

What is Wilderness Therapy?

By Keith C. Russell

Despite a growing number of programs operating in the United States under the guise of "wilderness therapy," a consistent and accepted definition is lacking. Rehabilitative, outdoor-based approaches, such as "challenge courses," "adventure-based therapy," or "wilderness experience programs," are often used interchangeably to describe "wilderness therapy." This paper attempts to shed light on this issue by presenting an integrated and consistent definition of wilderness therapy to guide program design and future research efforts. Three trends in the industry are also explored which support the notion that wilderness therapy programs are searching for recognition by state agencies, national accreditation agencies, insurance companies and mental health professionals. These trends support the idea that consistent wilderness therapy practices may be emerging which support the use of a consistent definition.

Key words: wilderness experience program, wilderness therapy

Introduction

Despite a growing number of programs operating in the United States under the guise of "wilderness therapy," a consistent and accepted definition is lacking. Numerous definitions have been presented in the literature making it difficult to compare and replicate research studies on wilderness therapy activities, processes, and outcomes from one program or setting to the next. Also, research studies are not specific in describing how presenting problems are assessed by wilderness therapy and how specific therapeutic approaches relate to these problems and target specific outcomes. Research studies that may utilize similar measures and generate consistent findings are, thus, difficult to compare, because the treatment approach remains somewhat of a mystery. The purpose of this paper is to compare and contrast numerous definitions of wilderness therapy found in the literature. The goal of this endeavor is to illustrate the variety of definitions found in the literature and suggest an integrated defini-

tion that may capture the essence of wilderness therapy practiced today. This attempt at a consistent definition serves to instigate a dialogue between practitioners, researchers, and other professionals as to help answer exactly what wilderness therapy is, and its target population of clients. Given recent deaths in the AT industry, and a growing misperception by the public as to what wilderness therapy is and does (Janofsky, 2001), a consistent definition could be useful to future research, by helping guide practitioners and agencies in determining key design features of their programs, and as well as educating the general public about wilderness therapy.

Wilderness Therapy Defined

Wilderness therapy has been defined and characterized in many ways. Rehabilitative outdoor-based approaches such as "challenge courses," "adventure-based therapy," or "wilderness experience programs (WEPs)," are often used interchangeably to describe "wilderness therapy." Also, the media often portrays wilderness therapy programs as "boot camps" (Janofsky, 2001; Krakauer, 1995),—a potentially a more serious false reference given recent research that has shown that boot camp approaches are not effective in treating adolescents with substance abuse disorders (Pearson & Lipton, 1999), and that practices used in boot camps can be considered cruel and unusual (Lutz & Brody, 1999).

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What separates the therapeutic approach used in boot camp programs from that of a wilderness therapy program? How different is a WEP, like Outward Bound, from a therapeutic program specifically designed to treat adolescent substance abusers? If you were a parent of a child with severe behavioral problems and went looking for a "wilderness therapy" program, what specific program elements would you use to differentiate between the myriad of programs operating in the public and private sector?

A good place to begin sorting through numerous definitions of wilderness therapy is by looking at the broader field of wilderness experience programs (WEPs), which have been defined as "organizations that conduct outdoor programs in wilderness or comparable lands for purposes of personal growth, therapy, rehabilitation, education or leadership/organizational development" (Friese, Hendee, & Kinziger, 1998, p. 40). Friese (1996) identified more than 500 programs currently operating in the United States under this broad definition. Wilderness therapy, as currently defined in the literature, is one type of program among the variety of WEPs, delineated by the characterized provision of therapy.

Multiple definitions of wilderness therapy posited by wilderness program practitioners, researchers, and psychologists are presented in this article to capture the evolution of the concept. A discussion and summary will follow. Two summary tables are presented. The first (see Table 1) will illustrate the range of definitions offered and the characteristics of those definitions that are different or similar. A second table (see Table 2) will attempt to differentiate key elements of wilderness therapy programs that distinguish them from other approaches, be they educational, recreational, boot camp, or other. A definition of wilderness therapy is suggested based on psychotherapy literature, current wilderness therapy practice, and the author's research experience.

An Outward Bound derivative. The use of Outward Bound as an alternative form of incarceration or treatment for delinquent adolescents emerged in the late 1960s and early 1970s. Consequently, a research interest developed to explore the outcomes of such an intervention (Bandoroff, 1989; Burton, 1981; Castellano, 1992; Kelly, 1974; Kelly & Baer, 1968; Plouffe, 1981). These early efforts referenced wilderness therapy based on an overriding Outward Bound philosophy. The first attempt at a comprehensive definition of wilderness therapy was presented by Kimball and Bacon (1993). They postulated that wilderness therapy derived from Outward Bound, the aforementioned wilderness challenge program founded by the innovative German educator, Kurt Hahn. The "Hahnian" approach to education was not only experience-centered, it was also value-centered. Learning through doing was not developed to

facilitate primarily the mastery of academic content or intellectual skills; rather, it was oriented toward the development of character and maturity" (Kimball & Bacon, 1993, p. 13). In this sense, the authors conclude that Hahn's ideas were better suited to a psychological model of change rather than an educational one.

The following activities and processes characterize the approach: (a) a group process, there is "no such thing as individual wilderness therapy," (b) a series of challenges which incrementally increase in difficulty, are high in perceived risk, and low in actual risk, (c) usually conducted in wilderness or an unfamiliar environment, (d) employs therapeutic techniques such as reflection and journal writing, individual counseling, and self-disclosure, and (e) varied length depending on funding, type of population served, etc. (Kimball & Bacon, 1993).

Kimball and Bacon describe the leader of a "wilderness therapy" program as a "wilderness therapist" who is an effective teacher that possesses a wide variety of wilderness living skills and judgment abilities. There is no mention of any type of degree or counseling certification required to be a wilderness therapy leader, or any indication that certification of staff is required for a program to purport to conduct "wilderness therapy." There is also no mention of a therapeutic approach that might guide wilderness therapy, only a reference to the "Hahnian approach" presented earlier.

Powch (1994) also refers to the historical roots of wilderness therapy in the Outward Bound model but approaches the definition from the perspective of wilderness therapy for women. She states "because they all share roots in the original Outward Bound model, terms such as 'adventure based therapy,' 'challenge courses,' and 'ropes courses' are often used synonymously with wilderness therapy" (Powch, 1994, p. 15). To address this confusion, she suggests these courses could be viewed as components of wilderness therapy, but not wilderness therapy itself, and should not be referred to as such. She disagrees with Kimball and Bacon (1993) that, "wilderness therapy can take place in an unfamiliar environment," and elaborates on this by stating, "wilderness therapy must occur in a wilderness setting, and that the wilderness must be approached with a therapeutic intent" (Powch, 1994, p. 14). She goes on to say that, "I do not dispute that therapy can occur in settings other than wilderness, but I would not call it wilderness therapy" (Powch, 1994, p. 14). A discussion of how one perceives wilderness given ethnicity, socio-economic status, and level of education is not in the scope of this paper, but is an important consideration nonetheless.

Powch (1994) presents theoretical components of wilderness therapy as: "(a) confronting fear in some

Table 1. Summary of Definitions of Wilderness Therapy

| Authors | Key Components | Wilderness Dependency | Theoretical Foundation | Licensed Staff |
|--------------------------------|---|---|---|---|
| KIMBALL AND BACON (1993) | Wilderness therapy contains: (1) a group process, (2) a series of challenges, (3) employs therapeutic techniques such as reflection and journal writing, individual counseling, and self-disclosure, and (5) a varied length. | No, can be conducted in an unfamiliar environment. | The Outward Bound model, based on the "Hahnian" approach where learning through doing was not developed to facilitate primarily the mastery of academic content or intellectual skills; rather, it was oriented toward the development of character and maturity. | None Required. |
| POWCH (1994) | Mechanistic components of wilderness therapy are: (1) confronting fear in some way, (2) experiencing trust in the group, (3) immediacy and concreteness of feedback in the wilderness environment, and (4) the even-handedness of consequences of wilderness. | Yes, and wilderness should be approached with "therapeutic intent." | Based on the Outward Bound model and Kurt Hahn. | None Required. |
| DAVIS-BERMAN AND BERMAN (1994) | It involves: (1) the careful selection of potential candidates based on a clinical assessment, (2) the creation of an individual treatment plan for each participant, (3) involvement in outdoor adventure pursuits under the direction of skilled leaders, (4) activities aimed at creating changes in targeted behaviors, (5) provision of group psychotherapy by qualified professionals, with an evaluation of individuals' progress. | Not required, natural areas suffice. | Mentions the importance of systems theory but does not reference specific therapeutic approach. Believe it should be left up to individual programs to incorporate in treatment practice. | Not all practitioners, but should have trained and licensed mental health supervisors of clinical component of program. |
| CRISP (1997) | He states that wilderness therapy is broken into two intervention formats: (1) wilderness base camping, which establishes a base camp with minimal equipment in an isolated environment, and (2) expeditioning, which consists of small groups moving from place to place in a self-sufficient manner using different modes such as back-packing, rafting, canoeing etc. | Not mentioned | He notes that therapeutic paradigms include generic group therapy and group system models, inter-personal behavioral models, the experience of natural consequences, and involves modified group psychotherapy applied into a wilderness activity setting. | Not direct care staff but program under clinical supervision. |

way, (b) experiencing trust in the group, (c) immediacy and concreteness of feedback in the wilderness environment, and (d) the even-handedness of consequences" (pp. 16-18). As with Kimball and Bacon, Powch offers no criteria or standards for wilderness therapy leadership or supervision, and discusses no therapeutic approach guiding interventions other than the reference to the Outward Bound model.

Davis-Berman and Berman definition. Another attempt at creating an empirically based theoretical framework for wilderness therapy was presented by Davis-Berman and Berman (1994) in the text *Wilderness Therapy: Foundations, Theory and Research*. They define wilderness therapy as "the use of traditional therapy techniques, especially for group therapy, in an out-of-doors setting, utilizing outdoor adventure pursuits and other activities to enhance personal growth" (Davis-Berman & Berman, 1994, p. 13). Wilderness therapy is presented as a methodical, planned and systematic approach to working with troubled youth. An interesting note here is the reference to youth. Most programs target adolescents as their primary clients, though there are a few wilderness programs who are currently working with adult populations¹.

We want to emphasize that wilderness therapy is not taking troubled adolescents into the woods so that they feel better. It involves the careful selection of potential candidates based on a clinical assessment and the creation of an individual treatment plan for each participant. Involvement in outdoor adventure pursuits should occur under the direction of skilled leaders, with activities aimed at creating changes in targeted behaviors. The provision of group psychotherapy by qualified professionals, with an evaluation of individuals' progress, are critical components of the program (Davis-Berman & Berman, 1994, p. 140).

Davis-Berman and Berman (1994) also address the history of therapeutic approaches using wilderness, characteristics of recent programs, a theoretical understanding of wilderness experiences including a systems theory perspective, and design and evaluation tools and resources. This comprehensive text established the first accepted and empirically based theoretical framework for understanding wilderness therapy.

The authors speak in practical terms regarding the design of wilderness therapy programs, stating that primary care staff need not be certified as counselors because "this goal is both unrealistic and unnecessary" (Davis-Berman & Berman, p. 141). They do, however, believe that supervisors of these programs should be trained and licensed in accordance with state statutes and national standards. Programs should also delineate staff who are responsible for the wilderness and physical components of wilderness therapy with those coor-

minating the counseling components. Specific models and other more detailed elements of wilderness therapy are not discussed, such as admission procedures, staff training, the length of time spent in the field, how staff and new clients rotate in and out of the field, what specific curriculum elements could be included in the approach, how families are integrated into treatment, and the role of aftercare services. They do state that accurate assessment of the client's problems and the development of an individual treatment plan are critical elements, and do provide guidelines for appropriate program evaluation and design.

Bandoroff and Scherer: A family systems model. A comprehensive discussion found in the literature on how to synthesize established therapeutic approaches with wilderness therapy was offered by Bandoroff and Scherer (1994). They believe that:

A comprehensive model for family therapy requires theoretical guidance. To this end, we have used the fundamentals of structural family therapy, combined with research on healthy family process, and the tactics employed in multiple family therapy as the primary components of the [wilderness therapy program], an innovative wilderness family therapy program (Bandoroff & Scherer, 1994, p. 178).

By specifying the therapeutic approach used in designing their program, Bandoroff and Scherer were able to use specific evaluation instruments which were empirically tested in studies conducted on conventional family therapy. Also, the data generated from their study of families were analyzed within the context of other research on family functioning. This study clearly illustrates the benefits of an explicit discussion of theory guiding wilderness therapy interventions and provides a good example of ways to blend wilderness therapy with other established therapeutic approaches.

Recent definitions of wilderness therapy. Crisp (1998) presented a definition of wilderness therapy based on a study of different mental health programs that use wilderness and adventure interventions. He also references a lack of professional unity and clarity on theoretical issues, as well as confusion in definitions of wilderness therapy. He states that wilderness therapy is broken into two intervention formats: (a) wilderness base camping, which establishes a base camp with minimal equipment in an isolated environment, and (b) expeditioning, which consists of small groups moving from place to place in a self-sufficient manner using different modes such as back-packing, rafting, canoeing, etc. Crisp notes that therapeutic paradigms include "generic group therapy and group system models, interpersonal behavioral models, the experience of natural consequences, and involves modified group psychotherapy applied into a wilderness activity setting"

(p. 6). This definition delineates different models (base camp and expedition) and discusses therapeutic paradigms. Although methods used to develop definitions were not elaborated upon, other than "discussions with numerous professionals and through observation of practice within programs," this definition makes an important distinction in how various models of wilderness therapy exist in practice.

In previous work on identifying common elements in theory and practice found in wilderness therapy programs (Russell, Hendee, & Phillips-Miller, 1999), a model of wilderness therapy based on analysis of interview responses made by key staff was presented. Research questions specifically targeted the following key elements of four wilderness therapy programs who participated in the study: (a) theoretical foundation, (b) role of wilderness, (c) process and practice of wilderness therapy, and, (d) common reported outcomes. Common responses across programs were identified and a model was built that captured the essence of theory, practice, and expected outcomes of wilderness therapy. It is important to note that this model was based on four programs included in this study and was not assumed to be representative of the wilderness therapy industry as a whole. The goal was to develop a model that could be used in future research to identify and validate core elements of theory, process and reported outcomes of wilderness therapy (Russell & Hendee, 2000b).

Towards an Integrated Definition

As wilderness therapy practitioners strive to validate wilderness therapy as a viable treatment for troubled adolescents and endeavor to gain respect in the mental health community, a more explicit and in-depth definition of wilderness therapy is emerging. Based on reviews of literature and recent research efforts, the following definition of wilderness therapy is suggested based on three guiding elements: (a) theoretical basis, (b) practice, and (c) expected outcomes. These elements are presented in hopes of creating dialogue among practitioners, researchers and agencies, as to what comprises wilderness therapy.

Theoretical basis of wilderness therapy. The design and theoretical basis of a wilderness therapy program should be therapeutically based, with assumptions made clear and concise in order to better determine target outcomes and evaluate the effectiveness of the intervention (Bandoroff & Scherer, 1994). Though each wilderness therapy program has a unique approach to wilderness therapy, there appears to be several common elements comprising their theoretical basis. Many of these common concepts are based on traditional wilderness programming ideas dating back to the 1960s in programs such as Outward Bound, but which are then inte-

grated with an eclectic therapeutic model based on a family systems perspective with a cognitive behavioral treatment emphasis. This approach integrates the therapeutic factors of a wilderness experience with a nurturing and intense therapeutic process, which helps clients access feelings and emotions suppressed by anger, drugs, alcohol, and depression.

A core theoretical element is the use of natural consequences as a therapeutic tool. Natural consequences experienced in wilderness living allow staff to step back from traditional positions of authority to which the client is accustomed. Interwoven in this integration of wilderness and therapy are often references to ceremony and ritual, including a rites of passage experience for clients. Wilderness therapy reflects rites of passage experiences practiced by cultures throughout the world, such as clients spending periods of time alone in wilderness solos to reflect on their lives and to receive insight and inspiration. Also included in the theoretical foundation are references to the use of metaphor, especially to represent the family, using an educational component with a sophisticated curricula that teaches communication skills, and traditional educational and psycho-educational lessons.

In wilderness therapy, the primary care staff will approach the therapeutic relationship in a nurturing, caring, and empathetic way (see Russell, 1999). This notion is in contrast to public perceptions of wilderness therapy based on highly publicized client deaths in Utah in the early 1990s. In these instances, wilderness therapy was depicted as a harsh, boot-camp, military approach, breaking clients down through forced marathon hikes and food deprivation, so as to then build them back up and "reshape them" (Krakauer, 1995). The therapeutic approach in wilderness therapy does not appear to force change, but instead allows the environment to influence client response through natural consequences. If the client is not ready, staff step back and let other factors continue to work, such as time away from family and physical exercise, until the client is ready to consider change.

Wilderness therapy process. Wilderness therapy utilizes outdoor adventure pursuits and other activities, such as primitive skills and reflection, to enhance personal and interpersonal growth (Kimball & Bacon, 1993). Involvement in outdoor adventure pursuits should occur under the direction of skilled leaders, with activities aimed at creating changes in targeted behaviors. The provision of group psychotherapy should be facilitated by qualified professionals, with an evaluation of individuals' progress being a critical component of the program. Base-camping and expedition-based models are employed (Crisp, 1998). Two types of expedition programs are noted: 1) continuous flow programs,

where leaders rotate in and out of the field, and new clients join existing groups, and which a therapist supervises groups and visits them on a weekly basis; and, 2) contained programs, where the therapist and wilderness guides comprise a treatment team which remain with the group the duration of the program (Russell, Hendee, & Phillips-Miller, 2000).

The wilderness therapy process is typically guided by phases, stages, or levels which can be broadly grouped into the following phases: (a) a cleansing phase, which occurs early in the program, (b) a personal and social responsibility phase; a particular emphasis once the cleansing phase is well underway or complete, and (c) a transition and aftercare phase.

The initial goal of wilderness treatment is to address client "presenting issues" and chemical dependencies by removing clients from the destructive environments that perpetuated their behavior and addictions. The cleansing begins with a minimal but healthy diet, intense physical exercise, and the teaching of basic survival and self-care skills. The client is also removed from intense cultural stimuli, such as dress, music, and food. This cleansing process prepares the client for more in-depth work later in the program.

After the initial cleansing phase, natural consequences and peer interaction are strong therapeutic influences, helping clients to learn and accept personal, as well as social responsibility. Self-care and personal responsibility are facilitated by natural consequences in wilderness, not by authority figures, which troubled adolescents are prone to resist. A goal is to help clients generalize metaphors of self-care and natural consequences to real life, often a difficult task for adolescents. Wilderness therapy takes place in very intense social units (usually six clients and three leaders) with wilderness living conditions making cooperation and communication essential for safety and comfort. Proper ways to manage anger, share emotions, and process interpersonal issues within the group are modeled and practiced in a neutral and safe environment. Therapeutic staff work with the parents and family to help them understand their role in the client's problem behaviors, and helps to restore family functioning through periodic contact with parents, and the facilitation of contact between client and parents. Thus, wilderness therapy provides hands-on learning of personal and social responsibility, with modeling and practice of appropriate social skills and cooperative behaviors, all reinforced by logical and natural consequences from the wilderness conditions.

The final weeks of the process involves clients preparing to return to the environments from which they came, or transition to appropriate aftercare environments. Staff are working with them to process what they have learned and how to take these lessons home

with them. Upon completion of the wilderness therapy program, clients must implement their newly learned self-care, and personal and social responsibility skills in either home or more structured aftercare placements. Preparation for this challenge is facilitated by therapists through intense, one-on-one counseling and group sessions with peers. If a goal for a client was to "communicate better with parents," the therapist helps develop strategies to accomplish this goal. If abstaining from drugs and alcohol is a goal, then the therapist will work with the client to develop a behavior contract and strategy, with clear expectations that include weekly visits to Alcoholic Anonymous (AA) meetings, and are reinforced by regular outpatient counseling sessions. Staff in each program, work carefully with mental health professionals to ensure that aftercare services are accessible, where appropriate, when the program is completed. This may include contact with an outpatient therapist in the client's home town, or communication with a professional responsible for the client, if an aftercare service is utilized.

Expected outcomes from treatment. Each client seems to leave wilderness therapy with a different set of outcomes, yet there exists similarities across these sets of expected outcomes (Russell, 2000). Completing a wilderness therapy program represents a sense of accomplishment for the client that is concrete and real, and can be used to draw strength from in the future. This sense of accomplishment is combined with physical health and well-being, which may help clients feel better about themselves, leading to increases in self-esteem and the first steps towards personal growth. The process also teaches clients how to access and express their emotions, and why talking about feelings is important. An enhanced self-concept represents a sense of empowerment and resiliency. Clients believe that if they completed wilderness therapy, they can also complete other formidable tasks. Clients leave wilderness therapy knowing that they have only just begun the journey and need to continue their own personal growth process.

Development of the self through the wilderness therapy process is combined with learning a multitude of personal and interpersonal skills, which include communication skills, drug and alcohol awareness, and coping skills. These skills help clients make better choices, and when combined with the enhanced sense of self, help clients avoid negative peer and cultural influences. Clients with drug and alcohol issues often complete the initial steps of the 12-Step model of recovery and begin the process of breaking the cycle of addiction.

Wilderness therapy helps clients understand changes they need and want to make after wilderness therapy. These realizations of past behavior, and proposed changes, are voiced to parents during graduation

ceremonies and post-trip meetings, and serve as a guide for parents, staff, and follow-up institutions in helping the client maintain and realize these changes. They often have a different perspective of their past problem behaviors, realizing that their behaviors were symptoms of other issues which were going on in their lives.

Summary

An integrated definition of wilderness therapy would contain the following key ideas: The design and theoretical basis of a wilderness therapy program should be therapeutically based, with assumptions made clear and concise, in order to better determine target outcomes and evaluate the effectiveness of the intervention (Bandoroff & Scherer, 1994). The careful selection of potential candidates should be based on a clinical assessment and should include the creation of an individual treatment plan for each participant (Davis-Berman & Berman, 1994). Wilderness therapy utilizes outdoor adventure pursuits and other activities, such as primitive skills and reflection, to enhance personal and interpersonal growth (Kimball & Bacon, 1993). Involvement in outdoor adventure pursuits should occur under the direction of skilled leaders, with activities aimed at creating changes in targeted behaviors. The provision of group psychotherapy should be facilitated by qualified professionals, with an evaluation of individuals' progress being a critical component of the program. Programs often work with the family to help the client and family understand their role in the treatment and post-treatment process. At the conclusion of the program, staff should work with the appropriate professionals in the follow-up environment to help the client maintain any progress that has been made as a result of treatment.

Base-camping and expedition-based models are employed (Crisp, 1998), for two primary types of programs: (a) private placement, where parents are custodians of the adolescent, and (b) adjudicated, where the state or other agency is responsible for the well-being of the client (Davis-Berman & Berman, 1994; Russell & Hendee, 2000a). Most clients in wilderness therapy are male adolescents aged 16-18, although a few adult programs have been established). Two types of expedition programs are: (a) continuous flow programs, where leaders rotate in and out of the field, new clients join existing groups, and a therapist supervises groups by visiting them weekly; and (b) contained programs, where the therapist and wilderness guides comprise a treatment team which remain with the group the duration of the program (Russell & Hendee, 2000a).

Discussion

A consistent definition of wilderness therapy is an

important consideration for parents, mental health professionals, social service agencies, and the court systems for several reasons. First, a consistent definition may help clarify the types of services offered, and for whom they are most appropriate. An example would be parents seeking treatment for their 17-year old son who has been diagnosed with depression, has a drug problem, and is not being reached by outpatient therapy. There are over 500 different wilderness experience programs currently operating in the United States. Which one would be most appropriate, and more importantly, safest, for their son? Second, a consistent definition may help agencies responsible for their oversight better monitor program compliance with established standards. And third, a consistent definition may be useful to track key indicators of program safety and standards of care, such as therapeutic holds, runaways, accidents, and even deaths in wilderness therapy practice—with the goal being to raise the standard of care in the industry by monitoring these indicators.

Support for why a consistent definition may be beneficial to the wilderness therapy industry can be found by examining recent trends in wilderness therapy. Each of these trends are reviewed here to provide support for the reasons presented above. The trends include: (a) the formation of industry trade associations like the Outdoor Behavioral Healthcare Industry Council (OBHIC), (b) the move toward state licensing, especially for wilderness therapy programs in several states, and toward national accreditation, through agencies like the Council on Accreditation (COA) and the Joint Commission on Accreditation of Healthcare Organizations (JCHAO), and (c) the establishment of consistent measures and monitoring procedures for baseline statistics to be used as indicators of best practices. Individual wilderness therapy programs can then be compared to industry norms, which can also be compared to alternative treatment modalities for similar populations. Table 2 outlines key elements of a wilderness therapy program that might distinguish it from other wilderness programs aimed at recreation, education or personal growth.

The Establishment of Industry Associations

The Outdoor Behavioral Healthcare Industry Council (OBHIC) was formed in 1996 as a coalition of more than twelve wilderness therapy programs to work for higher standards in wilderness and outdoor treatment programs. To be member of OBHIC, certain standards must be met, including clinical supervision by qualified professionals, and valid operating permits on public lands. Meeting quarterly, they expanded cooperation through open dialogue about methods, process, equipment, staff training and qualifications, safety, pub-

lic relations, and land use ethics. This trend highlights the recognized need of a group of wilderness therapy programs to define themselves differently from the wide range of wilderness programs offered, and educate the public about their treatment services.

The Trend Toward State Licensing and National Accreditation

As wilderness therapy programs began to establish themselves in Utah and Arizona in the late 1980s, another trend emerged. Wilderness therapy programs realized that with recognition from insurance companies, more families would be able to afford the interven-

tion and treatment. The Anasazi Foundation program founders, Larry Olsen and Ezekiel Sanchez, first approached a number of insurance companies in Arizona in 1988 and were told that if they could meet state requirements for adolescent residential treatment they would recognize their program. Adjudicated programs like VisionQuest, established in 1973, had prompted the State of Arizona to develop standards for programs under the category of Mobile Program Agency Standards (personal communication, M. Merchant, June 1, 2000). These standards had an important impact on program design and process at The Anasazi Foundation, and were also a guide for other programs in forming

Table 2. Unique and Common Characteristics of Wilderness Therapy Programs and Wilderness Experience Programs (WEPs)

| Unique to Wilderness Therapy | Common to other WEPs |
|---|---|
| <ul style="list-style-type: none"> • Program is licensed by a state agency or moving toward licensure where appropriate. • Program is supervised by a licensed mental health practitioner and client has periodic contact with licensed therapist either in one-on-one or group therapy sessions. • Program works with the family to help them understand the nature of the client's problem behaviors and enhance treatment objectives. • Program has trained therapeutic staff in their area of specialty (drug and alcohol treatment, family therapy, etc.). • Primary-care staff has training in specialty areas appropriate for the population of clientele (therapeutic holds, de-escalation, etc.). • Clients have individualized treatment plans that are monitored by licensed therapeutic staff. • Client has routine medical check-ups to monitor well-being. • A formal evaluation of treatment effectiveness is conducted to determine treatment effectiveness. • Therapeutic staff work with aftercare services and the family to ensure that any progress made by the client can be maintained. | <ul style="list-style-type: none"> • Use of outdoor and unfamiliar environments to help the client leave their familiar culture behind and have a unique experience. • The use of adventure activities and wilderness living to challenge the client to have an experience that will facilitate meeting specified learning objectives. • Takes place in a group setting where group development processes facilitate learning. • Use reflective-activities to help the client process what it is they have learned from the experience. • Facilitated by qualified professionals meeting a standard set of requirements. A formal assessment procedure is used at intake with all new clientele. |

agreements with insurance companies (and social service agencies) in seeking co-payment for client treatment.

Standards included developing an individual treatment plan for each client; supervision by professional clinical staff; regular medical check-ups by medical staff; appropriate back-up procedures while in wilderness (radio and cell phone contact); and a required number of calories per day for each client. The emerging recognition by insurance companies and state agencies, and the growing third party co-payment from insurance companies, distinguished wilderness therapy programs from other wilderness experience programs and is an important trend to recognize.

To become accredited by a national accrediting organization, a wilderness therapy program must go beyond state requirements and meet higher standards of care. According to the Council on Accreditation of Services for Families and Children (COA) programs must fulfill several criteria to meet the national standards, which include: a formalized process for evaluating the quality of service, state licensure, and proof of insurance (<http://www.coanet.org>). Again, the goal of accreditation by these national agencies is recognition by third party payers to help make the intervention more affordable.

Establishment of a monitoring system for key indicators. In 1999, the Outdoor Behavioral Healthcare Research Cooperative at the University of Idaho was formed to help fund research important to the wilderness therapy industry. A current objective of the research cooperative is to establish baseline measurements of key indicators like therapeutic holds, runaway and incident rates, to use as a reference to help monitor program safety.

Table 2 outlines unique characteristics of wilderness therapy programs that may distinguish them from other wilderness programs. This is by no means a comprehensive list of all essential components, but rather, could be used as a tool to reference unique elements of programs. It may allow those not familiar with wilderness therapy and other experiential programs to better understand the purpose and aim of wilderness therapy juxtaposed to other wilderness experience programs.

Summary

This paper explored the variety of definitions of wilderness therapy found in the literature and presented an integrated definition based on the literature and recent research. The goal of this paper was to explore the significance and need of such a definition. The perception of wilderness therapy today can be gleaned from articles by Krakauer (1995) and Jenkins (2000), in reporting on deaths caused by vanguard programs or other negative incidences. These and other popular articles depict wilderness therapy as a harsh, "boot camp" approach, in which adolescents are broken down only to be built back up. They also portray wilderness therapy programs as being un-regulated, under-staffed, and nonchalant about evaluating outcomes. Does these perceptions accurately characterize the wilderness therapy intervention? Davis-Berman and Berman (1994) present a definition far from these perceptions, as do Bandoroff and Scherer (1994), and Crisp (1998). Despite upwards of 200 studies found by some reviewers (Friese, Pittman, & Hendee, 1995), wilderness therapy is still viewed in the mental health profession with great trepidation because of loosely defined treatment approaches and inconsistent research.

Trends in the industry support the notion that wilderness therapy programs are searching for recognition by state agencies, national accreditation agencies, insurance companies and mental health professionals. Key elements, not found in past definitions of wilderness therapy theory and practice, are emerging, which support an integrated and consistent definition of wilderness therapy. The ultimate goal in the field of wilderness therapy will continue to be improved standards of care, increased treatment availability, enhanced treatment effectiveness, and expanded understanding of what wilderness therapy is, and for whom the intervention may be most appropriate.

Notes

- ¹ Aspen Achievement Academy and Wilderness Quest, both operating in the state of Utah, work with adult substance abusers.

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