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

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Abstract

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

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

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

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

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

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

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

DIAGNOSIS/ASSESSMENT AND THERAPEUTIC GOALS

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

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

Psychological Testing

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

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

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

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

Ongoing Assessment of Treatment Goals

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

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

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

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

TREATMENT

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

Resistance

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

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

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

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

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

Ongoing Treatment

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

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

Group Dynamics/Adlerian Therapy

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

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

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

Wilderness Activities

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

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

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

Satisfaction in the Mundane versus Entertainment

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

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

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

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

Narrative Family Therapy

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

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

POST INTERVENTION, TREATMENT AND FOLLOW-UP

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

Maintaining the Heartbeat

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

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

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

Aftercare Recommendations

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

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

One Year Follow-up

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

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

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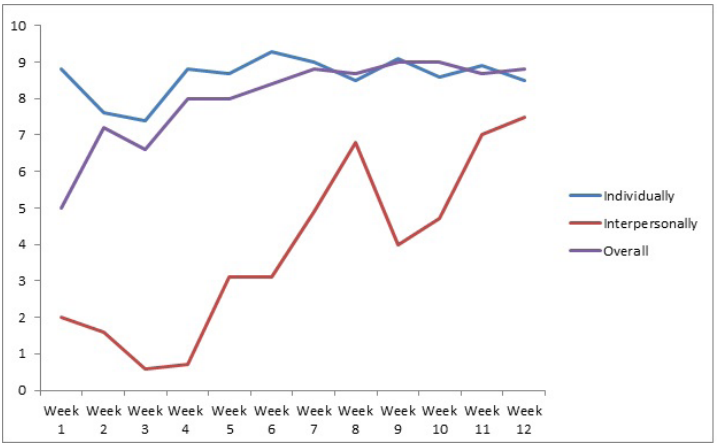
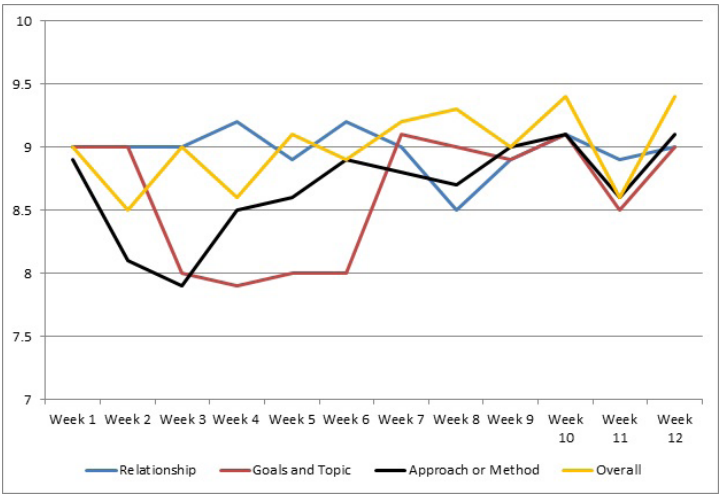
When David was asked about the aspects of the program that influenced him most he responded, "Definitely the people. One of my favorite parts of my stay at RedCliff was the environment, but in reality, the people are what mattered to me. When I was first at RedCliff I didn't want to do anything, but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

Appendix

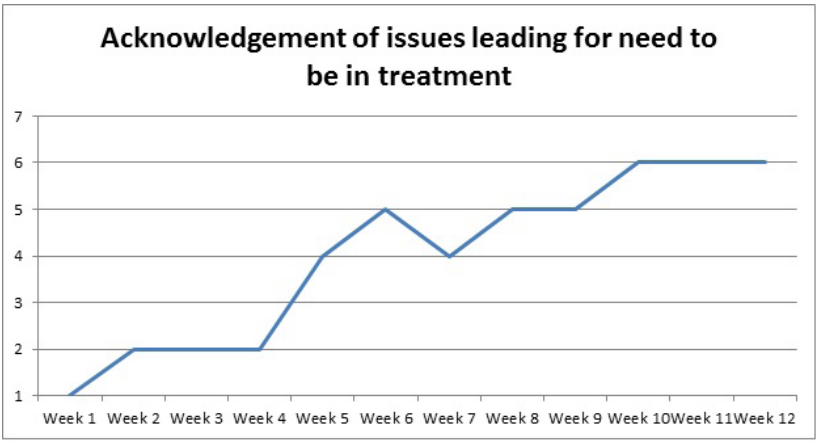
Graph 1. Outcome Rating Scores (ORS)



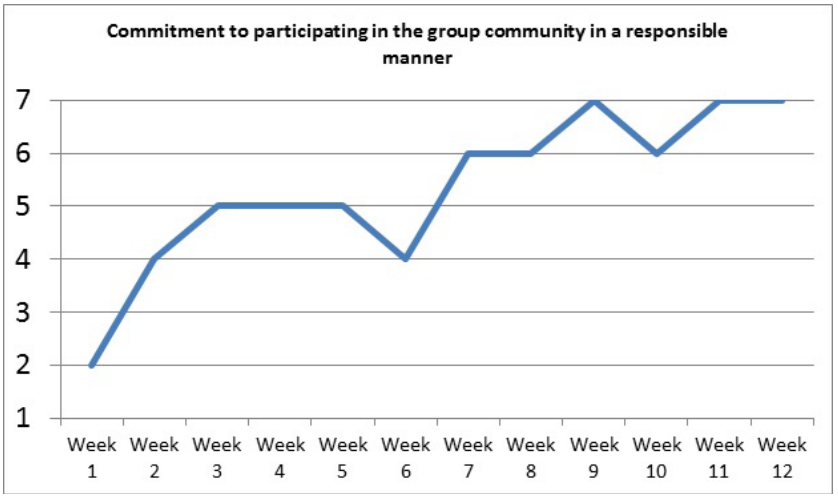
Graph 2. Session Rating Scores (SRS)



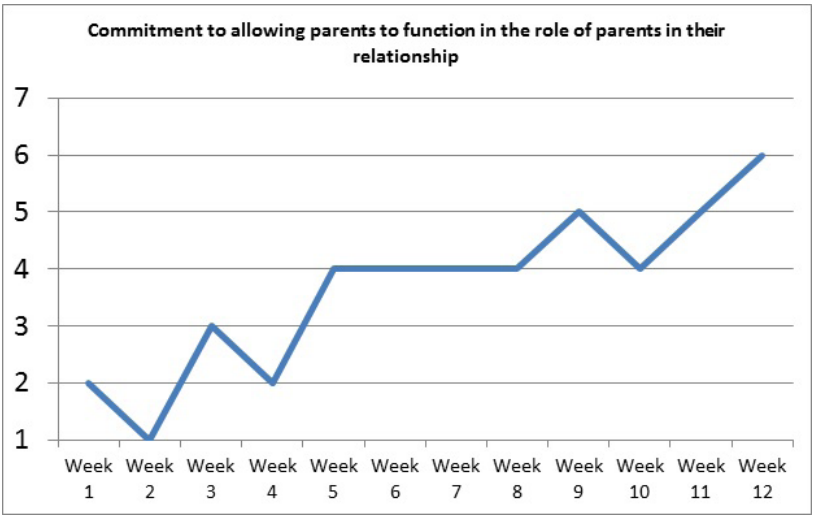
Graph 3. Clinical Rating Score. Therapy Goal 1



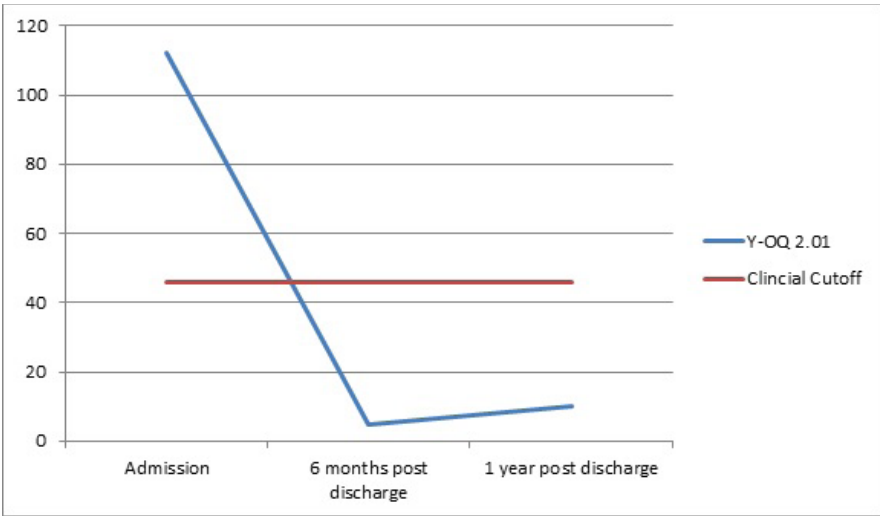
Graph 4. Clinical Rating Score. Therapy Goal 3



Graph 5. Clinical Rating Score. Therapy Goal 4



Graph 6. Youth-Outcome Questionnaire 2.01



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