2016

Integrating Narrative Family Therapy in an Outdoor Behavioral Healthcare Program: A Case Study

Steven M. DeMille

Marilyn J. Montgomery
George Fox University, mmontgomery@georgefox.edu

Integrating Narrative Family Therapy in an Outdoor Behavioral Healthcare Program: A Case Study

Steven M. DeMille, Marilyn Montgomery

Abstract Adolescent mental health is a significant societal concern in the United States. Diagnosable mental health disorders have been reported at rates of 10–20 % among children and adolescents and this does not include adolescents experiencing personal and interpersonal distress not meeting diagnostic criteria. Adolescents who do not respond to traditional mental health services are often placed in residential treatment centers or other out-of-home treatment programs. Outdoor Behavioral Healthcare (OBH) is growing as a viable treatment option for adolescents who struggle with emotional, behavioral or substance related problems; however, questions have been raised about how to integrate the family into an OBH treatment setting. This article describes a case study illustrating how techniques from Narrative Family Therapy can be used to accomplish this integration, and offers a view of using Narrative Family Therapy to further involve families in the treatment and post-treatment process in an OBH program.

Keywords Outdoor behavioral healthcare, Narrative family therapy, Wilderness therapy, Adolescents, Case study

Adolescent mental health is a growing societal concern in the United States, with diagnosable mental health disorders reported at rates of 10–20 % among children and adolescents (Kieling et al. 2011). An even greater number of adolescents experience personal and interpersonal distress that does not meet diagnostic criteria (O'Connell et al. 2009). Diagnosable disorders and other interpersonal problems are concerning as they interfere with the accomplishment of normal developmental tasks; this includes developing healthy interpersonal relationships, social relationships, success in school, and transitioning into the workforce (O'Connell, Boat, & Warner). If not addressed, they may lead to adult mental health problems (Belfer 2008) and chronic health concerns, including premature mortality (Brown et al. 2009).

Adolescent problems with mental health also negatively affect the lives of family and friends (O'Connell et al. 2009), not just the adolescent. The impact of a struggling teen on the family system often drives families to seek professional help. According to the Substance Abuse and Mental Health Services Administration (SAMHSA 2012), approximately 2.9 million youth are receiving professional services for emotional and behavioral problems. However, when conventional practices do not work, families often seek alternative treatment modalities such as out-of-home treatments. Of those estimated 2.9 million youth who received services in the last year, nearly 600,000 received inpatient treatment (hospital, residential treatment, and foster care), and of these approximately 80,000 received long-term inpatient treatment (longer than 25 consecutive days; SAMHSA 2012). Some estimates are even higher, suggesting that there may be as many as 375,000 youth treated in residential treatment settings each year (Russell and Gillis 2010). However, it is unknown how many of these settings systematically engage in theory-based innovation or program evaluation that advances our understanding of effective out-of-home approaches to assist these troubled adolescents and their families.

Several studies support the importance of family involvement in the treatment of adolescents (Cottrell and Boston 2002; Diamond et al. 1996; Fauber and Long 1991) and specifically, adolescents in residential care (Safran et al. 2009). Hair (2005) reviewed 18 studies and found evidence that frequent family visits and participation in family therapy are associated with successful outcomes. In one study, when an adolescent participated in family therapy while in residential care, the odds were eight to one that they would transition to a less restrictive environment. In contrast, adolescents who experienced parent abandonment were more likely to be discharged to juvenile detention or a psychiatric hospital (Stage 1998). In addition, Leichtman et al. (2001) found that family and community involvement predicted successful maintenance of gains post psychiatric inpatient treatment. These findings were corroborated by the National Building Bridges Initiative (2007), which identified family support as a predictor of post-treatment success for adolescents in residential care. In sum, there is a growing body of literature that indicates family involvement and family therapy is a significant indicator of post treatment success in residential care for adolescents.

Outdoor Behavioral Healthcare (OBH) is a promising alternative option to traditional residential care for struggling adolescents. OBH builds upon an established tradition of using the wilderness as a therapeutic setting with unique opportunities for fostering change (Russell and Hendee 2000). As an out-of-home treatment alternative, OBH is growing in popularity and at the same time is accruing evidence of effectiveness (DeMille 2015). In a survey by Russell et al. (2008), approximately 10,000 youth received services annually in programs that identify as OBH. As an emerging and contemporary approach, OBH is receiving attention in the professional literature and professional conferences (Outdoor Behavioral Healthcare Research Cooperative; OBHRC 2015), in professional magazines (Bray 2014; DeAngelis 2013) and in the popular media (Telep 2014). While most of the OBH research has focused on its general effectiveness for struggling adolescents, some research has been conducted to explore the integration of aspects of family therapy in OBH (DeMille and Burdict 2015; Faddis and Bettmann 2010) and to evaluate family change resulting from the OBH process (Harper and Russell 2008; Harper et al. 2007). Although the ideal role and quantity of family involvement in OBH treatment is currently unclear in the literature (Becker 2010), family involvement will likely be identified as a predictor of post-treatment outcome, as seen in other studies of family involvement in adolescent treatment and residential care. To help bridge the research gap on family involvement in OBH, this paper explores the integration of Narrative Family Therapy techniques in an Outdoor Behavioral Healthcare setting and their impact on one adolescent in treatment and his family.

Outdoor Behavioral Healthcare

Outdoor Behavioral Healthcare, often described as wilderness therapy, has made significant strides as a profession in the last decade. In 1996, a small group of programs formed the Outdoor Behavioral Healthcare Industry Council (OBHIC; now call the Outdoor Behavioral Healthcare Council or OBHC) which was intended to promote program standards and excellence in OBH (OBHC 2015). The council has grown and currently has 22 member programs. In addition, an Outdoor Behavioral Healthcare Center was established at the University of New Hampshire in 2015 with the mission to "advance the Outdoor Behavioral Healthcare field through the development of best practices, effective treatments, and evidenced-based research" (OBHC 2015). The growth of OBH has led to the development of accreditation standards, managed by the Association of Experiential Educations (AEE) (AEE 2015).

Although various definitions of OBH and wilderness therapy have been proposed, the outdoor behavioral healthcare accreditation manual describes OBH as the "the prescriptive use of wilderness experiences by licensed mental health professionals to meet the therapeutic needs of clients" (Gass et al. 2014, p. 1). Specifically, OHB has been described as consisting of:

> (a) Extended backcountry travel and wilderness living experiences long enough to allow for clinical assessment, establishment of treatment goals, and a reasonable course of treatment not to exceed the productive impact of the experience. (b) Active and direct use of clients' participation and responsibility in their therapeutic process. (c) Continuous group-living and regular formal group therapy sessions to foster teamwork and social interactions (excluding solo experiences). (d) Individual therapy sessions, which may be supported by the inclusion of family therapy, (e) Adventure experiences utilized to appropriately enhance treatment by fostering the development of eustress (i.e., the positive use of stress) as a beneficial element in the therapeutic experience. (f) The use of nature in reality as well as a metaphor within the therapeutic process. (g) A strong ethic of care and support throughout the therapeutic experience (Gass et al. 2014, p. 1).

Russell and Hendee (2000) provide a briefer description of OBH as a therapeutic program or modality that uses outdoor settings and counseling interventions to assess, diagnosis, and treat clients. A common feature of OBH

programs is the immersion of a client in an unfamiliar environment, where they engage in group living with peers and guides. Participants also engage in individual and group therapy overseen by a licensed mental health professional and an educational curriculum designed to foster changes that clients can integrate into their lives upon returning home.

The outdoors has been used for centuries as a stage for change and healing (White 2011). In modern times, the outdoors has been used to foster personal growth, character development, and to build traits believed to be necessary for healthy functioning (Cason and Gillis 1994; White 2011). Walsh and Golins (1976) were some of the first authors to describe the role of the outdoors in fostering change; asserting that the outdoors provide the individual with a contrasting environment to see generality that is often overlooked is a familiar environment. In other words, the outdoors provides a contrast for an individual to gain a new perspective on old patterns that occurred in their familiar environment. Walsh and Golins argued that this is the first step in helping an individual reorganize the meaning and direction of their experience. Additionally, these authors argue that the outdoors is particularly useful as a contrasting environment because it is a highly stimulating environment with much to see, hear and touch, while also providing a sense of uncertainty and risk. At the same time, the outdoors is a neutral environment. Rules exist in nature that are not arbitrary and which must be respected—there are no human buffers to protect individuals from nature, the elements and consequences that can ensue from taking unwise risk. Individuals must take on an awareness of their context and responsibility for their actions in an outdoor setting to a higher degree than typically required in other settings (Walsh and Golins 1976).

General effectiveness research on OBH has provided promising evidence of positive outcomes for struggling adolescents who receive treatment, indicating that adolescents with emotional, behavioral and substance related disorders improve during the course of treatment and these improvements are maintained post discharge (Bettmann et al. 2012; Clark et al. 2004; Lewis 2013; Magle-Haberek et al. 2012; Norton 2008, 2010a, b; Russell 2003, 2005a, b, 2008; Russell and Farnum 2004; Russell and Sibthorp 2004; Tucker et al. 2011, 2014; Zelov et al. 2013). Positive physiological outcomes have also been found (DeMille et al. 2014). In addition, OBH appears to be effective for a variety of populations and problems, including adolescents in the Juvenile Justice system (Jones et al. 2004; Russell 2005a; Wright 1983), adolescent sex offenders (Gillis and Gass 2010; Lambie et al. 2000), and adolescents with various diagnosable disorders (Clark et al. 2004; Russell 2006, Russell 2008).

Many residential treatment programs for individuals claim to improve family functioning, In OBH, the family has received some research attention which has supported this claim. In one study, Harper et al. (2007) developed a questionnaire to measure adolescent and family outcomes in an OBH program. The 60-item questionnaire contained five subscales; (a) *Family Functioning*, (b) *Adolescent Mental Health*, (c) *Adolescent Behavior*, (d) *School Success*, and (e) *Positive Social Relations*. These authors found numerous improvements in family functioning at 2 months post discharge, with the exception of family arguments which increased at 2-month post treatment. Another study by Harper and Russell (2008) also found a positive trend toward improvements in family functions post OBH treatment. The authors noted that families reported a stabilizing effect and a generally rewarding experience from the wilderness treatment process.

Narrative Family Therapy

Narrative approaches to therapy have grown in popularity, particularly in the field of family therapy (Carr 1998). This is in large part due to the efforts of Michael White and David Epston (Epston and White 1992; White 1989), who describe their approach to therapy as based on principles rather than methods. Narrative therapy grew out of the postmodern perspective, which is reflected in its principles: (a) there is not one universal reality but reality is socially constructed; (b) language constructs reality; (c) reality is maintained through narratives; and (d) not all narratives are equal (Freedman and Combs 1996). From those foundations, narrative family therapy views human problems as arising and being maintained by oppressive stories that dominate a person's life. Problems occur when individual stories do not fit with their lived experience. According to the narrative perspective, treatment is a process of re-authoring personal narratives by providing a new and different perspective on a problem-saturated narrative. Re-authoring a narrative is done through a process of helping the client (a) externalize the problem(s) they are experiencing, (b) deconstructing problem-saturated narratives through questioning, (c) identifying unique outcomes or times when a person was not oppressed by their problem, (d) link unique outcomes to future and provide an alternative and preferred narrative, (e) Invite members of a person's social network to witness the new narrative, (f) document new knowledge (Carr 1998; O'Connor et al. 1997).

Because postmodern perspectives place emphasis on principles rather than techniques, formal techniques are limited in narrative therapy. However, some authors have identified practices that are useful in assisting a person in

re-authoring a personal story such as the "telling and re-telling of story," letter writing, and documentation (Carr 1998). For example, letter writing has been used in individual, family and group therapy to address a variety of issues including improving family communication, trauma, grief and loss, identity development, and crisis management (Riordan 1996; Tubman et al. 2001).

Narrative therapy has been used extensively in outpatient settings, but it has also been used in inpatient settings, including OBH. For example, Faddis and Bettmann (2010) describe the use of reflection teams in an OBH setting. Reflection teams were heavily influenced by Milan's therapeutic approach (O'Connor et al. 2004) and have been adapted and incorporated into the narrative therapy approach. The authors describe a process of using field staff and other families as part of a reflection team. The reflection team observes the session and at the end is asked specific questions based on their observations of the session.

Narrative Family Therapy in an Outdoor Behavioral Healthcare Setting

Narrative family therapy provides some structural and theoretical advantages that can be useful in an Outdoor Behavioral Healthcare setting. As noted above, OBH consists of "extended backcountry travel and wilderness living experiences long enough to allow for clinical assessment, establishment of treatment goals, and a reasonable course of treatment" (Gass et al. 2014, p.1). Immersion in the backcountry and wilderness living brings many logistical challenges for families who wish to be actively involved in the treatment process. First, wilderness programs are often located in rural and difficult to access locations. Thus, significant travel is required for most adolescents and families in order to participant in OBH. Second, the time and money required for travel limits a family's ability to physically participant in family therapy. Attempts are often made by programs to have individuals involved in the therapy process through family visits and therapy sessions; however, these visits tend to be limited during the treatment process because of financial and time constraints. Third, the backcountry environment limits the potential for electronic communication between the adolescent and family. Therefore, communication between a family and adolescent in an OBH program often occurs through letter writing.

As a result of the limitations to conducting family therapy in an OBH setting, creative approaches to implementing family therapy are needed. Narrative family therapy provides potential advantages that compensate for some of these limitations. Narrative therapists often work alone with a client, or flexibly, as Harlene Anderson described, "with individuals, parts of families, and members of the larger system" (1997, pp. 66–67). Freedman and Combs (1996) noted that they prefer to "interact with one person in the family while the others listen" (p. 187). This process makes family members an audience to each other and their personal narratives. The telling and retelling of the story occurs with the family as an audience to the story. This approach is useful in an OBH setting, as adaptation can be made to tell and retell the narratives through writing, a common feature of OBH programs. Family members who are distant can still be involved in the process through being asked to reflect on stories that are being told (Freedman and Combs 1996).

There have been criticisms made against this "distance" approach to family therapy. For example, the lack of observation of interpersonal patterns among the family members has been criticized (Minuchin 1998). However, the use of letter writing as a ways for families to tell, retell, and reflect on stories has great potential as a means of integrating the family during the entire treatment, even when the adolescent is in the backcountry. The following case study illustrates the application of Narrative Family Therapy techniques in an OBH setting.

Case Study

The case study method is useful in documenting, evaluating and disseminating new approaches or the new applications of an approach (McLeod 2010). Case studies provide an in-depth understanding of a new or innovative approach and have a long history of use in the field of psychology and medicine (Creswell 2007). In this case study, the Narrative Family Therapy treatment of an adolescent male with severe intrapersonal and interpersonal issues will be described, with a focus on the application and outcome of the family therapy. OBH is a dynamic treatment modality that includes individual, group, and family therapy combined with the prescriptive use of the outdoors and wilderness living, all occurring within small peer group dynamic. Thus, the overall treatment integrates many techniques and modalities. Greater detail on the different components of treatment such as the individual, group, wilderness-living and backcountry travel can be found in DeMille and Burdick (2015). This case study will highlight the implementation of narrative techniques as a key aspect of the family therapy.

The Program

The OBH program used in this case study is located in the Western United States. Adolescents who are receiving

treatment are referred to as "students" while they are in the program; academic credits are earned through completing the education/experiential curriculum. Students also receive weekly individual and group therapy while in treatment. Parents meet with the therapist weekly via conference call. The program uses a continuous flow expedition model (Russell 2003), which entails students being immersed in wilderness living and backcountry travel during their entire stay. The backcountry travel entails hiking/backpacking. On average, participants participate in hiking/backpacking expeditions four to five times a week for three to five miles each trek. The wilderness living involves setting up and breaking down a campsite using low-impact camping principles (Marion and Reid 2007). In addition, students learn wilderness skills practical for their living situations. For example, students learn primitive fire making for warmth and preparing meals.

Adolescents are referred to this OBH program for various emotional, behavioral, relational, and substance related problems. The program reports that families they work with have "exhausted emotional, familial and community resources" (*Who Do We Serve*?, 2015, p. 7). The overall treatment goal is to disrupt dysfunctional relational and behavioral patterns that are impeding healthy adolescent development and restore clients' age-appropriate functioning. The dysfunction that is impeding healthy adolescent development may come from mental health disorders, trauma, interpersonal problems at home or in the community, and/or substance use. Treatment goals are achieved by integrating evidenced based therapies with clinical expertise in the context of patient characteristics, culture, and preferences (Anderson 2006). In addition, goals are achieved through the use of wilderness living, interpersonal relationships, an experiential curriculum, and a healthy lifestyle (healthy diet, sleep habits, work and exercise).

Family involvement in the treatment process occurs through different methods, both in person and at a distance. Families (parents or legal guardians) participate in an "end of trails" ceremony with their child as part of the treatment process. The "end of trails" ceremony involves the parents visiting their child in the outdoor environment and camping with their child. Parents are involved in a series of group and family therapy sessions, with their child and without them. In addition to the in-person involvement, families also participate in family therapy through a series of narrative writing assignments that the student and family complete when the student is in the backcountry and are unable to attend. The narratives are designed to be a way for the adolescent and the family to tell and retell their story, to identify problem-saturated stories, and to look for unique outcomes. Sharing and reflection are also built in through exchanging narratives. Students are asked to share their narrative with their peers in group therapy. Parent narratives are shared with the student in therapy, where they are given an opportunity to reflect on their parents' narratives. Following is a description of the implementation of narrative family therapy with one case in an OBH program.

History and Reason for Treatment

Sam is a 16-year-old male who was referred by his parents for treatment in an OBH program in the Western United States. Parents reported that they sought treatment because of Sam's emotional dysregulation, poor family relationships, and academic problems. Parents described Sam had been "out-of-control" within the home. He was refusing to go to school, refusing to attend local counseling sessions, and refusing to socialize outside of playing interactive video games online. His parents reported that whenever they would attempt to place restrictions or boundaries on his behaviors, Sam would become emotionally volatile and make threats to hurt himself. They also reported that Sam stop talking with his family, was ignoring everyone in his home, and had refused to engage in outside activities (sports, school, travel, work).

Sam's parents reported that in the past they believed they had a close relationship with their son. They described Sam as being intelligent and academically gifted, athletic, and talented both intellectually and physically. In the past Sam was treated for depression; however, his parents noted it was never very successful. He was also previously in treatment for family problems that emerged around his use of video games, primarily, conflicts that arose when his parents would put limitations on his gaming. During the last 2 months before entering treatment, Sam had refused to leave the couch, even to bathe. This was reportedly in response to having restrictions placed on his gaming console.

Assessment and Therapeutic Goals

When Sam arrived for treatment at the OBH program, his parents identified three goals for their son. First, they wanted him to reengage socially. They wanted him to leave the house, spend time with friends, attend school again, and to start making progress towards independence and adulthood. Second, the parents wanted to improve the family relationships, which had become hostile and dysfunctional for all family members. Finally, they wanted to see more interpersonal flexibility from Sam. They noted that when Sam would set his mind on something he would not back down until he got what he wanted.

When Sam was asked what he wanted to work on in treatment he stated "I want to teach my parents they cannot control me." Sam denied any other treatment needs or past

need for treatment. Sam also noted that he was not "depressed" or "addicted" to games and it upset him when people would insist otherwise. Sam acknowledged that his relationship with his family was poor and that he had lost most his friends.

In response to Sam's adverse reaction to the use of diagnostic labels, a functional approach was taken in Sam's treatment planning. This was done by focusing on functional goals and not the treatment of symptoms associated with diagnoses. The first goal with Sam was to help him actively engage in the treatment process and during the fourth session, Sam collaboratively developed the following goals. The first goal was to engage in appropriate behaviors with peers and authority figures. This included meeting basic expectations, following directives, and being a positive influence on others in his peer group. The second goal was to improve family relationships. This goal included two parts: Sam would start communicating with his parents through letter writing, and he would send and receive narratives with his parents, addressing the problems that he perceived in their relationship.

Narrative Family Therapy

Initially, Sam did not want to engage in therapy or any form of reflective process. As a result, the first three therapy sessions focused on developing a working relationship and helping Sam feel safe. In addition, the first sessions focused on helping Sam develop hope that his life could be different and hope that his relationships could improve. This was a major issue for Sam as he did not believe he or his family could change anything. He felt stuck. Finally, therapy also focused on assisting Sam with adapting to his new contrasting outdoor environment. During the first three sessions Sam was encouraged to reflect on his old environment, relationships, and choices. At first Sam was rigid and did not want to look at his environment, relationship and choices. However, as Sam spent time in the outdoors and had opportunities to contrast his old familiar environment with his new unfamiliar environment, he began to identify aspects of his life that he did not want to maintain going forward with his life.

In the fourth therapy session Sam acknowledged his new perspective; stating that he wanted to "try something different." He noted that he was not happy with his current situation and current relationships. During that session, Sam set goals for himself and became more open to share his story. Family therapy began with Sam by creating a safe therapeutic environment where he shared about his struggles prior to being placed in treatment in an OBH program. While Narrative Therapy posits the necessity of creating a collaborative or egalitarian relationship between therapist and client, a therapist in this OBH program has an evaluative and gate-keeping role with the student that makes an egalitarian relationship in therapy unrealistic. The therapist is the gate-keeper of the decision about when the student is ready to transition to a less restrictive treatment environment, and students are aware of this dynamic. Thus, initially in therapy, the goal is to minimize the impact of that dynamic on the treatment process and to create a safe therapeutic environment.

In the fourth session, Sam provided the "thin description" of his problem. Sam identified the different areas of his life where the dominant story was imposed upon him. However, Sam described that his problems were not due to his acceptance of the dominate story but from his resistance to accepting the dominate story. Sam discussed his issues with being described as "depressed" and "addicted." Sam insisted that is not "who he is." Sam also mentioned a professional who labeled him with "Aspergers" and how he never wanted to return to that professional. In addition, Sam indentified his struggles with being identified as "smart" and being pressured to attend a prestigious boarding school where he received a scholarship. Through the use of "how" and "when" questions Sam was challenged in the session to explore in more depth the struggles he was experiencing.

At the end of the session, Sam was challenged to continue to "tell his story" and "re-tell his story." He was given a few open ended questions to reflect on and respond to before the next therapy session. This process would continue throughout Sam's entire stay and his answers in the assignments were labeled as Sam's autobiography. The reflection questions Sam was given after the fourth session related to his home, family, authority, and significant events of childhood. Some of the questions included "what did your home look like as a child?" "What did it take to live in your home?" "Who was in charge in your home and what did it take to be in charge?" "What were the most fearful events in your childhood?" In addition, Sam's parents were given open-ended reflection questions similar to Sam's; their answers were called the parent narratives. Those questions included "What did you child's home look like?" "What were the roles and expectations of each family member and how were they communicated?" "What were the most significant events that defined the family?"

In the fifth therapy session, Sam shared his autobiography and the parent narrative was read to Sam. Some of the themes that came out of the parent narrative included an emphasis that the children in the family were expected to "do the best their abilities enabled them to," and to "be polite and respectful." Furthermore, the narrative stated "we tried to communicate this primarily by example, although we're far from perfect." Some of the significant events that were identified in the parent narrative included

significant loss, great academic success in school, and Sam's being bullied in school. Sam was asked to reflect on what he read and heard from his parents. He was asked "How was it to read your story and then hear your parents' story?" "What stood out to you?" and "Was their anything that surprised you?" These questions were intended to produce a "thick description" or "thickening" of Sam's story by allowing him the space to make interpretations.

Sam was asked to identify situations from his parents' narrative that were surprising or that did not fit into his problem-saturated narrative. A few parts of the narrative stood out to Sam. Sam noted that he felt much pressure to be successful because of his physical and academic capacities. His parents did expect him to do "the best his abilities enabled him," and Sam stated how hard that was for him. Sam also noted that he always felt like the problem in the family and he was surprised to hear his parents say, "…although we're far from perfect." Sam also responded to the bullying by saying that he did not think it was as significant of an event as his parents did. Some of the unique outcomes, such as the identified patient story Sam had for himself, were used to begin to reconstruct an alternative story.

At the end of the session, Sam was challenged to continue to "tell his story" and "re-tell his story" and was given new open-ended questions to reflect on before the next therapy session. The questions that Sam was given focused on discipline and self-discipline, such as "Who was in charge of the discipline in your home?" "How was discipline administered and how did you respond to the discipline?" "What areas in your life have you shown self-discipline and what areas are out-of-control?" "How do others know that you are self-disciplined?" Sam's family was also given open-ended reflection questions similar to Sam's. They included "From where did you derive the method of discipline you implemented in your home?" "Was this different from the kind of discipline you encountered as a child? How so?" "How did your child respond to the discipline you provided?" "What seemed to be successful?" "What would you have changed and why?" "When were you most encouraged by the actions of your child?" Finally, at the conclusion of the fifth session, Sam was challenged to share his autobiography with his peer group. The peer group would become the witness to the thickening description and the alternative story. This was done to increase the probability that the alternative story will take root for Sam outside the therapy session and later outside the OBH program.

In the sixth session, Sam shared his autobiographies and his parents' new narrative was read to him. After exchanging writings, Sam was asked similar questions to help produce a thick description of the story. Sam noted in this narrative his parents seemed the most pleased with him when he was interacting and playing with his siblings and not when he was achieving or accomplishing. Sam's parents stated "we are most encouraged by Sam when he was caring with his sisters, honest with us and everyone else, when he showed love to us and to his sisters." Sam noted that he liked the high relational focus of the narratives and not the focus on achievement. The shared beliefs that Sam experienced through telling and retelling his story and hearing his family story started to highlight shared values and beliefs within the family.

At the conclusion of the session, Sam was challenged to continue to "tell his story" and "re-tell his story" and was given new open-ended questions to reflect on and respond to before the next therapy session. Sam's family was also given new open-ended questions similar to Sam's to reflect on and answer. Again, Sam was challenged to share his autobiography with his peer group, who witnessed the thickening description and the alternative story. The process of exchanging narratives occurred eight times during the course of treatment while Sam was in the backcountry of an OBH program. Each situation was followed by the group witnessing the process through the sharing autobiographies with the peer group.

Concluding Therapy and Follow-up

The family narratives concluded with an incorporation practice. On Sam's last day of treatment in the OBH program, Sam shared his alternative story with his family. The alternative story incorporated what he had experienced in the outdoor program, with his peer group and throughout the narrative therapy process. After Sam shared his narrative, Sam's parents were asked to reflect on what they heard and experienced. Parallel experiences were identified and used as bridges for Sam's parents to become a resource for Sam going forward instead of part of the problem.

In an exit interview Sam reported the most valuable thing he had taken from his time in the outdoors was how it "helped improve my family relationship." This improvement was apparently sustained. One year after Sam had completed treatment he and his family responded to a questionnaire about their experience. Sam noted in his questionnaire:

> I think the most important part of [Program Name] 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… I began to become who I am. I don't think that I could have learnt to be myself had I been at home. I think that learning to sit with myself and being okay with who I am is something that started for me out there.

Sam also noted in the questionnaire about the impact of having his group as a witness:

> The first time I told my group as a whole my life story I cried a hell of a lot because it was the first time that I had told anyone my age about what was going on back home. My friends were extremely helpful and respectful of me, and that experience helped me a lot for a while to feel comfortable with people.

In addition to feedback from Sam, his parents were asked to reflect on their treatment experience in an OBH program. Sam's parents reported:

> [Program] helped us understand [Sam], his concerns, his fears, and his needs. We could not have done this while he was at home as he was unwilling to communicate with us. Removing him from the house for a few weeks gave everyone involved the chance to rethink what was going on and it helped us all get a bit of perspective on the issues [Sam] was dealing with.

The parents continued:

> [Program] made us think about our relationship with our son, and how our role might have had an influence in [Sam's] lack of development. [Program] did this without blaming us and without resentment. Our changes as parents somehow came to us from inside ourselves; [Program] helped us become a better version of ourselves as parents without us noticing, without blame, and without resentment.

Sam's parents were also asked what aspects of the treatment process was the most helpful.

> For us parents, narratives were very helpful in two ways. Firstly it helped us rethink about our relationship with our son, and about how our role might have had an influence on [Sam's] development. Writing the narratives had a huge impact on our way of parenting our kids. Secondly, the parents' narratives made us get involved in [Sam's] improvement, it allowed us play a part in his progress even though he was miles away from home. It was a way of staying in touch with [Sam] while he was staying in the wilderness, a way of working together with him even though we were miles away from him.

Suggestions for Family Therapists

The benefits of family involvement in therapy (Cottrell and Boston 2002; Diamond et al. 1996; Fauber and Long 1991) and in residential care (Hair 2005; SafranGass et al. 2009) have been well documented. Narrative Family Therapy provides methods for family therapists to integrate family involvement when there are limited opportunities for conjoint sessions. Here, we offer suggestions for family therapists interested in applying these techniques to increase family involvement in OBH or other out-of-home treatments.

First, the therapist must be aware of the nature of their relationship with the client in treatment. In OBH and residential care there is often an evaluative and gate keeping role that the therapist must maintain. This power differential makes it impossible to create a truly egalitarian relationship and the therapist must acknowledge this dynamic. Nevertheless, the therapist should attempt to create a safe environment for the client to discuss difficult family dynamics. Working within a narrative framework supports therapists in taking an authentically inviting stance, despite the evaluative role. O'Connor et al. (1997) found that clients valued the therapists who used the narrative approach because the therapists appeared to respect their perceptions and experiences. In addition, the non-punitive physical distance that OBH provides offers some safety for the clients to feel open to discussing problems and challenges without the fear of what happens after the session, as well as the freedom to imagine and create a new narrative. Sam noted in his feedback at 1 year that "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 [Program] I began to become who I am." The physical distance can create a sense of safety for describing family problems, while the outdoor setting provides fresh standpoints for taking new perspectives and creating new narratives.

Family therapists can use the contrasting outdoor environment to encourage willingness to reflect and find new perspectives that challenge old dominant stories. In the case of Sam, family therapy was not pushed. When Sam acknowledged that he wanted to "try something different," this came after he had spent time in the outdoor environment. The outdoor environment gave Sam a neutral and stimulating environment to reflect on his dominant story and eventually led him to look for new perspectives and alternative stories. The outdoor environment enhances family therapists' invitations for clients to create new perspectives.

The narrative approach works with the individual parts of the system and with others as an audience to the stories being told in therapy. For family therapists working in OBH, this method of family involvement is very conducive to the treatment setting. The telling of stories and being an audience for stories are practices that can be delivered in an asynchronous format through letters or structured writing assignments. The asynchronous format provides an

opportunity for the family therapist to discuss reactions to the stories separately with families and adolescents, which may increase a sense of safety and allow the client to more fully develop their "voice," and then to share their reflections with each other through writing.

Finally, it is important to note the use of the group as a witness of the alternative story. An advantage of writing the stories is the potential for the stories to be shared and thickened by having a peer group witness the story and then be a witness to the development of the alternative story. Witnessing supports the development of the story, and fosters internalization of the alternative story and generalization of the story to new settings such as home environments reentered after treatment.

Conclusion

One of the greatest struggles of out-of-home treatments is the involvement of families in the treatment process. The Narrative Family Therapy techniques described here illustrated how families can be involved in the therapy process, even at a distance. In the case of Sam, a struggling adolescent placed in an OBH program, techniques from Narrative Family Therapy were used to meet the therapeutic goal of improving the family relationship. Specifically, the process of deconstructing the dominant story and reconstructing an alternative story was facilitated by the contrasting outdoor environment offered in an OBH treatment setting. The narrative family therapy integrated into his treatment included techniques of collaboration, identifying unique outcomes, thickening the story, inviting outsiders to witness, and incorporation practices with families. The case illustrates several techniques family therapists can use to further involve families in inpatient treatment programs, particularly OBH programs for struggling teens.

References

Anderson, H. (1997). *Conversation, language, and possibilities A postmodern approach to therapy*. NewYork: Basic Books

Anderson, N. B. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285.

Association of Experiential Education (AEE, 2015). Accreditation for outdoor behavioral healthcare programs. Retrieved from http://www.aee.org/accreditation-for-outdoor-behav-health.

Becker, S. P. (2010). Wilderness therapy: Ethical considerations for mental health professionals. *Child & Youth Care Forum, 39*(1), 47–61. doi:10.1007/s10566-009-9085-7.

Belfer, M. L. (2008). Child and adolescent mental disorders: The magnitude of the problem across the globe. *Journal of Child Psychology and Psychiatry, 49*(3), 226–236. doi:10.1111/j.1469-7610.2007.01855.x.

Bettmann, J. E., Russell, K. C., & Parry, K. J. (2012). How substance abuse recovery skills, readiness to change and symptom reduction impact change processes in wilderness therapy participants. *Journal of Child and Family Studies, 22*(8), 1039–1050. doi:10.1007/s10826-012-9665-2.

Bray, B. (2014). Going Wild. *Counseling Today.* Retrieved from http://ct.counseling.org/2014/12/going-wild/.

Brown, D. W., Anda, R. F., Tiemeier, H., Felitti, V. J., Edwards, V. J., Croft, J. B., & Giles, W. H. (2009). Adverse childhood experiences and the risk of premature mortality. *American Journal of Preventive Medicine, 37*(5), 389–396. doi:10.1016/j.amepre.2009.06.021.

Carr, A. (1998). Michael White's narrative therapy. *Contemporary Family Therapy, 20*(4), 485–503.

Cason, D., & Gillis, H. L. (1994). A meta-analysis of outdoor adventure programming with adolescents. *Journal of Experiential Education, 17*, 40–47.

Clark, J., 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. doi:10.1177/105382590402700207.

Cottrell, D., & Boston, P. (2002). Practitioner review: The effectiveness of systemic family therapy for children and adolescents. *Journal of Child Psychology and Psychiatry, 43*(5), 573–586. doi:10.1111/1469-7610.00047.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

DeAngelis, T. (2013). Therapy gone wild. *Monitor on Pscyhology, 44*(8), 48–53.

DeMille, S. M. (2015). *Do therapeutic factors and client gender impact treatment outcomes for adolescents participating in outdoor behavioral healthcare treatment? (Doctoral dissertation)*. Minneapolis, MN: Capella University.

DeMille, S. M., & Burdick, M. (2015). A theoretically anchored and multi-modal treatment approach in an outdoor behavioral healthcare program. *Journal of Therapeutic Schools and Programs, 7*(1), 19–30.

DeMille, S. M., Comart, C., & Tucker, A. R. (2014). Body composition changes in an outdoor behavioral healthcare program. *Ecopsychology, 6*(3), 174–182. doi:10.1089/eco.2014.0012.

Diamond, G. S., Serrano, A. C., Dickey, M., & Sonis, W. A. (1996). Current status of family-based outcome and process research. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(1), 6–16. doi:10.1097/00004583-199601000-00007.

Epston, D., & White, M. (1992). *Experience, contradiction, narrative and imagination*. Adelaida: Dulwich Centre Publication.

Faddis, T. J., & Bettmann, J. E. (2010). Reflecting teams and other innovative family therapy techniques adapted for outdoor behavioral healthcare. *Journal of Therapeutic Schools and Programs, 1*(1), 57–69.

Fauber, R. L., & Long, N. (1991). Children in context: The role of the family in child psychotherapy. *Journal of Consulting and Clinical Psychology, 59*(6), 813–820. doi:10.1037/0022-006X.59.6.813.

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

Gass, M., Logan, P., Christensen, N., Hallows, G., Liebing, M., Smith, P., Pace, S., & Tierney, S. (2014). *Manual of Accreditation Standards for Outdoor Behavioral Healthcare Programs* (1st ed.). Boulder, CO: Association of Experiential Education.

Gillis, H. L., & Gass, M. A. (2010). Treating juveniles in a sex offender program using adventure-based programming: A matched group design. *Journal of Child Sexual Abuse*, *19*(1), 20–34.

Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies, 14*(4), 551–575. doi:10.1007/s10826-005-7188-9.

Harper, N. J., & Russell, K. C. (2008). Family involvement and outcome in adolescent wilderness treatment: A mixed-methods evaluation. *International Journal of Child and Family Welfare, 1*, 19–36.

Harper, N. J., Russell, K. C., Cooley, R., & Cupples, J. (2007). Catherine Freer wilderness therapy expeditions: An exploratory case study of adolescent wilderness therapy, family functioning, and the maintenance of change. *Child & Youth Care Forum, 36*(2–3), 111–129. doi:10.1007/s10566-007-9035-1.

Jones, C. D., Lowe, L. A., & Risler, E. A. (2004). The effectiveness of wilderness adventure therapy programs for young people involved in the juvenile justice system. *Residential Treatment for Children and Youth, 22*(2), 53–67.

Kieling, C., Baker-Henningham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., et al. (2011). Child and adolescent mental health worldwide: Evidence for action. *The Lancet, 378*(9801), 1515–1525.

Lambie, I., Hickling, L., Seymour, F., Simmonds, L., Robson, M., & Houlahan, C. (2000). Using wilderness therapy in treating adolescent sexual offenders. *The Journal of Sexual Aggression, 5*(2), 99–117. doi:10.1080/13552600008413302.

Leichtman, M., Leichtman, M. L., Barber, C. C., & Neese, D. T. (2001). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry, 71*(2), 227. doi:10.1037/0002-9432.71.2.227.

Lewis, S. F. (2013). Examining changes in substance use and conduct problems among treatment-seeking adolescents. *Child and Adolescent Mental Health, 18*(1), 33–38. doi:10.1111/j.1475-3588.2012.00657.x.

Magle-Haberek, N., Tucker, A., & Gass, M. (2012). The effects of program differences within wilderness therapy and residential treatment center (RTC) programs. *Residential Treatment for Children and Youth, 29*(3), 202–218. doi:10.1080/0886571X.2012.697433.

Marion, J. L., & Reid, S. E. (2007). Minimising visitor impacts to protected areas: The efficacy of low impact education programmes. *Journal of Sustainable Tourism, 15*(1), 5–27. doi:10.2167/jost593.0.

McLeod, J. (2010). The role of case studies in the development of theory and practice in counselling and psychotherapy. In Mc. Leods. Case (Ed.), *Study research: In counselling and psychotherapy* (pp. 1–15). London: SAGE Publications Ltd.

Minuchin, S. (1998). Where is the family in narrative family therapy? *Journal of Marital and Family Therapy, 24*(4), 397–403.

National Building Bridges Initiative (2007). Innovative Practices for Transformation. Workgroup webinar. March.

Norton, C. L. (2008). Understanding the impact of wilderness therapy on adolescent depression and psychosocial development. *Illinois Child Welfare, 4*(1), 166–178.

Norton, C. L. (2010a). Exploring the process of a therapeutic wilderness experience: Key therapeutic components in the treatment of adolescent depression and psychosocial development. *Journal of Therapeutic School and Program, 4*(1), 24–46.

Norton, C. L. (2010b). Into the wilderness—A case study: The psychodynamics of adolescent depression and the need for a holistic intervention. *Clinical Social Work Journal, 38*(2), 226–235. doi:10.1007/s10615-009-0205-5.

O'Connell, M. E., Boat, T., & Warner, K. E. (Eds.). (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington DC: National Academies Press.

O'Connor, T. S. J., Davis, A., Meakes, E., Pickering, R., & Schuman, M. (2004). Narrative therapy using a reflecting team: An ethnographic study of therapists' experiences. *Contemporary Family Therapy, 26*(1), 23–39.

O'Connor, T. S. J., Meakes, E., Pickering, M. R., & Schuman, M. (1997). On the right track: Client experience of narrative therapy. *Contemporary Family Therapy, 19*(4), 479–495.

Outdoor Behavioral Healthcare Council (OBHC, 2015). About us. Retrieved from https://obhcouncil.com/about/standards/.

Riordan, R. J. (1996). Scriptotherapy: Therapeutic writing as a counseling adjunct. *Journal of Counseling and Development, 74*(3), 263–269.

Russell, K. C. (2003). Assessing treatment outcomes in outdoor behavioral healthcare using the Youth Outcome Questionnaire. *Child & Youth Care Forum, 32*, 355–381. doi:10.1023/B:CCAR.0000004507.12946.7e.

Russell, K. C. (2005a). Preliminary results of a study examining the effects of outdoor behavioral healthcare treatment on levels of depression and substance use frequency. *Journal of Experiential Education, 27*, 305–307.

Russell, K. C. (2005b). Two years later: A qualitative assessment of youth-well-being and the role of aftercare in outdoor behavioral healthcare treatment. *Child & Youth Care Forum, 34*, 209–239. doi:10.1007/s10566-005-3470-7.

Russell, K. C. (2006). Evaluating the effects of the Wendigo Lake Expedition Program on young offenders. *YouthViolence and Juvenile Justice, 4*(2), 185–203.

Russell, K. C. (2008). Adolescent substance-use treatment: Service delivery, research on effectiveness, and emerging treatment alternatives. *Journal of Groups in Addiction and Recovery, 2*(2–4), 68–96. doi:10.1080/15560350802081264.

Russell, K. C., & Farnum, J. (2004). A concurrent model of the wilderness therapy process. *Journal of Adventure Education and Outdoor Learning, 4*, 39–55. doi:10.1080/14729670485200411.

Russell, K. C., & Gillis, H. L. (2010). Experiential therapy in the mental health treatment of adolescents. *Journal of Therapeutic Schools and Programs*, *4*(1), 47–79.

Russell, K. C., Gillis, H. L., & Lewis, T. G. (2008). A five-year follow-up of a survey of North American outdoor behavioral healthcare programs. *Journal of Experiential Education, 31*(1), 55–77. doi:10.1177/105382590803100106.

Russell, K., & Hendee, J. (2000). *Definition, common practice, expected outcomes, and a nationwide survey of programs (Technical Report 26)*. Moscow ID: University of Idaho.

Russell, K. C., & Sibthorp, J. (2004). Hierarchical linear modeling of treatment outcomes in outdoor behavioral healthcare. *Journal of Experiential Education, 27*, 176–191.

Safran, J. D., Muran, J. C., & Proskurov, B. (2009). Alliance, negotiation, and rupture resolution. In R. Levy & S. J. Ablon (Eds.), *Handbook of evidence based psychodynamic psychotherapy* (pp. 201–205). New York: Humana Press.

Stage, S. A. (1998). Predicting adolescents' discharge status following residential treatment. *Residential Treatment for Children and Youth, 16*(3), 37–56. doi:10.1300/J007v16n03_03.

Substance Abuse and Mental Health Services Administration. (2012). *National survey on drug use and health: Mental health findings*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Telep, T. (2014). The man who takes troubled youths to therapy camp. *BBC News Magazine*. Jan 1, 2015. Retrieved from http://www.bbc.com/news/magazine-26513805.

Tubman, J. G., Montgomery, M. J., & Wagner, E. F. (2001). Letter writing as a tool to increase client motivation to change: Application to an inpatient crisis unit. *Journal of Mental Health Counseling, 23*(4), 295–311.

Tucker, A., Smith, A., & Gass, M. (2014). The impact of presenting problems and individual client characteristics on treatment outcomes in residential and wilderness treatment programs. *Residential Treatment for Children and Youth, 31*(2), 135–153.

Tucker, A. R., Zelov, R., & Young, M. (2011). Four years along: Emerging traits of programs in the NATSAP Practice Research Network (PRN). *Journal of Therapeutic Schools and Programs, 5*(1), 10–28.

Walsh, V., & Golins, G. (1976). *The exploration of the Outward Bound process*. Denver, CO: Outward Bound School.

White, M. (1989). *Select papers*. Adelaide: Dulwich Centre Publications.

Who Do We Serve? (2015). The wilderness advisor, *1*, 7–8.

White, N. W. (2011). *Stories from the elders: Chronicles and narratives of the early years of wilderness therapy*. Franklin Pierce University.

Wright, A. (1983). Therapeutic potential of the outward bound process: An evaluation of a treatment program for juvenile delinquents. *Therapeutic Recreation Journal, 17*(2), 33–42.

Zelov, R., Tucker, A. R., & Javorksi, S. (2013). A new phase for the NATSAP PRN: Post-discharge reporting and transition to the network wide utilization of the Y-OQ 2.0. *Journal of Therapeutic Schools and Programs, 6*(1), 7–19.