury and illness rates of field guides will be described.

All incidents meeting the criteria outlined in the definitions section were included in this data. Finally, the number of clients who completed treatment for each year will also be reported. This important metric looks at a program's ability to maintain the health and wellness of their clients long enough for them to complete their stay in the program. Where applicable, comparisons are made between incident rates of OBHIC programs and wilderness programs like NOLS, SCA, and OB discussed earlier. A discussion section will follow highlighting important implications of these results.

## Results

### Therapeutic Holds and Restraints

Figure 1 shows the total number of therapeutic holds (Level I and II) per 1000 clients served for the period 2001-2004. In general, therapeutic holds had dropped steadily from 2001–2003. In 2004 the total number of therapeutic holds had increased slightly to levels seen in 2002. Another way to interpret the data is to compare the therapeutic holds to the number of days the client spent in the field. For example, in 2004, there were a total of 50,356 client field days, and less than 80 therapeutic holds were recorded. More specifically, almost 60 of those reported were Level I TH or "physical assists." This translates to 1.5 therapeutic holds per thousand client field days, meaning that almost 1000 days of treatment would pass before a client would experience a physical assist.

Figure 1. The number of therapeutic holds for every thousand clients served.

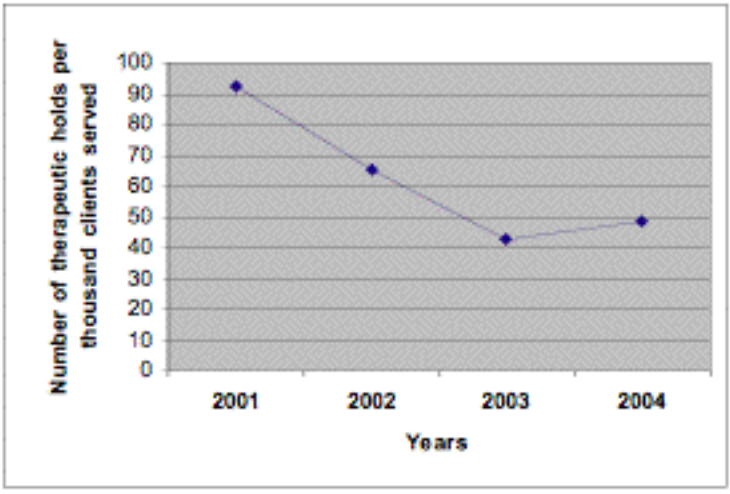
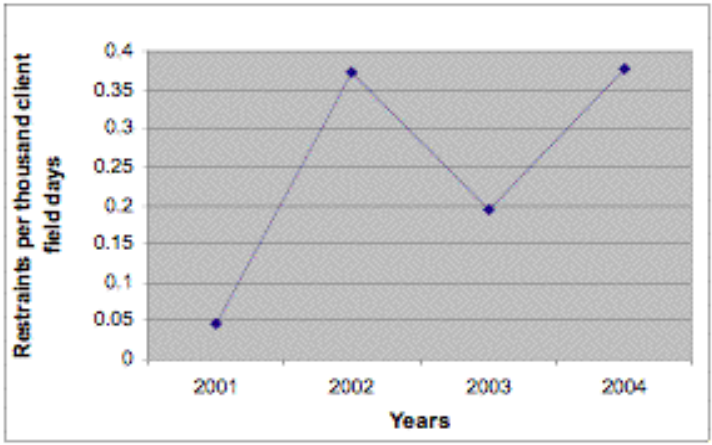



Figure 2 depicts the occurrence of restraints (Level II-TH exceeding 30 minutes) for every 1000 client field days. The highest rate of restraint was reported in 2004 at 0.38 per 1000 client field days. This translates to one restraint occurring every 3000 client field days. This also translates to

approximately one restraint for every 2800 clients served. The occurrence of restraint appears to fluctuate between the years 2001 and 2004, with a low number of restraints reported in 2001 (N=4) and a high number reported in 2002 (N=28). The graphical depiction does suggest that restraints are increasing over this time period.

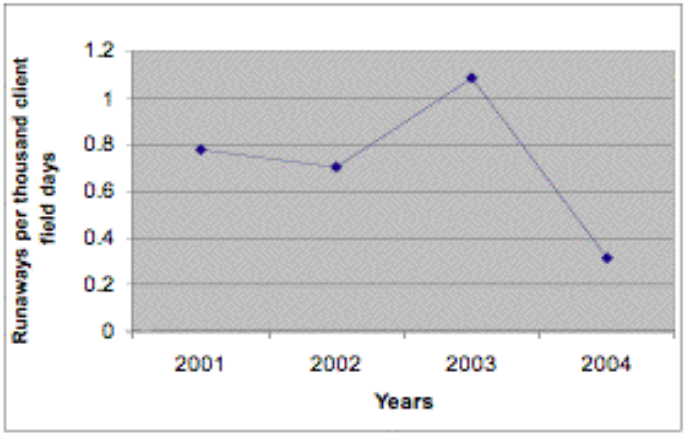
Figure 2. Number of restraints for every thousand client field days.




**Runaways**

The occurrence of runaways declined from 2001 to 2004. Figure 3 shows a range of runaway rates for every 1000 client field days from a high of 1.1 in 2003 to a low of 0.3 in 2004. For example, in 2003 there were a total of 67 runaways by the 1,700 clients served in treatment. Of these 67 runaways, two were the more serious Level II runaways, where the client is away from the group for more than 24 hours. Therefore, 97% of all runaways recorded for this year were Level I, where the client is away from the programming area for more than 60 minutes. For 2004, this also means that that approximately one out of every 98 clients will attempt at least a Level I runaway while in treatment, or about one client for every 12 groups in the field.

Figure 3. Number of runaways for every thousand client field days.




## Injuries and Illness

Injuries are monitored and recorded for both clients and field guides. Client occurrence of injury shown in Figure 4 has ranged between 0.25 per 1000 field days to 0.51. This translates, for example, to one injury every 2000 client field days in 2001 and 2002, and one injury every 4000 client field days in 2003. This rate of injury means that on average, for the years 2001 to 2004, one injury is expected to occur for every 55 clients who entered treatment (i.e., the injury took the client out of regular programming for more than 12 hours).

The number of guide injuries has been steadily rising from 0.3 per 1000 guide field days in 2001 to 0.59 per 1000 guide field days in 2004. These figures translate more practically to a guide experiencing an injury approximately every1800 – 2000 field days. Illnesses are reported for both clients and field guides. Client illnesses reported in Figure 5 have more recently been in decline since 2001, with 2004 rates of occurrence a slow as 0.05 per 1000 client field days. This figure translates to an illness being reported once every 20,000 client field days. Guides reported one illness for every 3,675 days spent in the field.

Figure 4. Number of injuries per thousand client field days.

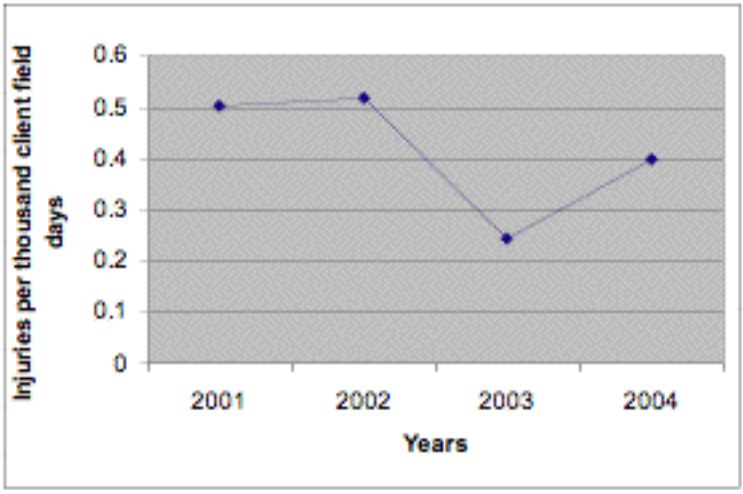
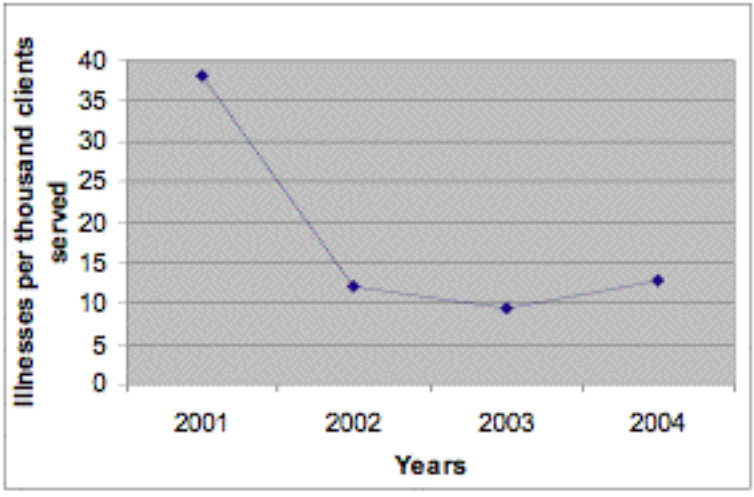



Figure 5. Number of illnesses per thousand clients served.




**Fatalities**

OBHIC programs have generated over 1 million total client field days since

1996, the year of their inception as an association (Cooley, 1998). For the ten OBHIC programs involved in risk incident monitoring, a total of three fatalities have been reported since 1996. Comparative rates of fatality among this high-risk, high-needs adolescent client group is difficult to make because of the lack of data available. One way to compare these rates is to examine the fatality rate reported by NOLS since it began collecting similar data. While NOLS had several fatalities during its early years, it had only two in the 16 years from 1989 to 1994, and during that time had over one million participant days (Schimelpfenig, 1996). NOLS experienced one death between 1995 and 1998 out of approximately 550,000 participant days (Leemon, 1999), a rate of 1.8 fatalities per million participant days. The rate for the 15- year period is approximately 2.0 fatalities per million participant days. The rate for OBHIC programs is 3.0 fatalities per million client field days.

## Treatment Completion

From 2001 to 2004, 93 % of all OBH clients completed treatment. This is a high rate of completion compared to other modalities that report treatment completion rates of 40 – 60 % for short-and long-term treatment for substance use disorders (e.g., see Substance Abuse and Mental Health Administration, 2005). This appears to be an important metric to assess the degree to which adolescent clients are emotionally and physically well enough to complete, on average, over 50 days of treatment in the wilderness environments of OBH programs.

## OBHIC Incident Data since 1998

Data were gathered on field days, injuries, and illnesses beginning in 1998 and are reported to offer a longitudinal perspective of risk incidents. Though definitions may have differed slightly prior to 2001, a pattern is noted in Figure 6, highlighting the decreasing incident rates for injury and illness for clients and guides since 1998, and a general leveling out of incidents between 2002 and 2004. Through discussion with OBHIC member programs, this trend was noted and has been discussed at each program, creating a culture of awareness with field staff responsible for the primary care of clients. It was agreed that both increased awareness by staff, and a sense of pride from reducing incidents in the field, played a role in lowering incident rates during this time period. The leveling out of incidents was also theorized as a potential after effect of this phenomena, suggesting that rates may have stabilized. This anecdotal theorizing would be an excellent subject of future research on the topic.

Figure 6. Percentage of OBH clients who completed treatment from 2001 through 2004.

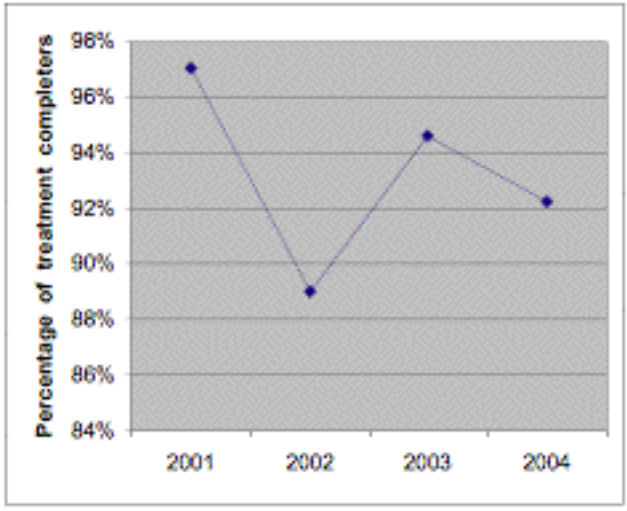
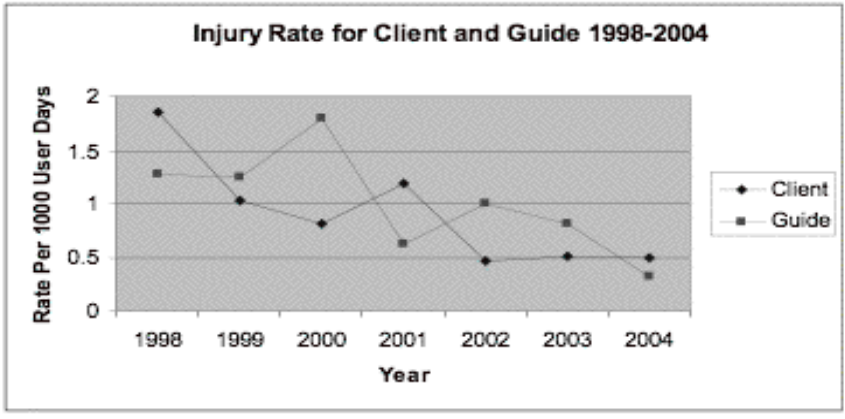



Figure 7. Injury rate per one thousand field days for clients and guides between 1998 and 2004.




## Discussion and Conclusions

One consistent finding from this study is that most risk-incident rates appear to decline between 2001 and 2004 (and which is supported by the

trend data from 1998 onward). Questions asked include: Could this be due to systematic strategies implemented by programs after initial monitoring began? If so, what collective and unique strategies are being implemented, and which ones are showing the most effect? Could monitoring efforts have increased discussion of incidents by program staff, creating a "cultural awareness" which influenced incident rates?

In regular meetings of these programs, these questions have been asked and anecdotal responses have been proposed. However, empirical answers derived from systematic research are critical and are beyond the scope of this paper. Moreover, how do these rates compare with other therapeutic residential facilities? Are they less, more? What factors may be driving these differences? Also of note is that restraints, though extremely low in terms of rates per client field day and clients served (approximately one restraint every 3,000 client field days), showed a slight increase during this time period. Is this due to an increase in pathology found in the clientele in recent years? Perhaps a lack of consistent training programs offered at each program? Or a high rate of turn over for primary care staff? It is hoped that these data will instill an industry-wide recognition of the need to focus on these issues through systematic research and engage in best practices to reduce the risk to clients, staff, and families utilizing this treatment.

Programs like NOLS and OB continue to set the industry standard in monitoring illness, injury, and fatality rates in outdoor activities. Further efforts are being made to better understand the rates of medical risks in related outdoor activities by wilderness medicine associations like the Wilderness Medical Institute (Boulware, Forgey, & Martin, 2003). Collaboration with these organizations on future research will allow critical analysis of incidents that may shed light on questions arising from the descriptive reporting of these data. These questions include: what are the leading causes of the injuries, illnesses, and other risk incidents? Where and when are they most likely to occur? How do rates reported in this paper compare to other residential therapeutic facilities? Though answers to these and the above questions are beyond the scope of this paper, it is possible to provide an interpretation of the results to help better understand their meaning in the context of adolescent behavior and treatment.

Rob Cooley (1998), the founder of a member OBHIC program reviewed several injury, illness, and fatality rates when asking the question: how risky is

wilderness treatment for adolescents? Published in the International Journal of Wilderness, Cooley provided a theoretical summary based on actual statistics reported by various competitive sports (e.g. high school football), adolescent risk behavior (e.g. driving in automobiles), and other activities. For example, according to Eric Zemper (1998) of Exercise Research Associates, the injury rate for high school football practices in 1997 was about 19.74 injuries per 1,000 twelve-hour days, and 61.4 for high school football games. This data showed that 22 percent of the high school injuries involve concussion, dislocation, or fracture. NOLS shows seven percent in those more serious categories. This rate is almost 18 times greater than that of OBH programs.

## Conclusions

Increased oversight by accrediting associations, licensing agencies, concerned parents and consumers, and others necessitates the continued monitoring, reporting, and analyzing of risk-related incidents in programs like those in OBHIC. No program or group of programs can ever be risk-free. However, understanding the characteristics of risk- related incidents ensures that programs have risk management plans to assess these risks in a systematic manner. Several conclusions were reached after reporting the results of this monitoring program that may be of use to other programs with similar clientele or service delivery, or other outdoor programs working in wilderness or natural environments.

### Conclusion 1.

Over 90% of all OBHIC clients complete treatment. Adolescent clients in OBH programs overwhelmingly complete their stays in treatment. This is an important finding that sheds light on the efforts made by OBHIC programs to provide for the health and well-being of clients. It would also seem appropriate to examine the 3-11% of clients that did not complete treatment to better understand the factors that led to their early dismissal. This is critical information because it is well documented in the literature that treatment completion is a major factor in predicting positive outcomes for clients (Winters, 1999).

### Conclusion 2.

OBHIC programs have relatively low rates of therapeutic

holds and restraints. Adolescent clients are rarely held or touched or physically made to do something against their will. The low rates for therapeutic holds (one for every 1,000 days a client is in the field) and restraints (one for every 3,000 field days) was quite surprising given that the majority of clients in these programs are there against their will (parents or other authorities require them to go) and have limited or no motivation to change or improve in the beginning of the programs (Russell, in preparation). The beginning phases of OBH treatment are fairly rigorous and demanding, causing many students to become frustrated and not want to continue. Despite these characteristics, staff members motivate clients to comply with safety procedures and engage in the process enough to want to complete treatment. Understanding the motivation strategies utilized by staff could also be an interesting area for future research.

**Conclusion 3.**

Injuries occur for approximately one in every 55 clients. The data suggests that one in every 55 clients will experience an injury while in treatment that will take them out of programming for more than 12 hours. This finding supports the assertion that programs need to have adequately trained personnel in the field to handle these injuries, as well as detailed evacuation and reporting plans in place to evacuate clients who are in need of medical attention. Due to strict licensing regulations in place at the state level, these are basic requirements of most outdoor programs, and minimum requirements for membership into associations like OBHIC. Accidents occur, and programs have to deal with them in an effective and safe manner.

**Conclusion 4**.

Illnesses occur once in every 20,000 client field days. This conclusion appears to contradict mainstream perceptions and rhetoric (mostly negative) that surround the OBH industry in general as gleaned from newspaper reports, magazine articles, and lately television shows (e.g. Krakauer, 1995). A common perception of spending on average 50 days in a wilderness environment is that participants will get dirty, and in turn sick, from the unclean environment that is daily wilderness living. Despite these common beliefs, it appears to be a myth. According to these results, a client will require attention for an illness once every 20,000 days in the field. Further, it is

important to remember that these adolescents were not in good physical shape prior to entering the program. Most have a history of substance abuse, poor diet and sleeping habits, and little to no physical exercise prior to entering treatment (Russell,2003). Physical exercise, a healthy diet, and regular sleep appear to facilitate good physical health for clients in treatment, evidenced by the low illness rates reported here. The physical health benefits of treatment are an important finding that could be examined in more depth as an outcome from treatment.

**Conclusion 5.**

The death rate is higher than that of the National Outdoor Leadership School and difficult to compare with other similar institutions. This issue is critical; each death that occurs in an OBH program comes under intense scrutiny by state agencies, legal entities, and other vested parties. It is not the purpose of this paper to examine the reasons underlying the deaths and analyze the factors that led to each. However, this issue is one that confronts all mental health service providers and one that needs to be examined in detail by appropriate entities. For example, the Joint Commission on the Accreditation of Healthcare Organizations has reported 124 deaths between the years 1995 and 2004 due to restraints alone among accredited organizations. There is no way to compare metrics because it was not reported how many organizations, clients, or "treatment" days had occurred during the time period these restraint-related deaths were recorded. However, it is clear that at-risk adolescents die in residential treatment centers, schools, correctional facilities, and service providers every year from many causes. The goal is to better understand these deaths and relate them to alternatives, which in the case of OBH treatment may mean an alternative residential treatment modality, or an in-patient hospital.

Finally, these incidents need to be placed in the context of a larger discussion of the outcomes that result from treatment. Though some positive outcomes have been reported from OBH treatment (Clark, Marmol, Cooley, & Gathercoal, 2004; Russell, 2003, 2005), more research is needed to better understand how OBH treatment can be made safer and more effective for adolescent clients and their families. The demand for these programs appears to be directly related to an overall demand for quality behavioral healthcare services, which at present time are not meeting the needs of adolescents. Approximately 2.7 million children are currently reported by their parents to experience severe emotional or behavioral

problems and while more than half of these parents contact mental health resources, less than 25% of these youth receive necessary treatment (National Institute of Mental Health, 2005).If this pattern continues, more parents and their children will turn to OBH treatment for help, necessitating the need for continued research and monitoring of the quality of care.

## References


Bandoroff, S., & Newes, S. (Eds.). (2004). Coming of Age: The Evolving Field of Adventure Therapy. Boulder: CO: Association of Experiential Education.

Boulware, D. R., Forgey, W. W., & Martin, W. J. (2003). Medical risks of wilderness hiking. The American Journal of Medicine, 114, 288-293.

Brown, T. (1998). Risk management: Research needs and status report. *Journal of Experiential Education*, 21(2), 16-24.

Clark, J. P., Marmol, L. M., Cooley, R., & Gathercoal, K. (2004). The effects of wilderness therapy on the clinical concerns (on Axes I, II, and IV) of troubled adolescents. *Journal of Experiential Education*, 27(2), 213-232.

Cloutier, R. (2000). Legal liability and risk management in adventure tourism. Winnipeg, MN: Hignell Printing.

Cloutier, R., & Valade, G. (2003). Risk management for outdoor programs: A handbook for administrators and instructors in British Columbia. Province of British Columbia: Ministry of Advanced Education.

Cooley, R. (1998). Wilderness therapy can help troubled teens. *International Journal of Wilderness*, 4(3), 18-22.

Davis-Berman, J. S., & Berman, D. (1994). Wilderness Therapy: Foundations, theories and research. Dubuque, IA: Kendall/Hunt Publishing.

Ewert, A. (1987). The risk management plan: Promises and pitfalls. In J. F. Meier, T. W. Morash & G. E. Welton (Eds.), High Adventure Outdoor Pursuits: Organization and Leadership (pp. 412-421). Columbus, OH: Publishing Horizons.

Ewert, A. (1989). Outdoor adventure pursuits: Foundations, models, and theories. Worthington, OH: Publishing Horizons.

Gass, M. A. (1993). Adventure Therapy: Therapeutic applications of adventure programming. Dubuque, IA: Kendall/Hunt.

Gentile, D. A., Morris, J. A., Schimelpfenig, T., Bass, S. M., & Auerbach, P. S. (1992). Wilderness injuries and illnesses. *Annals of Emergency Medicine*, 21(7), 853-861.

Gillen, M. C. (2003). Pathway to efficacy: Recognizing cognitive behavioral therapy as an underlying theory for adventure. *Journal of Adventure Education and Outdoor Learning*, 3(1), 93-102.

Hanna, G. (1991). Outdoor pursuits programming: Legal liability and risk management. Edmonton, AB: University of Alberta Press.

Krakauer, J. (1995, October1995). Loving them to death. Outside, October,1-15.

Leemon, D. (1999). Injury, Illness and Near Miss Profiles: A Review of Leading Types and Causes of Incidents on NOLS Courses in 1995-98. Paper presented at the Wilderness Risk Management Conference, Lander, WY.

Luiselli, J. K., Kane, A., Treml, T., & Young, N. (2000). Behavioral intervention to reduce physical restraint of adolescents with developmental disabilities. *Behavioral Interventions*, 15, 317-330.

Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry*, 48(5), 330-337.

National Institute of Mental Health. (2005). Childhood Indicators. Retrieved October 3, 2005, from http://www.nimh.nih.gov/healthinformation/childhood_indicators.cfm

Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D., & Allen, D. (2003).Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*, 10, 3-15.

Priest, S., & Gass, M. A. (1997). Effective leadership in adventure programming. Champaign, IL: Human Kinetics.

Russell, K. C. (2003). An assessment of outcomes in outdoor behavioral healthcare treatment. *Child and Youth Care Forum*, 32(6), 355-381.

Russell, K. C. (2005).Two years later: A qualitative assessment of youth well-being and the role of after care in Outdoor Behavioral Healthcare Treatment. *Child & Youth Care Forum*, 34(3), 209-239.

Russell, K. C., & Phillips-Miller, D. (2002). Perspectives on the wilderness therapy process and its relation to outcome. Child and Youth Care Forum, 31(6), 415-437.

Schimelpfenig, T. (1996). A Look at Ten Years of NOLS Field Safety Statistics. NOLS Newsletter. Lander, WY.

Substance Abuse and Mental Health Administration. (2005). Office of applied statistics. Retrieved October 7, 2005, from http://oas.samhsa.gov/

vanderSmissen, B. (1997). Creating a risk management plan. *The Outdoor Network*, 8, 1, 16-17, 26.

Weiss, E. M. (1998). Deadly Restraint: A Hartford Courant investigative report. Retrieved September, 18, 2005, from www.charlydmiller.com/LIB05/1998hartforddata.html

Winters, K. C. (1999). Treating adolescents with substance use disorders: An overview of practice issues and outcomes. *Substance Abuse*, 20(4), 203-225.

Zemper, E. (1998). Athletic injury monitoring system, high school football. Retrieved October 12,, 2005, from www.era.org

**Footnotes:**

1) HOLDS (Level I and Level II)
   a) A "therapeutic hold" occurs when "a client's freedom of movement is physically restricted."
      i) This would not be the case when a client is led along the trail, or moved to his/her campsite, by a hand pulling gently on a backpack strap or guiding her/his elbow. The client in such a case may not "want" to go in the direction encouraged, but is "willing to go" when urged along; any resistance is passive. This situation may be termed a "physical assist." However, OBHIC members agreed that we would no longer report physical assists. A program may, if it chooses record and count them, but need not report them to OBHRC.
      ii) The line between a "physical assist" and a "therapeutic hold" occurs when actively resists, and is propelled or held still against that resistance. The h pack strap or the upper arm may still be all that is used, but now it is strongly pulling or pushing a client who has "dug in her heels" and is actively trying not to go in the direction desired by the staff person. Usually, in such a case, it would take a staff member on each side of the client to propel the client against his/her resistance, but this is not necessarily so. Immobilizing a client against his/her

resistance in a standing, sitting, or prone position is a more common type of therapeutic hold.

b) A "Level II Therapeutic Hold" is one which lasts longer than 15 minutes. This is not recommended.

c) A hold lasting longer than 30 minutes is a "Restraint," even when no physical restraint devices are used.

2) INJURY AND ILLNESS INCIDENTS

a) An incident becomes reportable when it takes a client out of regular program than 12 hours.

i) The time out of programming may be spent entirely in the field, for exam client resting in his/her sleeping bag while recovering from intestinal ups camp with a mild sprain. The incident should be counted even when it does not affect the program or the client or the group. For example, the staff might decide group lay-over day to accommodate a client's illness, with the client attending all or some groups and doing the same journal assignments as other group members. In this case, if the client is in need of bedrest or camp rest for 12 hours or more, the incident should be counted, even though the program was able to continue with only mild adjustments.

ii) The incident time may include evacuation for medical examination. In this case, the evacuation time is counted as part of the 12 hours. For example, if the doctor's visit and treatment procedure takes 2 hours, but the evacuation time each way is 5.5 hours, the total time is 13 hours and the incident should be counted.

iii) However, extra time spent at a base camp due to purely logistical considerations need not be counted. For example, a client might be evacuated at 7p.m., arriving at the emergency room at 10 p.m., finishing there at 11 p.m., but due to the lateness and the hour, the client might be held at base camp until the next morning before the 2 - hour return drive to the field from 7 a.m. to 9 a.m. If the doctor suggested that the client be kept at base overnight, then that would be a 14-hour incident and would be counted. However, if the doctor gave permission for the client to return to the field right away and the client could have returned

by 1 a.m., then that would be a 6-hour incident would not be counted.

iv) When state regulations or prudence require an evacuation for a medical exam and it turns out that there was in fact no genuine injury or illness in evidence, the incident should not be counted regardless of the time involved.

Note: Although we are sticking with the "12 hours" criterion used by NOLS in order to develop data, which is useful in the real world of outdoor programming, this will generate some problems. Keep in mind that the real point here is simple: any illness or injury which is serious enough to cause the equivalent of a "missed day of school" should be counted and reported.

b) A "Level II" injury or illness is one which requires an overnight hospitalization equivalent, as judged by the program.

3) NOSOCOMIAL/PROGRAM CAUSED ILLNESSES

a) We agreed to change the reportability boundary for these from 48 hours to 7 admission to the program. This is based on advice from several of our medical consultants, who suggested waiting periods ranging from 48 hours to 14 days. Some common illnesses require incubation periods as brief as 12 hours; some are 14 days or more. The 72-hour definition is a compromise.

b) A few well-known and readily identified illnesses, including chicken pox, measles, mumps, do require 10 -14-day incubation periods. When these illnesses are clearly identified and their incubation period is known to be longer than the time a child has been in the program, they should not be reported.

c) Keep in mind, however, that we are interested in getting figures as solid and straight forward as possible: Thus, it is better to err on the side of over-reporting.

4) RUNAWAYS (Level I and Level II)

a) We will continue to use the definition developed earlier: Away from program oversight without permission for more than 60 minutes. If a client walks away from camp and is

followed by staff who keep him/her under observation or continue to engage a client in conversation, the incident is not considered a runaway.

b) A Level II runaway is one in which a client is away from staff oversight for more hours without permission.

c) The question of when a runaway has occurred is, as with other incidents, one of seriousness of risk rather than the client's intentions or the logistics of the situation. A client might walk for several hours or miles but beat essentially no risk because a staff member remains near the client and could provide protection. Another client, away from camp for little more than an hour, might be lost in an unlikely location or hitching a ride with a po dangerous driver, and hence be at substantial risk.

# Improving the Moral Reasoning of Staff

**Dr. Daniel Garvey, Ph.D.**
*Prescott College*

**Jordana DeZeeuw Spencer**
*Prescott College*

## Abstract

Staff who work with clients in residential settings are required to explain rules and expectations as well as help shape appropriate behavior. This article examines the possible effects of a program designed to improve the moral reasoning of staff responsible for the care of others. Fifty-four (54) university staff were pre-tested when they were hired. These same staff members were post-tested at the end of one school year. An experimental group of staff (12) took part in a series of outdoor adventure weekend retreats designed to improve moral reasoning. The experimental group scores were compared with the scores of other staff who held similar positions but who did not take part in the moral development weekends. The Defining Issues Test (DIT-P) was used as the pre/post-test instrument to measure changes in moral reasoning. Significant differences were found in the pre-post test scores for all staff, and although there was a marked increase (+8%) between the experimental and control groups in moral development, this difference was not statistically significant.

## Improving the moral reasoning of staff

It seems logical that the more developed and sophisticated the moral reasoning of our staff, the more likely they are to use this capacity as a tool to help clients navigate their way through the labyrinth of possible choices between appropriate and inappropriate behavior. Despite the compelling argument of this logic, little research has been done to help identify the moral reasoning level of staff or to suggest ways to catalyze further moral growth in staff. Without a focus on the moral development, we may be secure that staff members are technically capable of implementing programs, but we cannot be certain they possess the skills necessary to fully utilize our programs in the service of deeper change in clients.

Rush Kidder, creator of the Institute for Global Ethics, has suggested that we are experiencing an increasing interest in ethics and moral reasoning. Not only are the helping and teaching professions interested in assisting clients to make good personal choices, but we also live in a culture that is often hyper-focused on current ethical issues. Moral reasoning and ethical action have received considerable attention in popular culture in the last 10 years. The exponential increase in "investigative reporting" on television and the increased proclivity of the media to cover social issues has brought to many more people an awareness of the behaviors of others. Newspapers, radio, TV, the internet and other forms of media have helped create a greater awareness of how other people act. For better or worse, we are exposed to the triumphs and failings of others.

Not only are people more aware of what others are doing, people are encouraged to form opinions about the behaviors of others and to share these opinions. These opinions are clearly demonstrated in national dialogues concerning the guilt or innocence of prominent people. Four relatively recent examples are the O. J. Simpson case, the impeachment hearings of President Clinton, Michael Jackson's trials, and the question of Karl Rove's level of responsibility in exposing Valerie Plame's identity. In these famous incidents, those interested in following the stories are given sufficient information to render an opinion concerning the morality or "right action" of those accused. The national conversation prompted by these cases underscores the difficulties many people face when trying to determine how to judge the behavior of others (and by extension, their own personal behavior). Questions of guilt or innocence occupy our news media and are part of our shared culture. Unlike prior times in our history when the general populace was often unaware of the actions of others outside a person's reference group, we are now exposed to the heroic and horrific in our culture, often on a daily basis.

Moral reasoning can be defined as "a psychological construct that characterizes the process by which people determine that one course of action in a particular situation is morally right and another course of action is morally wrong" (Rest, Thoma, & Richards, 1997, p.5). Because we are social beings, the behavior of every individual has the potential to positively or negatively affect the welfare of others. Individuals are free to act in a manner that satisfies their personal desires, but if all people acted to meet only their personal desires, conflict with other people would be inevitable. In order for the social world of human interaction to function, a balance must

be struck between the needs of the individual and the needs of society. "The function of morality is to provide basic guidelines for determining how conflict in human interests are to be settled and for optimizing mutual benefits of people living together" (Rest, 1986, p.1). Rachels (1999) similarly asserts, "Morality is, at the very least, the effort to guide one's conduct by reason–that is, to do what there are the best reasons for doing–while giving equal weight to the interests of each individual who will be affected by one's conduct," (p.19). Morality is simply the practical expression of an understanding that some actions are more appropriate than others in support of the common good.

Although we might agree that the world would be a better place and our clients would be happier if they made choices that accounted for the wellbeing of others, limited study has focused specifically on how to advance moral reasoning, and those studies that have been published have revealed mixed success. Hurt (1974) found no significant change when students took part in a 10-week empathy skills training. Conrad and Hedin's assessment (1981) demonstrated "the combination of significant role-taking experiences and active reflection to be an effective means of promoting growth in [moral] development." (p.15). Rest's meta-analysis of 56 educational programs (1986) reinforced connections made between advanced cognitive abilities and moral reasoning stages. Garvey (1991) found improved moral reasoning in 50 college students as a result of a semester-long study abroad program. Change in moral development was found by Panowitsch (1975) as a result of a semester long course in ethics. More recently, Penn (1990) and DeZeeuw (2002) have documented significant improvement in students' moral development as a result of carefully-designed classes and programs in which ethical scenarios are thoroughly discussed, and Giampietro (2001) noted elevated moral reasoning in discussions and post-conventional thinking in DIT testing with a group of University of New Hampshire Outdoor Education students.

Perhaps the most consistent research focused on the variety of educational interventions used to improve moral reasoning has been done by Norman Sprinthall. After more than 25 years of research attempting to implement and measure educational interventions that positively affect the moral development of students, Sprinthall (1994) concluded there are two fundamental conditions necessary for moral development: (1) active problem solving and (2) reflection and integration of the experience. Sprinthall's conclusions were reinforced by the

emergent themes in DeZeeuw's (2002) research, where participants reported that experiential methodologies had a positive influence on their moral reasoning growth.

Intentional programming that includes elements of problem solving, reflection, and integration has been shown to enhance moral growth in a wide variety of contexts. The research findings listed above coincide and support the logical notion that if we help people focus on the moral diminution of their actions, people will view their behavior in a broader and deeper context.

One area that has not been thoroughly studied is the possible link between acting in the role of staff member in a residential setting and moral development. We know from Rest that:

> "…development involves the cumulative impact of people trying to construct moral meaning in their lives in response to stimulating social experiences…The challenge is to devise ways to measure richness of experience or stimulating experience." (Rest et al., 1999, pp.124-125)

Considering the experientially educative nature of working and growing with individuals in a residential context, it would seems valuable to examine the catalysts that may enhance moral growth in such programs. More specifically, does the experience of working in a residential program increase the moral reasoning of staff? Also, can the experience of taking part in a training program specifically designed to improve moral reasoning through the use of adventure experiences cause any additional positive changes in moral reasoning?

Staff members who work in residential programs are placed in a role that is very complex and often unfamiliar to them. Their jobs require that they understand, explain, and enforce the rules and policies of the institution where they work. Moral reasoning becomes more than an isolated personal process for these staff. Staff must consider their beliefs and values, the expectations of the institution, and the moral development levels of those clients with whom they interact. Each of these considerations must be addressed as they help clients make good decisions while maintaining a harmonious institutional culture.

Little information is available in the outdoor adventure education field that attempts to connect outdoor adventure education with improved moral development. Hattie, Marsh, Neill, and Richards (1997) did a meta-analysis of 96 studies that measured the possible outcomes of adventure education programs on participants. These 96 studies attempted to report changes in eight categories: (1) academics, (2) leadership, (3) self-concept, (4) personality, (5) interpersonal skills, (6) willingness to adventure, (7) physical fitness, and (8) environmental awareness. None of the 96 studies specifically addressed the possible link between outdoor adventure education and improvements in moral reasoning.

## Method

A pre/post-test nonequivalent comparison group quasi-experimental research design was used for this study. Fifty-four (54) residence hall staff from the University of New Hampshire volunteered to participate in this research project. These volunteers were randomly assigned to control and experimental groups. Once assigned to a group, they were pre-tested to determine their level of moral reasoning. All participants were subsequently post-tested nine months later at the end of an academic school year. Rest's (1979) Defining Issues Test (DIT-P score) was used as the pre/post-test instrument.

The DIT has been used by over 100,000 subjects for the past 35 years. A number of studies support the internal structure and reliability of the DIT, as more than 20 years of Cronbach alpha tests show results in the high .70s and low .80s (Rest, 1999). The DIT score examined in this study was the P score, which is used as an index for moral judgment and a percentage measure of how often people implement post conventional moral reasoning strategies. It represents "...the sum if weighted ranks given to 'principled' items, and it is interpreted as the relative importance given principled moral considerations in making moral decisions" (Rest, 1979, p. 101).

Twelve (12) of the 54 staff were placed in the experimental group. This was a serious limitation in this study; ideally the groups would have been equal size to allow for more powerful statistical comparisons between the groups. It was difficult to achieve equal group size because of the logistics of the program only allowing 12 members to be considered "experimental" due to staffing and resources. Because of this, the results should be interpreted with caution and the study should be considered exploratory. In addition to their

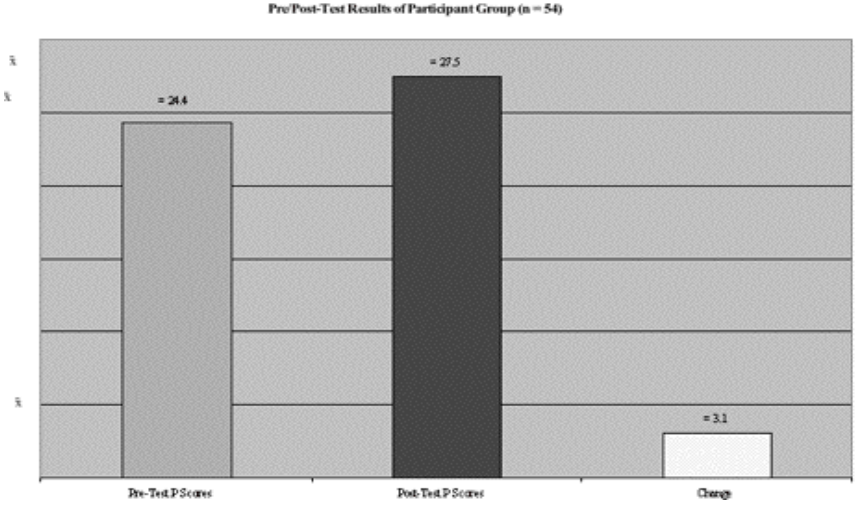
work as residential staff members, these staff took part in three weekend outdoor adventure retreats focused on moral development. The remaining 42 participants were placed in the control group and did not participate in any of the weekend outdoor adventure retreats.

The weekend retreat activities were designed by a group of experienced outdoor adventure educators. This planning group was introduced to the theories of moral development and asked to help construct, or reorganize, outdoor experiential activities so that these initiatives addressed the various stages of moral development. The activities selected for the experimental group followed the recommendations of these educators. Paired t-tests were run comparing the pre- and post-test scores on the DIT-P of all 54 staff to examine differences between the control (N=12) and treatment (N=42) groups due to exposure to the program.

## Results

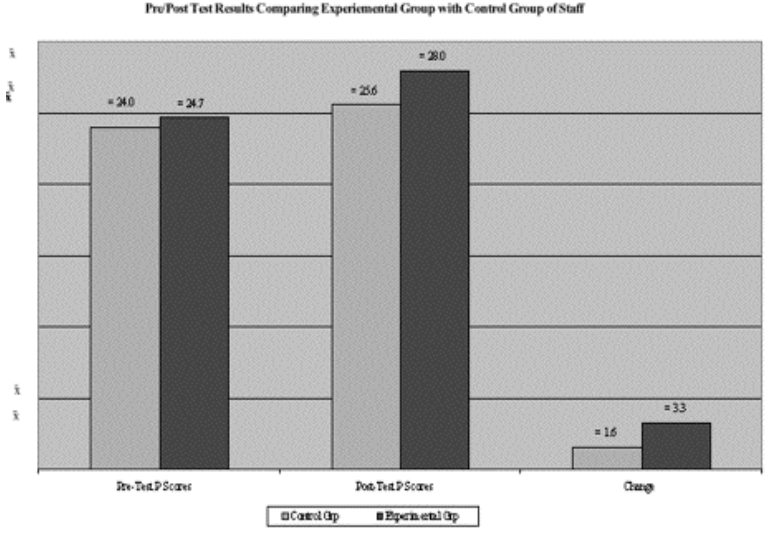
Significant change in moral reasoning as measured by the DIT-P was found for the entire group of 54 who took part in the study. The post-test scores for all participants were significantly higher (p=.05) than the pre-test scores as shown in Figure 1.

Figure 1:



When comparing the group who received the outdoor adventure program (experimental) to the control group of staff who did not participate, real differences were found in change scores, with the experimental group showing a higher increase in scores. However, no statistically significant differences were found between these change scores at $p > .05$. This can probably be attributed to the small sample size of the experimental group as the difference in effect sizes (ES) between groups was .41, considered a medium effect size (Cohen, 1988). The standard deviation (SD) for the experimental group was 3.64 and 7.80 for the larger control group.

Figure 2:




No significant differences were found in the pre/post-test results of participants based on gender for either the experimental or control group. Women showed slightly higher pre-test DIT-P scores which were also slightly higher at the post-test. Age was also not found to be a factor in this study.

## Discussion

Though this study should be interpreted with caution, it does suggest the potential of an outdoor adventure education program to effect moral reasoning of participants in outdoor adventure programs. The demonstrated

increase in the moral reasoning of staff could have a positive influence on staff who are required to make daily moral and ethical judgments about students' behaviors. There is no doubt that it is in the best interest of human service organizations to seek staff who are as morally developed as possible and to support and help improve the moral reasoning of staff once hired. Research has showed that the higher the level of staff moral development, the more likely they are to truly understand the need for appropriate behavioral standards (Rest et al., 1999). This deeper understanding allows staff to offer more comprehensive reasons for why students should behave in a reasonable manner.

In addition to the explaining and enforcement dimension, staff members that possess high levels of moral reasoning will be much more valuable as co-creators of new or amended organizational policies and procedures. Because this is almost always a fluid process in human service organizations, staff members responsible for the direct care of clients are on the frontlines of this process, involved in daily interaction and decision-making processes. Explaining rules and enforcing policies helps staff think more deeply about the consequences of their behavior and how their clients react to these behaviors. The consequence of this enhanced process of thinking is that behavior can be fundamentally changed, which is ultimately driven by ethical and moral decision-making that is made in real-time through daily social interaction. As Coles has asserted:

> A reflecting and self-reflecting mind at some point gives way to a "performing self": the moral imagination affirmed, realized, developed, trained to grow stronger by daily decisions, small and large, deeds enacted, then considered and reconsidered. Character is ultimately who we are expressed in action, in how we live, in what we do…(p.7)

The staff members who showed the most change were those individuals in the experimental group who took part in the three outdoor education retreats. Although the difference was not found to be statistically significant at p=.05, it is the opinion of these authors that this was due to the small sample size involved in the study. Observable increased positive change in the experimental group suggests these retreats had a positive effect on participants beyond those effects that resulted from being a staff member. Outdoor adventure education has been seen as a valuable methodology through which participants

can learn about and practice acting in an appropriate manner, making decisions consistent with ever evolving levels of moral reasoning (Garvey, 1999). Rest (1986) found that improved moral reasoning resulted from new and different learning experiences. He states "Change in one's cognition comes from experiences that do not fit one's earlier (and simpler) conceptions. Cognitive disequilibrium is the condition for development" (p. 32).

During the outdoor adventure education weekend retreats, staff members were also encouraged to discuss moral issues at a deeper level than normally available to them in their contact with their clients. The interactive nature of these retreats may have helped participants make the connection between experience and learning in a way that is consistent with existing theories of experiential learning (Conrad and Hedin, 1981; Gass & Priest, 1997; Joplin, 1981; Kolb, 1984). The outdoor adventure education weekend retreats seem to allow staff to maintain and improve their moral reasoning. This focus on advanced levels of moral discussion may have had a positive effect on the experimental group. Rest, et al. (1999) cite the meta-analysis done by Schlaefli, Rest, and Thoma (1985), of 55 intervention studies all of which used the DIT in a pre-test/post-test capacity:

> The type of intervention having consistently the greatest pre/post effect is the "dilemma discussion" intervention, having an effect size of .41, a significant but "modest" effect size by meta-analytic standards. (In comparison, control/non-experimental groups show an effect size increase of only .09)… (p. 74)

It is reasoned that this outdoor adventure education program reflected the "dilemma discussion" model, and due to the unique environment that the program took place, may have accentuated this effect.

Successful staff learn to view the world from the perspective of their clients. In order for staff members to be effective, it is necessary that they understand the orientation and values of the clients with whom they work. Sprinthall (1994) demonstrated that this process of "taking the role of another" improves moral reasoning. Similarly, Noddings (1984) points to the power of "feeling with" another in enhancing moral growth.

The notion of "feeling with" that I have outlined does not involve

projection but reception. I have called it "engrossment." I do not "put myself in the other's shoes," so to speak, by analyzing [his/her] reality as objective data and then asking, "How would I feel in such a situation?" On the contrary, I set aside my temptation to analyze and to plan. I do not project; I receive the other into myself, and I see and feel with the other. (p. 30)

A final factor that could have contributed to positive change was the opportunity staff had to work in an environment where careful supervision and mentoring by more experienced staff members are structured parts of their job. This supervision by experienced staff provided an opportunity for younger staff to reflect upon and discuss decisions they had made in a supportive environment.

## Conclusion

This pilot study suggests that creating intentionally framed and facilitated experiences for staff in residential settings that provide opportunities for problem solving, dilemma discussions, reflection, and integration may be an effective way of enhancing moral reasoning. However, further research is needed to demonstrate this potential. The relative size of the experimental group (12) is a serious limitation. Further study with a more robust experimental group must be recommended before a conclusion can be made about the ultimate effectiveness of enhancing moral reasoning through experiential retreat weekends. Another limitation of this study is that all participants were residential staff at a large university. The authors believe that the results of the study may be suggestive for review by professionals working in other residential settings, including youth care and therapeutic environments. A program to help improve the moral reasoning of staff in other residential settings should be developed. If we want to improve the ability of our clients to learn right from wrong and improve their moral reasoning, we might consider improving the moral reasoning of staff who work with these clients. This research provides some support for the notion that experiential education can help improve the moral development of staff working in residential programs.

## References

Cohen, J. (1988). Statistical power analysis for the behavioral sciences (3rd ed.). New York: Academic Press.

Coles, R. (1997). The moral intelligence of children: How to raise a moral child. Penguin Putnam Inc.: New York, NY.

Conrad, D. and D. Hedin. (1981). National assessment of experiential education: Summary & implications. *Journal of Experiential Education* 4 (2): 6-20.

DeZeeuw, J. (2002). An examination of the impact of experiential education methodologies used in cross-cultural programs on the moral reasoning of high school students. (Master's thesis. University of New Hampshire, 2002). Durham, NH.

Gaff, J. G. & Gaff S. S. (1981). Student-faculty relationships. In A. W. Chickering & Associates (Eds.), The modern American college: Responding to the new realities of diverse students and a changing society (pp.642-656). San Francisco, CA: Jossey-Best.

Garvey, D. (1991). The effects of cross-cultural experiences on the moral development of a select group of college students. (Doctoral dissertation. University of Colorado, 1991). Boulder, CO. Q

Garvey, D. (1999) Understanding right and wrong: The use of outdoor adventure education to increase moral development. In J. Miles, & S. Priest, Adventure Education: A Book of Reading, (2nd. ed.) Venture Publishing, State College, Pennsylvania.

Gass, M. and S. Priest. (1997). Effective leadership in adventure programming. Champaign, Illinois: Human Kinetics Inc

Giampietro, P. J. (2001). The moral reasoning of undergraduate outdoor education majors. (Master's thesis, University of New Hampshire, 2001). Durham, NH.

Hurt, B. L. (1974). Psychological education for college students: A cognitive-developmental curriculum. (Doctoral dissertation. University of Minnesota,1974). Minneapolis, MN.

Hattie, J., Marsh, H. W., Neill, J., and Richards, G. (1997). Adventure Education and Outward Bound: Out-of-class experiences that make a lasting difference. *Review of Educational Research*, Spring, 67 (1), 43-87.

Joplin, L. (1981). On defining experiential education. *Journal of Experiential Education*. (Spring).

Kolb, D. (1984). Experiential learning: Experience as the source of learning and development. Englewood Cliffs, NJ: Prentice-Hall.

McNeel, S. P. (1994). College teaching and student moral development. In Rest, J., & Darcia, N. Moral development in the professions. Lawrence Erlbaum Publishers, Hillsdale, NJ 27-50.

Noddings, N. (1984). Caring: A feminine approach to ethics and moral education. Berkeley, CA: University of California Press.

Panowitsch, H. R. (1975) Change and stability in the Defining Issues Test. (D dissertation. University of Minnesota, 1975). Minneapolis, MN.

Penn, W. Y., Jr. (1990). Teaching ethics-A direct approach. *Journal of Moral Education*, 19 (2), 124-138.

Rachels, J. (1999). The elements of moral philosophy. 3rd ed. Boston: McGraw-Hill College.

Rest, J., D. Narvaez, M. Bebeau, and S. Thoma. (1999). Post conventional moral thinking: A neo-Kohlbergian approach. Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Rest, J., Thoma, S. & Edwards, L. (1997). Designing and validating a measure of moral judgment: Stage preference and stage consistency approaches. *Journal of Educational Psychology*, 89 (1), 5-28.

Rest, J. (1986). Moral development: Advances in research and theory. New York: Praeger.

Rest, J. (1979). Defining Issues Test. University of Minnesota Press, Minneapolis, MN.

Sprinthall, N. A. (1994). Counseling and social role taking: Promoting moral and ego development. In, Rest, J., & Darcia, N. Moral development in the professions. Lawrence Erlbaum Publishers, Hillsdale, NJ 85-101.

# The Role of the Therapist Within the Gestalt of a Clinical Residential Setting

**Dr. Jared U. Balmer, Ph.D.**
*Island View Residential Treatment Center, Syracuse UT*

This article supports the notion that within a well-integrated, multi-disciplinary residential treatment setting, a multiplicity of dyadic relationships contributes to the change process of the client and does not pivot exclusively on the dyadic relationship between client and the individual therapist.

In most cases, the placement of a child in a residential treatment setting is implemented after one or more failures in outpatient therapy. The weekly visit(s) to the therapist could not effect desired behavioral changes, resulting in the youth needing a more restrictive approach.

In addition to formal therapy, delivered by professionals, a residential treatment setting uses additional elements to establish change processes in the child. In addition to the single dyadic relationship between child and therapist, multiplicities of other relationships are called into play. These relationships are forged from a number of delivery systems including (but not limited to): educational processes, the structure of daily living activities, recreational and leisure activities, a regimented and predictable environment, a well-designed therapeutic milieu, and vigilant oversight of possible medical interventions including psycho- pharmacological approaches to behavioral change. The totalities of all of these building blocks produce something more than the sum of its parts. They produce the gestalt of the overall program.

On occasion, parents and referring professionals myopically focus on the therapist's "power" to effectuate change in the child. By doing so, they undervalue the gestalt of the program and "place all the chips" on the services provided by a single magical individual therapist for an hour or two a week.

The literature clearly speaks volumes of the overall importance of the fundamental dyadic relationships between the change agent and the child. In

reviewing the professional literature, Eisenstein (1994) and Marmor (1994) have written extensively about the power of the change agent. The data indicates that the dyadic relationship between client and therapist is a better indicator of outcome than the therapeutic modality employed by the therapist. That is to say, the relationship between therapist and client is more important than whether or not the therapist utilizes Transactional analysis, Rational-Emotive Therapy, Neuro-Linguistic Therapy, Rogerian Counseling, Cognitive-Behavior Therapy, or any other form of therapy. While these findings are supported by a host of researchers (e.g., Bergin & Lambert, 1978; Beutler, 1979; Dobsen, 1989; Gaffan et al.,1995; Lambert & Bergin, 1994; Rachman & Wilson, 1980; Robinson, Berman & Neimeyer, 1990), many clinicians embrace the latest "hot brand" of therapy in search for the "holy grail" or the "magic bullet." (Note: one exception to these findings is that behavioral techniques have been found to be highly effective in the treatment of phobias and panic disorder) (Asay & Lambert, 2002). What all the researchers agree on is that fact that therapy works. In essence, when it comes to psychotherapy, it is the nature of the dyadic relationship that usually towers over the applied technique.

But if residential treatment is called for, is it that simple? Do we simply hook-up Johnny with Suzy Magic or Joe Wonderful and never worry about the gestalt of the program? Not so. Such logic would suggest that the child simply needs a place where he has great difficulties escaping the efforts of establishing a productive therapeutic relationship. Such practice would lead to "programmatic ware-housing," while Suzy Magic or Joe Wonderful work their magic.

In the minds of most responsible change agents, the value of a sound, well thought- out, and dynamic therapeutic milieu is paramount to the desired outcome. Such change agents understand the reality that the therapeutic milieu, the gestalt or program "allows" the therapist to be more effective than an outpatient therapist who does not have the benefit of a 24 hour a day structured, controlled, and predicable milieu available to them. In other words, if change is principally based on the creativity, whit, genius, and applied techniques of the therapist, than the credit for such change should not myopically be accredited to the therapist alone, but shared between the dyadic relationship and the milieu with all the multiplicities of one-on-one relationships across a number of staff. In addition, a witty, clever and dynamic therapist who conducts individual therapy in a vacuum of the larger therapeutic milieu is probably not the

optimal change agent in any residential setting. No amount of communication and sophisticated articulation of clinical data to parents and referral sources can hide the fact that such a therapist is not operating in the most effective manner.

But using recent investigations through meta-analytic techniques, Asay & Lambert (2002) asserted that the therapeutic relationship between client and therapist accounts for 30% of the change, while extra therapeutic variables, (e.g., environment, motivation) count for 40% of the change. The residual 30% of the variables are evenly divided between placebo effects and other techniques. Asay & Lambert (2002) asserted that while "some practitioners, especially the inexperienced, imagine that they or their techniques are the most important factor contributing to outcome, the research literature does not support this contention"(p. 30).

Because many residential treatment environments are highly controlled around the clock, one may not want to underestimate the role of the therapeutic milieu with its multiplicity of relationships. It is not difficult to assume that the most potent therapeutic approach in a residential setting is based on the dynamic relationships of the client and therapist, in conjunction with other important relationships that are being nurtured on a daily basis by a number of other staff. These other critical relationships with direct care staff, educators, and others can often be further supported by a vibrant therapeutic milieu.

Assuming a child is offered two hours of individual therapy per week, what impact or role do the remaining 166 hours of the week have? To suggest that the change process pivots on the back of the therapist is a horrible over-simplification and misinterpretation of the literature. Trieschman, in his book "The other 23 Hours" (1969), asserts that the child- care worker is the most important figure of the child in the institution. He goes onto ask the questions: "Are the events and interactions of the day thought of merely as time-fillers between psychotherapy sessions, or only as providers of life's necessities such as eating, sleeping, and recreation?" (p. 2).

Our own informal research with our clients validates Trieschman's assertion. Over the last eight years, Island View has administered an exit questionnaire where we ask program graduates to list one or more people that were of greatest impact in their change process. Aggregated findings from

this questionnaire show that while the primary therapist is mentioned 75% of the time, childcare workers are mentioned 100% of the time. What is equally important is that many graduates routinely list some of their peers as having played an important role in the healing process! My own professional opinion would suggest that other residential treatment facilities show similar results.

Residential treatment is at its best when a multi-disciplinary staff, along with a therapeutic and supportive milieu of peers, all work together to impact each individual program participant. Each discipline and sub-program within the therapeutic environment must focus on making a contribution to the change process of each individual participant. This gestalt of residential programming is bigger than the sums of all its parts.

Dr. Jared U. Balmer, Ph.D., is the Executive Director and co-founder of the Island View Residential Treatment Center in Syracuse UT.

## References

Asay, T. P. & Lambert, M. J. The Empirical Cause for the Common Factors in Therapy: Quantitative Findings. In Hubble, et al. (2002). The Heart and Soul of Change: What Works in Therapy. Washington, D. C.: American Psychological Association.

Bergin, A. E., & Lambert, M. J. (1978). The Evaluation of Therapeutic Outcomes. In S. L. Garfield & A. E. Bergin (Eds.) Handbook of Psychotherapy and Behavior Change: An Empirical Analysis (2nd ed.) (pp. 139 – 189). New York: Wiley.

Beutler, L. E. (1979). Toward Specific Psychological Therapies for Specific Conditions. *Journal of Consulting and Clinical Psychology*, 47, 882-892.

Eisenstein, S., et al. (1994). The Dyadic Transaction: An Investigation into the Nature of the Psychotherapeutic Process. Piscataway, NJ: Transaction Publisher.

Hubble, M. A. et al. (2002). The Heart and Soul of Change: What Works in Therapy. Washington D.C.: American Psychological Association.

Lambert, M. J., & Bergin, A. E. (1994). The Effectiveness of Psychotherapy. In A. E. Bergin & S. L. Garfield (Eds). Handbook of Psychotherapy and Behavior Change (4th ed.). pp. 143-189. New York: Wiley.

Marmor, J. Psychiatry in Transition. Piscataway, NJ: Transaction Publisher.

Rachman, S. J., & Wilson, G. T. (1980). The Effects of Psychological Therapy (2nd ed.). New York: Pergamon Press.

Trieschman, A. E., (1969). The Other 23 Hours. New York: Aldinede Gruyter.

# WILL'S CHOICE by Gail Griffith A Book Review

**Dr. John A. McKinnon, M.D**.
*Montana Academy*
*1 October 2005*

It is unconventional for one of a book's minor characters to compose a book's review. Readers may wonder how I can be objective, since I am a walk-on actor in Gail Griffith's urgent account of her son's depression, nearly lethal try at suicide, and recovery. However, my role was quite minor during Will's grumpy passage through Montana Academy. Since I briefly appear in this story I may have lost some objectivity, but I also may be able to provide useful insights into her heartfelt story not possible for a traditional book reviewer.

That said, I do think this is a splendid book—vivid, well-researched, good-hearted, smart, honest, and beautifully written. All of us who work professionally with teenagers should read this and come away with a renewed humility about our limitations. And parents—all parents, for we all expect at some point to raise a teenager—can learn much that will be practical should such troubles come. All of us can also receive a strong sense of inspiration after reading this book by what parents do for their children when they are in trouble. And if that is not enough, Will's Choice (HarperCollins, 2005) is hard to put down.

Given the title's echo of William Styron's blockbuster novel (Sophie's Choice, Vintage,1979) and given that Styron also wrote an all-but-unbearable public account of his own struggle with melancholia (Darkness Visible, Vintage, 1992), it should surprise no one to learn that Will's Choice is about depression and attempted suicide. Unlike Styron's book, except in the breath-taking opening account of a woman finding her son dying in his bed, Griffith does not dwell on depression's bleak dysphoria. She thinks of depression from a more optimistic, biological point of view. Like Styron, she takes this misery to be a genetic, physiological syndrome. She thinks it can and ought to be detached conceptually from domestic, family, and personal experience. And like so many modern psychiatrists, she sees depressed mood as a disease caused by sub-atomic forces that are not tied up in the bonds of the nuclear

family. She and her family struggle to live past this near catastrophe, but she thinks of depression, both her own and Will's, as a neurological disease to be understood in physiological terms.

Because of this, she is unabashedly enthusiastic about the pharmacological approach to treatment. When the use of SSRI anti-depressants in adolescents recently came under public attack, Griffith took up the microphone in Congressional hearings to defend them. Certainly, this biochemical approach has led to remarkable gains, relatively limited side effects, and huge differences to sufferers. Results of this approach have even converted psycho-dynamic psychiatrists like Peter Kramer, MD, whose well-received professional memoir (Listening to Prozac, Penguin Books, 1993) could be a companion piece to Griffith's personal memoir. Both books are approachable, reliable guides. And both professional and lay readers will come away from Will's Choice knowing a great deal about this technical subject. Griffith provides parents of troubled teen-agers with a trove of sensible, well-informed advice.

---

I offer one caveat—not a cavil about this splendid book, but an added, modest proposal. For good reason, Gail Griffith concentrates upon Will's symptoms and tells the story of his recovery from a dysphoric nihilism. However, I would add that when the patient is an adolescent, neuro-transmitter chemistry does not describe the whole problem, and pharmacology does not provide the full solution. Why? Because depression does not occur in a vacuum. Depressed mood is also cause or consequence of a broader disruption in a teen-ager's life. As in cases of profound trauma or chronic intoxication, a mental illness (e.g., depression) disrupts maturation. Or again, as in other family disruptions (e.g., parental addiction, mental illness, death or divorce), such disturbance rarely fails to interfere with the critical contributions parents need to make to promote psychological maturation. The result of divorce, depression, or both, is often enough a delay in growing up, a relative immaturity producing its own intractable problems for boys and girls trying to meet the challenges of adolescence.

There is not a one-to-one algebra. Not every depression, nor every divorce, nor every attentional difficulty, produces developmental delay. But when an obstacle does delay growing up, there are two problems, not one. This is why

treating depressed teen-agers with anti-depressants rarely resolves all of the many troubles—at school, at home, among peers, and personally—that make childish teenagers unhappy and awaken parents in the night.

These comments are not meant to be critical of Will's Choice—only to point to a subtle but key dimension in this striking account of a teenager's depression. Griffith has not left anything out. In fact, readers will be startled by her frankness and her willingness—in order to help other sad teen-agers and terrified parents—to speak directly about what her family has been through. Moreover, Will and his then-girlfriend, Megan, share diaries and letters. Yet there is a dimension to this story that should not be missed. Certainly, I am not going to intrude further upon Will's privacy, but at the time of his overdose he had a lot of growing up to do. This is not hard to see. Will dropped out of high school, lacked ambition or purpose, had no plausible future, no goal, no plan. Megan also thought he was childish. In retrospect she told Will of her distrust of such a boy, who in his self-preoccupation could be so careless about her feelings.

At the end of Will's Choice the good outcome Gail and Will both imply is not only about feeling better. By the close, Will has not merely recovered his sense of humor or equanimity. He has also achieved an appreciation for the impact of his behavior on others. He has decided he wants to go to college. And he now plans to put to use his splendid talent for the benefit of others, not just to please himself. He thinks now in terms of duty, honor and justice, not merely about his own happiness. These points are touched glancingly, but with a seemly modesty. Neither mother nor son makes too much of them.

But to me, after years of listening to teen-agers, the emergence of goals and a plan, the arrival of empathy and consideration, and the onset of abstract and social ethical concerns, all remind me that for adolescents, whatever the obstacle, are summed maturity is always half the treatment goal. And if he had not reached those milestones by the time he left Montana Academy, Will reaches them by the end of his mother's book. His mother has also recorded this outcome. Her son now makes other choices. His life trajectory and prospects have greatly changed. He has grownup, and she is proud of him. After a scary and painful interlude, Will has again set off on his way to fulfill the promise we all saw in him years ago. He has become a fine young man.

**NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS**

# CALENDAR OF EVENTS

February 2-4, 2006
2006 National Conference
"Foundations for Tomorrow"
Clearwater, Florida

April 2006
Southeast Regional Conference
Atlanta, Georgia

May 2006
Montana Regional Conference
Kalispell, Montana

June 2006
Utah Regional Conference
Salt Lake City, Utah

August 2006
Northwest Regional Conference
Bend, Oregon

September 2006
Southern Utah Regional Conference
St. George, Utah

October 2006
Northeast Regional Conference
New England

February 2007
2007 National Conference
La Jolla, California

NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS

## SUBSCRIBE TO JTSP

The National Association of Therapeutic Schools and Programs offers the following options for the semi-annual publications of the Journal of Therapeutic Boarding Schools (JTSP).

1. Single Copy – Check applicable category

Institution($30)__Individual ($20) ____MemberProgramStaff ($15)___

2. Annual Subscription (2 issues) – Check applicable category

Institution($50)__Individual($30)___MemberProgramStaff($25)____

3. Previous Volumes – Check applicable category

Institution($30)__Individual($20)__MemberProgramStaff($15)_____

Previous Volume(s) Requested
Volume, Number, Date _____

Volume, Number, Date _____

Volume, Number, Date_____

Name (please print clearly):_____
Company/Organization:_____
Address:_____
City:_____State:_____Zip:_____
Telephone Number:_____
Email:_____

Mail this page and enclose check for full amount to:
NATSAP • 126 North Marina • Prescott, Arizona 86301

NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS

The National Association of Therapeutic Schools and Programs publishes a directory annually to inform professionals, programs, and families about the many residential placement alternatives available to help struggling young people. All programs and schools listed in the Directory are members of the National Association of Therapeutic Schools and Programs and follow our ethical principles and principles of good practice.

## DIRECTORY ORDER FORM

Name: _____

Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

**********

Number of Copies Requested : _____
Total Shipping and Handling Charges Due (see below): _$_____

Although there is no charge for NATSAP directories, there is a shipping and handling fee for your order. Please see below to calculate your cost. All directories are shipped via United States Postal Service Priority Mail.

Shipping Charges:

| | |
|---|---|
| 3 or fewer directories……...…...$3.95 | 11 to 20 directories…..$16.00 |
| 4 to 10 directories…….....$7.80 | 20 to 35 directories…..$24.00 |
| 35 or more…….....contact the NATSAP office | |

Mail this page and enclose check for full amount to:
NATSAP • 126 North Marina • Prescott, Arizona 86301

**NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS**

## CALL FOR PAPERS

If you are interested in presenting at a NATSAP Conference, please complete and submit the following to: NATSAP • 126 North Marina • Prescott, Arizona 86301

Presentation is for the NATSAP Conference

Title of Presentation:_____

Name of Primary Presenter:_____

(Please include all appropriate degrees and certifications.)

Title:_____

Address:_____

Base: _____ Clinical _____ Theoretical _____ Research

q Please include an abstract of 300-500 words prepared specifically for this request of papers.

q Enclose a copy of your curriculum vitae or resume including prior presentations to regional and national conferences, along with a short (4-6 line) biographical statement. This will be used for our application to continuing education provider organizations. Please attach this sheet to the front of your abstract and personal information. This is to include what qualifies you to make the presentation.

q Presentations will be limited to one or two speakers/authors, unless it is a panel format.
Presentations will be fifty minutes in length.

q All of the above must be submitted.

Presenters agree to bear their own expenses and registration fees along with accommodations for the conference.

JTSP
Journal of Therapeutic Schools & Programs
APublicationoftheNationalAssociationofTherapeuticSchoolsand dPrograms

# PERMISSIONS AND COPYRIGHT INFORMATION FOR POTENTIAL AUTHORS

Authors must provide the Journal of Therapeutic Schools and Programs (JTSP) with all necessary permission store produce in print and electronic for many copyrighted work prior to acceptance of publication (e.g., photographs of people, quotations longer than 500 words). JTSP policy prohibits an author from submitting the same manuscript for consideration by two or more publication sat the same time. When appropriate, authors must provide journal editors with assurance that subjects rights were respected, and research protocols were ethical prior to the publication of any data.

Authors are required to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test procedure, external funding provided by program) when their manuscript is submitted.

It is the policy of the National Association of Therapeutic Schools and Programs (NATSAP) to retain the copyright of its publications and the contributions contained therein in order to protect the interests of the Journal of Therapeutic Schools and Programs (JTSP) and its authors, and at the same time to facilitate the appropriate reuse of this material by others.

Therefore, upon acceptance of their manuscript for publication by the JTSP, authors will be sent a copyright assignment form to complete and return to the editor. Publication of the manuscript will be contingent upon receipt of the completed copyright transfer form. In the event that the JTSP decides to republish an article that has already been published in copyrighted form, the Board will require explicit permission from the copyright holder.

Note NATSAP and the JTSP reserve the right to publish these materials in both written and electronic form. Authors will be notified of the use of their material.

Questions may be directed to: Dr. Michael Gass, Editor - JTSP

NH Hall, 124 Main
Street University of
New Hampshire
Durham, NH 03824
(603) 862-2024 • mgass@unh.edu

# INSTRUCTIONS FOR AUTHORS
# Journal of Therapeutic Schools and Programs (JTSP)

Manuscript Topics: 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 APA style as presented in the fifth edition of Publication Manual of the American Psychological Association. Authors are reminded to keep a current copy of their manuscript to guard against loss. Manuscripts may include, but are not limited to, case studies, topical clinical articles, overview articles, book reviews, and research. Topics of interest may identify and address diverse issues encompassing program enhancement and development, continuum of care, and transition planning. Articles may address specific interventions for special populations or clients with special needs such as substance abuse dual diagnosis, develop mental disorders, or adoption issues. Articles are encouraged that address issues of staff training and retention and general personnel management and leadership, as well as articles that address govern mental/regulatory topics. Submissions are encouraged that relate relevant theory to clinical practice or provide original research relating to program or treatment effectiveness.

Submitting the Manuscript Electronic submission is encouraged. Manuscripts may be sent as email attachments in Word format to Dr. Michael Gass at mgass@unh.edu with a copy to the NATSAP Executive Director at info@natsap.org Manuscripts will be accepted by mail, whereby the author(s) is asked to send six (6) copies to the editorial office to Dr. Michael Gass, JTSP, NH Hall, 124 Main Street, Durham, NH 03824. All manuscripts should be submitted in a form that allows blind refereeing (see APA guidelines–5th edition).The author's name and any identifying information must be visible only on a detachable front page. Manuscripts will be retained by the JTSP Editorial Board and will not be returned to the author(s).

Manuscript Evaluation Submitted manuscripts will initially be reviewed and evaluated by Dr. Michael Gass and Dr. Keith Russell. After the initial evaluation, manuscripts will be sent to a Review Board who will forward their recommendations to Dr. Gass. The JTSP management team reserves the right to editor to require editing of content, format or style, or to make other revisions before accepting a manuscript for publication. Dr. Gass will make final decisions regarding publication status.

Manuscript Format Manuscripts should be formatted to 8 1/2"x11" paper as follows: •Font to be used is "Times New Roman–Size12" •Italics and Underline are accepted •Document must be in black text only •1-inch margins are required on all sides •Double line spacing is required •Pages are to be numbered in the top right hand corner

Total manuscript length including abstract, tables, and references should ordinarily not exceed 15 pages. The entire manuscript including footnotes, references, and quoted

material and figures/illustrations should conform to the style specified in The Publication Manual of the American Psychological Association – 5th Edition.

Submit manuscripts in the following order: 1)Title Page; 2) Abstract (no more than 100words); 3)Text; 4) References; 5) Figures (Tables, Charts, Graphs)

Images depicting aspects of the contribution are strongly encouraged. Insertion notations for figures, tables, and images should be included in their intended place within the document though the actual figures, tables and images along with appropriate captions should be appended to the end of the submitted manuscript. Please attach original camera-ready art or jpeg/gif files for figures and images.

Author Bios Submit a 50 word or less biography of the author(s) with the manuscript.

Journal Management The National Association of Therapeutic Schools and Programs (NATSAP) Board of Directors has engaged Michael Gass, Ph.D. for the editorial and managerial responsibilities for the Journal of Therapeutic Schools and Programs (JTSP).

## THE NATIONAL ASSOCIATION OF THERAPEUTIC SCHOOLS AND PROGRAMS ETHICAL PRINCIPLES

Members of the National Association of Therapeutic Schools and Programs (NATSAP) provide residential, therapeutic, and/or education services to children, adolescents, and young adults entrusted to them by parents and guardians. The common mission of NATSAP members is to promote the healthy growth, learning, motivation, and personal well-being of our program participants. The objective of all our therapeutic and educational programs is to provide excellent treatment for our program participants; treatment that is rooted in good-hearted concern for their well-being and growth; respect for them as human beings; and sensitivity to their individual needs and integrity.

The members of The National Association of Therapeutic Schools and Programs agree to:

1. Be conscious of, and responsive to, the dignity, welfare, and worth of our program participants.

2. Honestly and accurately represent ownership, competence, experience, and scope of activities, and to not exploit potential clients' fears and vulnerabilities.

3. Respect the privacy, confidentiality, and autonomy of program participants within the context of our facilities and programs.

4. Be aware and respectful of cultural, familial, and societal backgrounds of our program participants.

5. Avoid dual or multiple relationships that may impair professional judgment, increase the risk of harm to program participants, or lead to exploitation.

6. Take reasonable steps to ensure a safe environment that addresses the emotional, spiritual, educational, and physical needs of our program participants.

7. Strive to maintain high standards of competence in our areas of expertise and to be mindful of our limitations.

8. Value continuous professional development, research, and scholarship.

9. Place primary emphasis on the welfare of our program participants in the development and implementation of our business practices.

10. Manage our finances to ensure that there are adequate resources to accomplish our mission.

11. Fully disclose to prospective candidates the nature of services, benefits, risks, and costs.

12. Provide an appropriate professional referral if we are unable to continue service.