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Jonathan Dukes
The management of transference and
counter transference in the
Wilderness Therapy milieu

ABSTRACT

This qualitative study set out to explore the ways in which clinicians in Wilderness Therapy (WT) manage and address the clinical phenomena of transference and counter transference as it arises in the field. Additionally, the topics of personal and professional boundaries were explored in order to help assess ways clinicians maintain appropriate boundaries and educate their para professional staff about this topic. Seven clinicians from various WT programs across the country participated in a thirty to forty minute long interview via telephone. Throughout the interview process, valuable information was gained pertaining to the process of transference and counter transference within the clinical encounter.

The major finding from this research shows that transference plays a key role within the clinical dialogue and practice of each participant. Clinicians reported using a multitude of resources to help address the transference relationship with clients. One of the most commonly referred to resources were the natural surroundings inherent in Wilderness Therapy. Further, it was noted that the majority of participants reported how transference arises more quickly during WT, when compared to traditional front country models. The findings from this research are intended to contribute to the ongoing discourse about the clinical aspects of Wilderness Therapy.

**THE MANAGEMENT OF TRANSFERENCE AND COUNTER TRANSFERENCE IN
THE WILDERNESS THERAPY MILIEU**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2012

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CHAPTER I

Introduction

Teen risk factors have continued to increase rapidly over the last 25 years (Behrens, E., Santa, J., & Gass, M. 2010). According to the Children's Defense Fund each day in this country, 5 youth commit suicide, 186 youth are arrested for violent crimes, 368 youth are arrested for drug charges, a total of 4,133 youth are arrested, 3,312 drop out of school, 18,493 public school students are suspended, and 2,058 youth are confirmed as abused or neglected (Children's Defense Fund Research Library, 2011). Additionally, there is currently an historically high rate of children being diagnosed with behavior, attention, mood, anxiety and substance disorders (Substance Abuse and Mental Health Service Administration, 2006). These statistics only begin to show some of the many risk factors experienced by today's youth. Though traditional counseling approaches have long been available to address teen risk factors, based on the uniqueness of some of these risk factors, there is a recognized need for alternative approaches to the traditional clinical interventions of individual therapy or residential care. One of the alternative modalities that take place outside of the traditional therapist's office or the confines of residential programs in Wilderness Therapy (WT). Within this last quarter of a century, Wilderness Therapy (WT) has become a more popular treatment alternative for many teens struggling with behavioral, emotional, and mental health issues (Russell, 2003; Bettmann, Demong, & Jaspersen, 2008; Becker, 2010). Its popularity stems from the fact that it provides outside activities in which referred youth are taught to work through identified issues while

engaging in wilderness expeditions (Russell, 2003). Along the way, staff, including both clinical staff and paraprofessional staff, offer counseling, support, guidance, and mentorship. WT is based heavily on inter-personal relationships between youth and staff, fostering a bond of mutual respect and trust (Russell & Phillips-Miller, 2002).

Though WT still lacks a common definition accepted by all practitioners in the field, Dr. Keith Russell of the Outdoor Behavioral Health Industry Council (OBHIC) defines Wilderness Therapy using the following criteria: the program is therapeutically based, each student has an individualized treatment plan (Davis-Berman & Berman, 1994), there is use of outdoor adventure to assist in interpersonal growth (Kimball & Bacon, 1993), the outdoor component is directed by skilled and trained individuals, and all individual and groups psychotherapy is implemented by qualified professionals (Russell, 2001). For the purpose of this research, this is the definition that will be used when referring to WT.

Additionally the Outdoor Behavioral Health Industry Council provides the WT industry with much of the current empirical data (Becker, 2010) backing the modalities effectiveness.

A review of current WT literature about managing transference and counter transference resulted in very little information. More literature was available proving WT efficacy through outcome studies, but lack an understanding of why this was true. Three articles were identified that addressed transference and counter transference in Wilderness Therapy/Adventure Therapy. Though dated, the authors Jerry Marx (1988), Simon Crisp & Matthew O'Donnell (1998), and Bryant Williams (2000) emphasize the importance of using WT as an intervention for struggling teens and discuss issues of transference while working with teens who attended wilderness programs. In fact, these authors offer that transference plays an important core role in WT's efficacy. It is WT's untraditional setting that allows for the clinical concept of transference to

occur at a faster pace. This constant contact between field staff and client allows for the relationship building process to progress more quickly, therefore hastening the therapeutic process. Teens are wary of adults, especially adult clinicians, and WT allows for adults to experience the process with these teens 24 hours a day, seven days a week. This creates an alliance that is difficult, even impossible, to mimic in any other type of setting. As emphasized by previous researchers, addressing the transference relationship in wilderness therapy is crucial to understanding its efficacy.

Because there appears to be little actual literature about transference and counter transference within WT programs, this study will certainly fill that gap. As noted by Bryant Williams (2000) transference is recognized to arise more rapidly in WT and therefore becomes a fundamental component in the therapeutic process. This research may help these programs to recognize the need to address and manage the transference process within their WT programs.

This is not only a concern with regard to WT as a legitimate clinical intervention, but about the role social workers play in the field. Social workers and other master's level therapists make up a majority of the clinical staff that implement treatment in WT programs. This research is beneficial to social workers because it offers a greater understanding regarding the transference process and will empower them to provide a greater level of care.

This study will look at how transference and counter-transference is addressed in the milieu of wilderness therapy. Many, if not all clinicians believe the relationship between transference and counter-transference in any therapeutic encounter is at the core of the therapeutic process. If this is true, how do WT programs use this to benefit their clinicians and how do the clinicians train the field staff to be aware of this phenomenon?

It is vital to know how clinical and non-clinical staff address and manage transference and counter-transference while in the field. As WT continues to grow as a treatment alternative, there is still a lack in research explaining the efficacy of WT.

CHAPTER II

Literature Review

The following literature review investigates the research, writings, and understanding surrounding the modality of Wilderness Therapy (WT) and the clinical understanding of transference and counter transference. The intention is to assess how transference and counter transference are managed in the relatively new field of WT. Included in this review is an examination of much of the literature written about Wilderness Therapy to date. Because there is literature about the clinical aspects of WT this study will help expand on the knowledge of this modality. The literature review will help to define how WT functions as a modality. The review will also explore the efficacy of WT as a course of treatment for struggling teens. Simultaneously, this literature review will analyze the clinical idea of transference/counter transference with a critical look at its importance and inevitably in any clinical encounter. This review will focus special attention on the ways in which teenagers experience transference and counter transference during participation in treatment.

Because WT is a relatively modern alternative to traditional intervention, there isn't a standard definition of "Wilderness Therapy", utilized by all individuals in the field. The first section of the literature review will examine the various definitions used by practitioners and academics in the field. Establishing a standard definition will increase the legitimacy of WT. Additionally, the first section of the literature review will include a detailed background of WT

and the therapeutic benefits and clinical aspects associated with WT as an intervention. Finally, there will be an exploration of the purported therapeutic benefits of WT.

The second section of the literature review is focused on the clinical aspect of the psychodynamic theory of transference and counter transference, beginning with an in depth analysis of what transference/counter transference is and how psychodynamic clinicians define this phenomena. Next, there will be an assessment of the importance and inevitability of transference and counter transference in the therapeutic encounter. Finally, the literature review will examine transference as it pertains to at-risk adolescents participating in group-type therapy and the ways in which both clinical staffers and para-professional field staffers address and manage these difficulties.

The third section of the review focuses on how transference is managed in the WT milieu, how clinical staff and field staff are trained on this ever-occurring clinical occurrence and how boundaries are put into place and maintained when working with identified patients daily in the same conditions as the adolescent participant. Finally, the training, education, and credentials of clinical and para-professional staff will be examined.

The end of the literature review presents authors who believe it is the transference relationship between WT staffers and their adolescent clients that resides at the core of WT efficacy. WT allows for defenses to be dismantled quickly and transference to show up rapidly, in turn, allowing for WT staff to use this transference to help build the therapeutic relationship with teenage patients. Some authors posit that it is precisely this hastened transference process that makes WT such an effective intervention for struggling teens with emotional, behavioral, and psychiatric difficulties.

Wilderness Therapy

Countless individuals have acknowledged the therapeutic value of wilderness therapy time and time again as a positive intervention for “at-risk” adolescents (Marx, 1988; Davis-Berman & Berman, 1994; Russell & Phillips-Miller 2002). Historically, the wilderness experience has always been viewed by various cultures throughout the world as a way to seek refuge from the chaos of daily life. It was not until the turn of the 20th century that wilderness as an intervention was first used in European-American societies with the use of “tent therapy”. Tent therapy was implemented by hospitals as a way to get patients out of the hospital and into the natural environment to help facilitate the healing process through a camping experience (Berman & Davis-Berman, 1994). In 1930, Kurt Hahn, a progressive German educator, developed a program in Scotland that offered a curriculum that valued character development and physical skills as important as academic achievement. This program expanded during World War II out of the need for British seamen to learn vital outdoor survival skills (www.outwardbound.net). One of Hahn’s students, Josh Miner, was inspired by Hahn’s philosophy and teaching model and in 1961, Outward Bound was established in the U.S. with the program goals to include “real and powerful experiences to gain self-esteem, the discovery of innate abilities, and a sense of responsibility toward others” (www.outwardbound.org). From Outward Bound came the National Outdoor Leadership School (more commonly know as NOLS), which was developed by Paul Petzold, an outdoor educator, who stressed the importance of technical skills rather than personal development. However, it was not until the late 1960’s that programs started to offer therapeutic support with goal-oriented outcomes within a wilderness context. At Brigham Young University in Provo, Utah, a program was initially developed to provide services for freshman at the university who were having academic

difficulties and in jeopardy of failing. These struggling students were taken into the desert where they were dropped off for duration of 26 day with support from various staff. Interest continued to grow and more programs were developed that focused on therapeutic intervention within a wilderness setting such as Aspen Achievement Academy and Anasazi Foundation, both of which are still in operation today (Russell & Hendee, 2000; Swaim, 2003). Outward Bound remains at the forefront of wilderness programs and continues to use natural settings, supportive groups, and experiential learning to create positive outcomes (Outwardbound.org). However, they do not provide any WT programming. Outward Bound has the Intercept Program, which is for struggling teens, but it provides no licensed clinical treatment. Outward Bound's programming for pre-adjudicated and adjudicated youth has shrunk to two base camps in Florida, providing service to teens only in the state (personal communication, March 13, 2012).

Since “tent therapy”, the idea of Wilderness Therapy (WT) has become quite popular as an alternative treatment modality for “at-risk” youth because it is a paradigm shift from traditional residential programs used for teens (Russell, 2003). Wilderness therapy is just one of the many terms used to describe this treatment modality. Other such terms include Adventure Programming, Adventure Therapy, Adventure Based Therapy, Adventure Based Counseling, and Outdoor Behavioral Health (Russell & Phillips-Miller, 2002; Swaim, 2003). At no point are ‘boot camp’ style programs included in this category, although they frequently erroneously associated with WT (Russell, 2003, p. 323). Boot camps follow a disciplined military approach that is geared towards “breaking the adolescents down before building them back up” (Russell, 2003) or “reshaping the student” (Krakour, 1995). This boot camp intervention is viewed as “inappropriate and unorthodox” when working with teenagers and has been shown to be generally ineffective for teenage populations (Russell, 2001). Michael Gass, (1993), a leading

researcher and professor at the University of New Hampshire, writes that there are only three specific types of outdoor therapeutic programs: Adventure Based Therapy (ABT), Wilderness Therapy (WT), and Long Term Residential Camping (LTRC) all three of which use the best practice model. However, as WT has become more popular, there still lacks a clear operational definition that is agreed upon by all professionals in the field (Russell, Hendee, & Phillips-Miller, 1999; Tucker & Rheingold, 2010).

There is no clearly identified field within academia that solely contributes to the understanding of WT because of its interdisciplinary nature. Additionally, there is no coherent and professional organization working to positively and adequately contribute to the development of WT as a whole (Itin, 2001). Throughout the literature review, commonly addressed topics include a need for meticulous and in depth research (Davis-Berman & Berman, 1994; Newes, 2001) as well as the need for accreditations criteria and professional standards. The research that exists is not specific in identifying how problems are assessed in WT or how clinical interventions are focused in order to provide positive outcomes for struggling teens (Russell, 2001)

Kimball and Bacon define WT as having four components that contribute to the efficacy of the modality: 1) the group process, 2) being in the wilderness where challenges are continually presenting themselves, 3) the use of therapeutic techniques to implement structured interventions that are specific for each individual participant, 4) involvement in the program for extended periods of time (Norton, 2010). Another definition from Davis-Berman & Berman defines WT as having five components: 1) a specific selection process to identify appropriate participants, 2) individualized treatment plans, 3) outdoor endeavors facilitated by a skilled and educated leader, 4) intervention focused on changing negative behaviors in students, & 5)

psychotherapy provided by “qualified professionals” that also monitors participant growth (Davis-Berman & Berman, 1994). Both of these definitions are vague about what defines ‘wilderness’ and what defines the experience and neither of these definitions require licensed clinicians. Keith Russell incorporates and elaborates on both of these definitions and draws from additional definitions to come up with: 1) therapeutically oriented and aimed at evaluation and assessing outcomes, 2) individualized treatment plans for each participants, 3) WT employs the out-of-doors to assist in personal growth, 4) all services are provided by skilled instructors and psychotherapists who provide help with clearly identified problem behaviors while providing continuous evaluations throughout the process and establishing after care plans (Russell, 2001; Russel & Phillips-Miller, 2002). For the purpose of this paper Russell’s definitions most accurately describe the parameters and scope of this treatment modality.

Even though the “wilderness” makes up a large component of the definition and nature’s importance is acknowledged, there is limited theoretical understanding of what the effects are of just “being in nature”. Empirical data is now starting to show the true healing powers that just “being in nature” holds (Beringer, 2004). Just as therapeutic interventions are planned and executed when working in front country treatment programs, significant time and energy must be put into finding the right wilderness experience for the each individual student. For example, some students might benefit less from a remote wilderness trip and instead would thrive in the “wilderness” of city parks and non-remote wilderness areas. These outdoor settings, a more loosely defined “wilderness”, can hold the same innate healing powers that a more remote setting does (Beringer, 2004). Studies have been compiled in which students, following their WT trip, reported that just being in nature was a crucial aspect to their recovery (Norton, 2010). Some theorists put much of the value on just “being in nature” while others believe that this alone is

not enough the help create therapeutic change and that nature is only one component of the holistic value of WT.

In discussing WT, there needs to be a division between Wilderness Therapy and Wilderness Experience Programs (WEP). WEP does not focus on therapeutic models (Davis-Berman & Berman, 1994; Russell, 2001; Russell, 2003; Bettmann, Demong, & Jaspersen, 2008; Becker, 2010) and does not use these four components of WT as defined by Russell (Russell, 2001; Russell, 2003). Some believe that wilderness itself does not create the therapy, but rather, it is the collaboration between group members, clinical staff, and the student's prolonged stay. The definition of WT continues to evolve and WT is working towards becoming viewed as a legitimate intervention for teens and young adults. By establishing industry standards such as a universal definition and focusing on the clinical requirements, WT can become viewed as a beneficial and legitimate alternative to more traditional therapeutic models (Becker, 2010).

Finding a universal definition that is accepted by all parties involved in the WT industry including traditional mental health providers is just the beginning (Russell, 2001; Russell 2003; Becker, 2010). Just as there are gaps in the definition, there are also holes and discrepancies in the research supporting why WT works (Becker, 2010). The idea of WT is relatively new, having only been around for the last few decades. There are multiple studies showing the positive and lasting effects of WT for adolescents who participate in WT programs, either voluntarily or by mandate. Keith Russell is the founder of the Outdoor Behavioral Health Research Center (OBHRC), which is an organization started in 1999 that is committed to providing the highest quality research in the field of WT (www.OBHRC.org). Russell completed a longitudinal repeated measures study looking at admission, discharge, and 12-month follow up data of students who had participated in a WT program showing its effectiveness with

this population. What the study found was that families and adolescents both reported a significant reduction in behavioral and emotional problems following treatment all the way through the 12-month follow up (Becker, 2010).

There is a lack of understanding about the theoretical aspect of the varied programs (Itin, 2001; Becker, 2010). A study done by Russell and colleagues (1999) found that the theoretical foundation of WT contains wilderness experience that is clinically based, and there is use of eclectic models grounded in a family systems approach (Russell, K. Hendee, J., & Phillipss-Miller, D., 1999). Psychodynamics has also been identified as a theoretical model used which is acutely aware of psychosocial, relational, and developmental needs of each individual teen participant (Norton, 2010). The group process in therapy solidifies quicker due to the development of a microcosm as explained by Dr. Irvin Yalom. Yalom (1995) explains, a microcosm occurs “When the group is so conducted that the members behave in an unguarded, un-self conscious manner, they will most vividly recreate & display pathologies” (p. 39). The development and maintenance of this microcosm is fundamental to the group working effectively (Williams, 2000). In WT, members of the group become responsible for different chores or tasks that they must complete in order for the group to succeed. These tasks range from hiking as a group, to carrying group gear in their backpacks, to helping to prepare and clean up dinner -- some of the daily tasks that must be completed in WT treatment. It is because of this prolonged exposure together that allows for this microcosm to form faster than in traditional in-patient settings. Groups suffer when individual’s action works against the group’s desired outcome. This relationship allows for the immediate addressing of individual’s actions and behaviors by the members of the group (Williams, 2000). WT relies on the fact that groups need to work together with one another in order to progress forward both literally and psychologically. Bruce

Tuckman labeled the different phases of group development as forming, storming, norming and performing. Later he added adjourning as the final phase of group development. Because teens are in the concrete developmental phase, it helps for them to physically see the consequences of their action. If group dynamics break down, WT has the time and space to sit and process the circumstance as long as needed. In this situation, underlying issues can therefore be immediately addressed so that both the individual and the group can function effectively.

There is no shortage of outcome research validating WT effectiveness as an intervention (Russell 2005; Hoag & Massey, 2011; Aspen Achievement Academy Outcome Study), additionally many WT programs post their own research through the use of the Youth Outcome Questionnaire (YOQ) on their websites. Upon surveying Outdoor Behavioral Health (OBH) Care Programs, Russell, Gillis & Lewis (2008) found that of the 63 participating programs, 95% reported either currently conducting outcome evaluations or having done so in the past. However, there is a limited amount written about what makes WT work, why it works, or how it becomes an effective intervention (Williams, 2000). It is estimated that 20,000 clients participate in OBH programs every year, even though there still remains little empirical evidence supporting its effectiveness (Russell et al. 2008).

WT mimics adolescents in the sense that they are “both intense physically and emotionally and therefore leading to unpredictability” (Marx, 1988, p.1). It is in this chaotic and unpredictable wilderness setting where teens learn important lessons such as how to find some control within the chaos of their lives. Some teens are too often not given the skills they need to succeed in the world in which they live. WT allows for these teens to learn life skills and independence through the mastery of experiential learning. In the wilderness one needs to be prepared in order to cope with the harshness of Mother Nature. Because of where teenagers are

developmentally, the importance of establishing a cause and effect relationship in concrete operations is vital. Concrete operations that occur within WT allow for adolescents to easily understand and participate in this type of treatment (Williams, 2000) in contrast to a more traditional talk therapy that may revolve around abstract ideas. According to Marx, many young adults in treatment are there because they have had dysfunctional relationships with adults and therefore are skeptical of adult caregivers and treatment providers (Marx, 1988). Additionally teens view adults in authoritative roles and therefore could be skeptical of a trusting relationship with an adult. Through trained and empathic clinical and field staff, WT can act as a corrective experience for adolescence helping them to build trust with adults and to develop self-reliance and autonomy that can prevent future mental health issues (Crisp & O'Donnell, 1998). At-risk teens are a vulnerable population and this makes working with them demanding for any treatment provider (Bettmann & Jaspersen, 2009).

Many of the programs operating today are private for profit companies as in contrast to state funded organizations that provide service to adjudicated youth. Russell's 2003 nation wide survey OBHP found that of the 86 programs volunteering for the study, 80% were private placement and just 18% were adjudicated programs. Half of the respondents from this study are traditional WT programs that spend the majority of their time on trail in the wilderness (Russell, 2003); the other half only use the wilderness as a small component to the their overall curriculum. Additionally, Russell found that only 3% of respondents have been in operation since 1960, 25% started by 1970- 56% have been operating since 1980. Over 26% began operation within the last decade. Of the nineteen programs that began since 1990, sixteen are private placement, making only three adjudicated (Russell, 2003).

76% of the teenage clients participating in private WT programs have received prior mental health treatment, compared to the adjudicated systems where only 26% of participants have received prior mental health treatment before entering into a wilderness program (Russell, 2003).

Some authors suggest that WT therapy is often the pre-cursor to longer-term treatment. Russell (2005) found that 85 percent of students would take part in some form of longer-term treatment as part of the continuum of care post WT experience. Russell (2001) found that benefits from WT have long-lasting effects even if the teen does not transfer into longer-term treatment. Though, it is understood that the positive attributes gained from a WT intervention might be short lived if there is no continuum of care (Norton, 2010).

Wilderness Therapy Staff

New research shows that the intensity of the WT experience is not only felt by the participants, but also felt by the adult staff members as well. According to Lawrence-Wood and Raymond who studied WT staff (N=62) following their 8-day wilderness course with “at-risk” youth (2011), staff members returning from the course experienced a period of adjustment with both negative and positive symptoms. There was a small number of the staff that labeled the course as a minor “traumatic event” for themselves with symptoms including feelings of sadness, sleep disruption, and self reflective rumination (Lawrence-Wood & Raymond, 2011). Another group reported having difficulty sharing and normalizing their experience with friends and loved ones. More follow-up research is still needed to address the intensity of the adult leader symptoms, how long symptoms persist post-course, and other factors that contribute to symptoms (Lawrence-Wood & Raymond, 2011). Additionally, a study by Marchand (2008) shows that field instructors are affected more by the challenges of their work once their course is

completed, often causing turmoil with interpersonal relationships. It is known that therapists have often experienced difficulty working with troubled or “at-risk” populations due to counter transference and vicarious trauma (Marchand, 2008). According to Marchand, there appears to be the same correlation with regard to field staff working in WT. In Marchand’s study, 45% of the field staff she interviewed had been working in WT for less than five months. In their study of OBH programs, (n=65) Russell et al. (2008) found that the mode (the value found most frequently) of field instructor’s time spent working was seven months, while half of their studied field instructors had been working less than five months. Only twelve percent had worked for 24 to 48 months with their organization (Russell et al., 2008). Marchand’s (2008) research showed, through the use of the Field Instructor Survey, that field staff encountered three main challenges: 1) time and schedule requirements; 2) difficulties connected to anxiety; 3) physical and emotional difficulties. Statistics show that it is a 6:1 ratio of field staff to clinical staff (Becker, 2010). The concern here is that many of the teenage clients are receiving much of their face time with paraprofessional staff that have not been working in the field that long and are responsible for implementing treatment when the clinician is not around.

Priest and Gass described that when outdoor educators, including WT staff, experience push back/resistance from group participants, leaders must be aware of these nuanced behaviors and have the ability to process with the individual/group as these feelings arise. Sometimes, in the chaotic experience of the wilderness, if leaders lack self-awareness, they could possibly miss the latent content participants are trying to impart upon instructors. Through sound theoretical training and clinical input will leaders gain more self-awareness that can help them to be more in tune with their group (Thomas, 2010).

Gass and Gillis (2010) explain how supervision is the keystone to any mental health provider's practice so as to ensure they are providing the highest level of care. These authors, however, go on to explain that just as WT is an alternative to traditional talk therapy, there also needs to be an alternative for clinical supervision for those working in the field of WT. The supervision needs to be experiential just as the treatment is experiential (Gass & Gillis, 2010). Alvarez & Stauffer (2001) also address the importance of clinical supervision for any clinician providing therapy. The authors address how often in the WT setting, it is possible for a therapist to get "mixed-up" in the client's situation and therefore needs to rely on clinical supervision as a tool in order to maintain boundaries and professionalism. Additionally, clinicians need appropriate training in WT in order to appropriately construct interventions that work for these types of settings (Alvarez & Stauffer, 2001). No studies have been compiled looking at the specific supervision provided to clinical staff working in WT (Becker, 2010).

The majority of outdoor leaders, industry wide, are well educated. According to one study 97% of leaders hold some type of college degree with 53% of that group holding a Master's degree or higher (Mitten, 2007). This research was representative of other studies that have been completed that also looked at the education level of outdoor leaders. This study was looking at outdoor leaders as a whole and was not specifically focused on WT staff. Although some of their research participants were recruited through list serves that are associated with WT, there was no differentiation between therapeutic leaders and those from non-therapeutic programs. This research goes on to elaborate on the fact that because such a high percentage of outdoor leaders have received higher education, this helps in developing an analytical and ethical framework associated with this line of work. This research identified that graduate education

helps with moral development as well as critical and analytical skills that aid them to clearly address many dilemmas that might arise in the field (Mitten, 2007).

Transference and Counter Transference

Very little research has addressed the transference relationships that occur in the WT milieu and how it is managed. Transference is defined by Joan Berzoff, as thoughts and feeling that are based in previous relationships and emotions with other individuals. Counter transference is the therapist's own thoughts and feelings towards clients that are based on their own past experiences (Berzoff, Melano Flanagan, L., & Hertz, P., 2008). It is as though someone is actually "transferring" their feeling and emotions onto someone else. In any therapeutic dyad or group, past experiences are being enacted upon by both the client and the clinician. This unconscious transference of emotions to other people is inevitable and complex because of everyone's own personal identities. Each individual has their own experiences that are viewed through their own personal lens that have been shaped by past experiences that were both positive and negative in nature. Because of this transference, it is extremely difficult for clients to accurately perceive the therapist without a distorted perception (Yalom, 1995). Transference does not only occur in a therapeutic dyad but is played out in all interpersonal relationships. Transference, however, becomes more volatile and elicits different responses in a therapeutic setting than it does non-therapeutic relationships (Shedler, 2006). Although all schools of analytic thought have their own vernacular and understanding to what transference and counter transference is, each one finds value in the transference relationship (Mitchell & Black, 1995).

Psychodynamics, a Freudian based theory, relies heavily on the conscious and subconscious interactions occurring in therapy. Many therapists are acutely aware of what is

being said as well as not said in sessions. Identifying the latent content that is occurring in a session is a major obstacle that any clinician will need to wrestle with. Sigmund Freud, the originator of psychodynamics, originally believed that transference must be avoided. After becoming aware of transferences inevitability, Freud realized the transference relationship was a crucial aspect to psychoanalysis (Berzoff et al. 2008). Freud observed that transference should not be a stumbling block, but rather the catalyst for change within treatment (Mitchell & Black, 1995). It is understood now that avoiding or ignoring these transference feelings obstructs the therapeutic processes. It is through this awareness, understanding and acknowledgement of transference that the true clinical work can begin (Berzoff et al. 2008). By accepting transference as being a vehicle for change, there also needs to be the awareness that if transference is not addressed or avoided, the clinical encounter will be therefore be encumbered (Yalom, 1995). It is imperative also that staffs and clinicians educate their clients about transference so as to normalize the upcoming thoughts/feelings as they arise in the clinical process. If patients are unaware of this process or are flooded by the shame of these thoughts, feeling, and behaviors, they might feel uncomfortable or scared to share these feeling openly (McWilliams, 2004).

Clinicians need to be constantly aware of the occurrence of transference and counter transference in order to accept their client's projections and help the client to then become aware of the unconscious enactments. It is through this deeper examination of this transference that the therapeutic alliance can progress. When clinicians work in an overly structured and regimented manner, they may be using this as a defense against their own anxieties that come up while working with patients (McWilliams, 2004). It is imperative that the clinicians not only examine their patient, but also explore the extent of their own "emotional burden" (Winnicott, 1949, p. 2)

they take on through their clinical relationships. The power in the therapeutic process lies within the clinician's ability to create a corrective experience that differs from the patient's past objects of attachment. The therapist must demonstrate their ability to hold previous patterns and behaviors as they are transferred onto the therapeutic dyad (McWilliams, 2004). D.W. Winnicott (1949) believes a therapist's responsibility becomes overburdened if they are unable to understand their own conscious "hate" towards those they work with. Regardless of how much the therapist enjoys working with any client, it is impossible not to hold resentment and hatred towards them at times. The more aware of these fears the clinician is, the more capable they become in implementing effective and sincere treatment (Winnicott, 1949). This hatred happens because of all the raw emotions that are being placed onto them by the patient. It is here that it becomes imperative for the therapist to be aware of this burdensome requirement prior to entering into a therapeutic relationship in order to address all the feelings that may arise throughout the therapeutic process (Winnicott, 1949). Clinicians must be able to be objective when working with clients and therefore this hatred must be objective and latent (Winnicott, 1949). It is the clinician's own work and analysis that helps to enable them to deal with their own counter transference (Winnicott, 1949). Winnicott (1949) understood that individuals could not tolerate the clinician's "love" until they first accepted their "hatred" (McWilliams, 2004) within the therapeutic relationship.

Irvin Yalom (1995) believes that transference is an "interpersonal perceptual distortion". Further Yalom addresses how these interpersonal distortions are amplified when working in a group setting. It is in these group settings that therapists are no longer able to just address the therapist-client relationship, but need to nurture the evolution of the group by focusing on the

interactions of the groups members (Yalom, 1995). Yalom (1995) has three basic principles about transference:

1. Analysis of transference is the major therapeutic task of the therapist.
2. The development of transference is crucial and it is vital that the therapist establish its development.
3. The most important type of interpretation the therapist can make is one that clarifies some aspect of transference (Yalom, 1995).

When adolescents are working through the developmental progression between economic and emotional independence, much anxiety and frustration within the teen is created. It is at this point of development that these teens start to look beyond just their familial groupings to larger social and peer groupings for support and comfort. Teens need to connect with a social group because it plays a large part in their physiological maturation (Crisp & O'Donell, 1998). Difficulty arises with teens when they have to support the delicate balance of their own identity and that of their family to now include larger social groups as they transition to adulthood (Crisp & O'Donell, 1998).

The uniqueness of transferential relationships in WT

The literature shows very clearly that any effective clinical encounter relies heavily on the understanding and acceptance of transference and counter transference. Empirical data substantiates that most therapists are aware of the nuances of transference and use those feeling to help propel treatment forward (Shedler, 2006). Additionally, just as transference is important to the clinician, educating their patients on transference is essential in helping the therapeutic process progress (McWilliams, 2004). Psychotherapy is laden with ethical and moral dilemmas and there is no situation more representative of these dilemmas than transferential relations. Just

as a psychotherapist needs to be conscious of these quagmires while providing treatment in the comfortable confines of the office, it needs to be understood that these same ethical concerns will arise on trail in WT (Becker, 2010).

It is assumed that many of these adolescents react emotionally and behaviorally from their unconscious minds. Their feelings and reactions towards the therapist, field staff and other teen participants all occur due to transference (Crisp & O'Donell, 1998). As therapist and field staffers interact with teenage clients, their own counter transference will arise (Crisp & O'Donell, 1998). Many individuals in any therapeutic setting view the therapist as the authority figure and base their expectations on previous interaction with authority. Nancy McWilliams (2004) states "We generalize from past experiences" (p.73) when interacting in the present. As patients view therapist as authoritative and powerful, it can create an inaccurate perception that the therapist has never had any life difficulties or struggles (McWilliams, 2004). However, in WT, patients and staff are together constantly thus allowing for the participant to view the therapist in a more realistic light. Just as the teenage patient struggles to hike or cope with the environmental conditions so does the staffer. Psychodynamic therapists believe that the more often treatment occurs, the more extreme the transference will become (Shedler, 2006). Transference in WT groups can happen more rapidly due to their intensive experience of outdoor expeditions and prolonged times together. These groups including field staff, treatment providers and teens who are constantly together day in and day out, any where from eight days to three weeks.

Studies have shown that all groups in the WT setting are facilitated by a minimum of two field staff and some times a maximum of three with teen participants numbering no more than ten. Having a co-leading team helps to provide different personalities and leadership styles to

connect the group and build cohesion and rapport among group members. Irvin Yalom (1995) believes that group therapy headed by more than one individual allows for a varying range of transference reactions to occur. There will be different reactions to different facilitators based on their relationship and unconscious understanding of the relationship (Yalom, 1995). This co-leader dyad becomes even more interesting if it is comprised of a male and female team. Often when groups do have one of each gender facilitating, stereotypical roles are projected onto and sometimes accepted by leaders (Yalom, 1995). Clinicians sometimes agree that co-ed facilitators have the uniqueness to develop into a clinical primary family (Yalom, 1995). These clinical primary families can help participants have a corrective experience in showing mutual respect and appreciation of one another and thus allow for the family to function in a more positive way.

Additionally co-facilitators are able to help and support one another in the clinical encounter. The co-leaders are able to objectively reflect back to the other observations about enactments and transference that might have been overlooked by one leader (Yalom, 1995). This leader dyad becomes even more important when working in remote areas days away from supervision. The leader dyad is in place in order to help process the problems effectively and timely while in the field. This allows for effective co-leader teams to make effective changes “on the go “ to better enable the group’s development and client’s growth. Transference especially in group therapy many times projects unrealistic authority onto the adult group leaders (Yalom, 1995). If leaders are aware of this and accurately acknowledge the transference as it occurs, they can help the patient to address these distortions about the leader and change their maladaptive perception about him/her. This can happen through two interventions: 1) by allowing for mutual validation and affirmation; 2) increased transparency (Yalom, 1995, p. 201).

Both of these goals are easily obtained and implemented in WT because of the close working proximity to one's client.

Many times patients are unable to express their true feelings and emotions through discussions and rather express more through their nonverbal communication in the therapeutic process (McWilliams, 2004). An example of this would be that a patient is more inclined to start a verbal altercation with the therapist rather than reflecting on what the feelings are that are provoking the confrontation (Mitchell & Black, 1995). Clinicians and staff need to be able to identify these feelings coming up from the clients in order to provide the opportunity of re-framing past relationships that had once seemed overwhelming (Mitchell & Black, 1995). Many classically trained clinicians believe that if transference is not addressed or acknowledged, the patient will then regress and fulfill the patients "infantile and self absorbed fantasies" (Mitchell & Black, 1995, p. 161).

Studies have been compiled to address the high turnover rate of WT instructors. According to Marchand et al. (2009) when looking at job-related stress for field instructors, negative aspects of the job outweighed the positive ones with a ratio of 9:1. Staff report that the reasons for this discrepancy are due to unrealistic expectations from management about performance, unsafe physical environment, lack of sleep, and the lack of space to discuss their intense experience on the course and post-course (Scott & Duerson, 2010). This study was only focused on field staff and did not look at the burnout rate among the clinical staff

Transference and Counter transference as core to WT effectiveness

After reviewing much of the literature on WT, there are three articles that have specifically looked at transference within the field that have made important points for transference being the catalyst for effective treatment. Many psychodynamically trained

professionals believe that the effectiveness of true psychodynamic therapy lies in the weekly multiple sessions where intense feelings are able to arise more rapidly. It is in these feelings that the therapist can use the transference to help effectively implement change in the patient's life (Shedler, 2006). Struggling teens typically spend on average 62 days in WT programs with a minimum stay of 28 days (Russell, 2003). Williams suggests from his past observation that what differentiates WT from other modalities is in the duration of treatment and its intensity. He then further elaborates on this acknowledging that the client-staff relationship creates transference more rapidly than other settings, such as in-patient treatment (Williams, 2000). WT, because of its uniqueness and isolation, helps to create its own independent community/microcosm away from the outside stressors. This community is without many of the stressors teens face in their daily lives at home, but creates a new set of difficulties connected to expedition-type living. It is in this expedition living where individuals are together not only with peers, but also the treatment providers. In contrast, many teen patients treated in outpatient settings quickly withdraw from treatment or only go to a few sessions. It is because of this that many families look to in-patient type programs to assist in treating adolescents (Bettmann & Jaspersen, 2009). WT is very different than an institutional type setting where staff and therapist frequently rotate during the adolescent's stay. As a result, it can become more difficult for staff to create or maintain any type of trusting relationship over the duration of the client's stay (Williams, 2000). In contrast, WT provides consistent interactions with a limited amount of staff and clinicians which leads to magnified transference issues (Marx, 1988; Williams, 2000). Not only does the group's dynamic play a role in this process of transference, but factors such as isolation, weather conditions, physical exertion, and new experiences contribute. Even in the vastness of a wilderness setting, there is not much room to escape the therapeutic community that has been

established. Adolescents that are not assisted in processing these developing transference feelings are unable to work through them in a healthy and supported manner (Williams, 2000). When staff does not address the issues of transference, misunderstanding and the escalation of inappropriate behaviors will likely follow. The intensification of an adolescent's experience helps to draw focus and attention to the issue of transference and therefore helps them to identify their issues and start on the recovery process (Williams, 2000). By addressing the transference, teenage students can then be encouraged to verbalize their discomfort and frustration (Mithcell & Black, 1995). It is Marx (1988) who believes that it is the therapeutic alliance in WT that allows teenage participants to work through issues of transference at a quicker pace than in other treatment modalities. Many of the clients in WT have no prior knowledge of remote living skills and therefore rely heavily on staff to demonstrate these skills and provide safety in this unfamiliar terrain. It is because of this reliance on the adult authority figures that the young participants quickly differentiate between WT staffers whom they grow to trust and past authority figures they might have distrusted for a myriad of reasons (Marx, 1988; Williams, 2000). It is through this bond and need that trust develops and contributes to building a positive therapeutic alliance (Marx, 1988; Williams, 2000). If WT is seen through the lens of Maslow's Hierarchy of Needs then before self-actualization can be obtained and accepted, the basic needs are first required. By helping to provide shelter and food, the WT staff is able to align themselves with the adolescent and their best interest. Additionally, a study by Shooter and colleagues shows that outdoor leaders' relationships with participants is built on high levels of trust, thus helping to create positive outcomes. Findings from their study show that outdoor leaders can positively affect the way participants gain trust in them by demonstrating their competencies in a range of areas, from technical skills to integrity (Shooter et al., 2009). First,

teenage participants need to trust WT staff with hard skills and safety skills, allowing for relationships to deepen and creating a solid stepping off point for therapy to begin. Trip leaders are essential to the effectiveness of the treatment in WT (Norton, 2010). A qualitative study done by Russell and Phillips-Miller (2002) found that out of their twelve participants, all twelve stated “the relationships established with counselors and leaders” was the key factor towards creating change and making the WT experience an effective one. Many of these teenage participants have been in prior treatment, (n=12/12) making them, as Russell states, “therapeutically savvy” (p. 422). Another study completed by Russell and colleagues (2008) stated that out of the 63 programs surveyed, 59 of them reported their clients had previous mental health treatment prior to enrolling in to WT. WT allows for an unfamiliar approach that differs from the adolescent’s past therapeutic experience (Russell & Phillips-Millers, 2002). Along with relationships with staff, twelve out of the twelve students reported “peer dynamics” as being helpful to the therapeutic process (Russell & Phillips-Miller, 2002). Because teenage participants are put into a group of their peers, it allows them to address one another’s problem behaviors, receiving feedback from peers as opposed to adults.

Russell and Phillips-Millers’ (2002) study found that a key factor to the effectiveness of WT lies within the relationships made throughout the process, including the therapeutic alliance. These authors state that it is well documented that the therapeutic alliance is vital to any therapeutic relations and that WT helps to establish it (Russell & Phillips-Miller, 2002). These bonds that are established in WT are at the heart of why this modality is an effective intervention for at-risk youth. This untraditional expedition-type living magnifies the connections between the staff and their teenage participants (Davis-Berman & Berman, 1994; Russell & Phillips-Miller, 2002). It is through these supportive relationships with WT staff that teenagers gain an

understanding of how to interact with adults appropriately. They are able to transfer this newly found understanding to their own interpersonal relationship with their family once they have returned home (Bettmann, Demong, & Jaspersen, 2008).

The uniqueness of WT allows for clinicians and field staff alike to step back when encountering resistant or avoidant behavior while on course. It is at these moments that the wilderness can be used as a therapeutic tool, allowing for natural consequences to occur. This allows staff to step away from the resistant or defiant student and be viewed less authoritatively; giving the student the autonomy they need before re-engaging with the therapist (Russell, 2001). An example of this is something as simple as a blister from hiking. If a defiant and agitated student is reluctant to trust or listen to the staff about self-care, they might become prone to blisters. This reestablishes natural consequences for not listening to the group leaders and clinicians who are there to provide help to the troubled youth. Because there are so many natural physical discomforts in WT, perhaps these aid in the discussion of the psychiatric discomforts that also arise.

Psychodynamic therapists believe that the routine of having patients lie down helps them to displace their free association by avoiding eye contact (Shedler, 2006). WT therapy lacks the literal “couch” to have adolescents lie down on, but rather uses the natural surroundings to help with free association. In order for therapy to occur in the woods there needs to be trained staff who are knowledgeable about using the wilderness to help facilitate the treatment in order for personal growth to happen (Williams, 2000). As Marx (1988) stated, “Without a strong counseling perspective, outdoor challenge adventure programs can become basically recreation programs” (p. 2).

Chapter III

Methodology

This qualitative exploratory study is designed to learn how clinicians in WT programs view and manage transference and counter transference as it occurs in the WT milieu. Additionally, how clinical staffers supervise and educate the para professional field guides about this clinical phenomena. The study sprang from both observations about the lack of focus on transference and counter transference during the researcher's work in WT, as well as an apparent lack of clinically focused literature in the WT field. This study will help to contribute to this growing body of literature. To that end, a qualitative research design was used to gather in-depth narratives from direct clinicians about their knowledge of transference and counter transference in the field, and how they have managed and been supervised in terms of this important clinical dimension of the WT experience. Data was collection was derived from semi-structured, open-ended interview questions developed to gain insight into direct care staff's perception and experience related to managing transference and counter transference during the course of treatment. Because the literature is lacking, this study looked at identifying specific techniques used to help manage the transferential process while in the field. The hope is that through these interviews, the research contributes to a nuanced understanding of how transference is viewed or understood during the therapeutic process of WT as it occurs in the milieu.

Sample

The sample includes seven clinicians that are of masters level or greater or individuals working towards those credentials. All clinicians will have been working in the field of WT either as a clinician or field staff member for a minimum of three years. The researcher used professional contacts in the field; including agencies previously worked at; as well as professional contacts made at other WT programs while working in the industry. Snowball sampling was also used in which members from the identified target population, in this case WT, help locate other individuals in the target population they knew might be interested in participation (Rubin & Babbie, 2007). Programs were contacted that are accredited through NATSAP (National Association of Therapeutic Schools and Programs) and members of OBHIC (Outdoor Behavioral Healthcare Industry Council).

The sampling objective was to gain perspectives from clinicians who have the clinical know how, understanding and responsible for treatment plans. This study was approved by the Smith College School for Social Work Human Subjects Review Board.

Data Collection

The data collected for this qualitative study was done through telephone calls that were audio-taped. A meeting time was chosen that was convenient for both researcher and interviewee. To protect the rights of the participants the study was first presented to Human Subject Review Board (HSRB) at Smith College School for Social Work (Appendix A) before any interviews took place. HSRB approval ensures respect, beneficent, and justice and the NASW code of ethics was adhered to. Prior to the interview process all participants were given an informed consent form (Appendix B) outlining their rights as a human subject and informing them of what they might anticipate from the research process.

An interview guide was developed in order to maintain consistency of the questions asked and to provide structure to the interview. All participants interviewed were given the questions prior to the interview. This was done to allow participants time to think about the questions prior to the interview, enabling more in-depth and thoughtful responses. All questions were used to engage participants and gain insight into their understanding of how WT works and how transference and counter transference are managed.

Initially this study intended to interview a total of 12 clinical staffers/field therapist. However, the sample size was decreased due to time constraints encountered through the administrative process. Due to the lack of time it became difficult to recruit the needed 12 participants. Because of the uniqueness of the work, field therapist spend much of their time out of the office in remote areas working with their adolescent clients. This contributed to the difficulty connecting with more field therapist. Additionally, clinical staff only make up 1/6th of all employees in WT playing a part in low participant numbers (Norton, 2010).

Data Analysis

Interviewing was completed when all scheduled interviews were finished. All audio tapes were transcribed manually by the researcher and assessed for thematic analysis using the grounded theory model and inductive coding (Padgett, 2008). The key units of measure were similarities between words and phrases across participant interviews. Based on the analytic model, themes were identified through commonalities and categorized according to corresponding themes. Transcripts were grouped by questions and then broken down into even smaller groups by similar words, phrases, or occurrence of words given by participants. Memo taking was used additionally documenting analytical decisions (Padgett, 2008). Analysis continued until a set of discrete, descriptive categories emerged. In addition for commonalities

across data, the researcher also sought to identify unique and unusual responses that were used to expand concepts represented in the literature.

Researcher Journal Log

A journal log was maintained in which the researcher jotted down initial, subjective impressions following each interview. This process helped to identify potential researcher bias, and also to maintain a log of unique interview observation for each research participant.

Chapter IV

Findings

The purpose of this project is to gain greater insight into the clinical aspect of Wilderness Therapy (WT), specifically, with a focus on how transference and counter transference issues are managed in WT programs. In general, clinical aspects of WT generally appear to be under-explored in the WT literature; studies about how transference issues are managed receive scarce attention by WT researchers. This chapter will present this study's findings, including a description of the data gathering process. Key findings are presented in terms of the major thematic findings. Each theme is presented as a finding subsection. Direct quotations are included that illustrate the perspective of respondents.

Sample Demographics

Though the original sample goal was twelve, the study sample included a total of seven clinical staff members at various private WT programs across the country. This is due in part to limitations imposed by administrative procedures and protocols. The participants' years of experience working in WT ranged from 4 years (n=2) all the way to 15 years (n=1) with one individual having worked in the WT industry on and off since 1987. Of the seven interviewed, four had worked in the field of WT prior to graduate school and five of the seven worked as para professional field staff leading wilderness expeditions before holding a clinical role within their organization. All seven hold varying roles within the industry and no two are the same; research (n=1), parent coordinator (n=1), clinical director (n=1), assistant clinical director (n=1), primary

therapist for adolescents (n=1), primary therapist for young adults 18-24 (n=1) and psychology consultant (n=1). The gender of the participants was broken down with four females and three males. All the clinical staff members that were interviewed work in WT companies that met criteria for this study: therapeutic programming that takes place entirely in the wilderness, focus on client assessment and evaluation, each client has an individualized treatment plan that is overseen by a masters level or above clinician.

Theme: Transference - Counter Transference as it applies to WT

The major question this study was designed to address was about the extent to which clinical aspects of WT are primary. Specifically, this study sought to clarify how transference and counter transference in WT is addressed and managed. All seven of the participants interviewed communicated that the topic of transference and counter transference is discussed among the clinical staff as well as field staff. Four of the seven staff members used the terms ‘transference’ and ‘counter transference’ regularly in the phone interviews and also included a definition of these terms in staff handbooks that provide a cursory introduction of this idea at all new staff trainings. Though the clinical vernacular is used many times in training programs, more practical scenarios are more commonly used to help explain this concept to field staff and connect it to their on course field experiences. The other three respondents acknowledged discussing transference and counter transference in their WT programs, but without using these nuanced clinical terms. The terms most commonly used were “your stuff”, “your shit”, “relationship building” or “what is coming up for you”. D.W. Winnicott (1949) has similarly referred to this as “emotional burden” (p. 2). Five of the seven participants reported using transference as a clinical tool that assists them in the therapeutic encounter with clients. Participant Number 4 reported:

If I notice transference coming up, my training tells me to take a step back and look at what a lot of people experience when they are in a relationship with other people and what does this mean for the client. It is intuitive for me to think about things in terms of transference and counter transference as I think it is true for most people in WT, whether they know about transference/ counter transference or not. I think transference is triggered more quickly and more intensely in WT. Field staff live with the clients 24/7...WT staff are more aware of transference than in any other type of therapy because of the relationships. Wilderness Therapists are more directive than in traditional treatments. I think we have to be because we have different goals, outcomes, and time frames. This is going to create more instances of transference and counter transference because we are not just sitting in a chair saying 'how does that make you feel'. We really have to engage with our clients on a more personal level. I teach my staff from day one to tune into their own personal responses and actions because it is an important assessment tool. Sometimes if my guides are having trouble pinpointing what is going on for a student I ask them what is coming up for them when working with this student.

Participant Number 1 stated:

Issues of transference and counter transference often come up in conversation, but it is not often referred to in those terms. Transference is discussed a lot in general, but is not called that with the field staff...I have noticed transference more in WT because it is so blatant and in your face. I was well into my time in the field that I finally realized that this is what was happening so often. I now understand transference differently since starting to work in WT. I feel like it is much stronger... You are living in this really tight unit, like a family. You are not just seeing these people for one hour a day, you are

living and working with each other in difficult situations. Transference is just more apparent.

Participant Number 2 focused on counter transference and the ways that it impacted their clinical decisions while working with their clients. This participant reported, “It is important to be aware of at what point that you are advocating for the kid when you realize you are actually advocating for what you think the kid needs or wants”.

Participant Number 7 reported finding major value in transference, not only in a WT milieu, but in an office setting as well.

In an experiential environment like WT, transference is important, but it might not be as crucial as when you are sitting in the office with someone. In an office setting, the only thing experiential is the transference and counter transference. Because that is what is real, you are having feelings, or emotions connected to what that person did and that is happening in real time.

Another participant, Number 5, stated that valuing relationship building is at the core of their treatment philosophy.

A lot of these kids have had therapy before and they don't like therapists. You need to find a way in through their past experiences. They are going to come in a lot of times already not liking what therapists represent. You have to find a way in and that is the first thing that needs to happen in order to build trusting relationships.

All seven participants of this study report the value and the importance of the transference relationships as being a key component of their effectiveness in working with this population within the WT framework. This is consistent with the findings in the literature

review which express the effectiveness in the clinical encounter that relies heavily on the understanding and proper management of transference and counter transference.

This study found that five of the seven participants discussed how issues of transference and counter transference happen at a more rapid pace in WT than in more traditional front country settings, such as residential programs or outpatient settings. These responses are representative of the literature review, in which other authors reported these same observations.

Participant Number 4 noted:

There is more exposure to transference and counter transference in WT in some respects. Because we interact with our clients more, we use our personal relationships with our clients as a tool in WT. There is so much about working with this population that is about role modeling and about the ways we interact with our students.

Participant Number 5 stated:

Everything happens quicker in the wilderness setting because you are removed from everything you know. All you have is yourself and the pack on your back. I think WT as an eight-week intervention, works quicker because you are removed from everything.

Participant Number 7 went on to explain:

Transference arises quicker in WT because there is a much stronger dependency; the student is relying on the instructors. Often student's stuff is taken away like watches, maps, shoes, and there is a high level of control and dependency on the instructors that you need to be careful with. Theoretically you could do in a day what it would take you months in an office to complete because of all the time spent on course.

Participant Number 6 said:

I think field staff and clinicians in WT can see through “BS” faster and are therefore capable to intervene quicker. So, we might see more of the transference and get a little closer to the heart of the issue because we are aware of it.

Four of the seven participants expressed the inherent value of the wilderness setting and said they used the natural surroundings to redirect sessions with clients when issues of transference or counter transference arose. The use of re-directing was discussed as a tool to step away from a session when inappropriate transference was encountered or when a therapist reported feeling uneasy or uncertain about the session’s trajectory. Because clients spend more time in WT than other traditional models, the therapist is able to be more flexible and avoid rushing for breakthroughs.

Participant Number 4 stated:

At times when I don’t think it is appropriate or safe or if I am so rattled that I cannot address to address transference or counter transference appropriately then I will use the natural surroundings to redirect the session...If things are becoming too personal and intense I will literally say lets go do a bow drill, put a log on the fire, lets talk to the field staff. I am able to change the situations and I would have never be able to have this ability in a traditional setting...For me one of the great things about WT is I am part of a treatment team and I always have resources of the natural surroundings and I always have a way to redirect i.e. guides, group, parents, hard skills, anything that might be able to defuse the situation...I know that the student will not be gone and that I will have another chance to see them again in one weeks time. I don’t feel the pressure to fight through it.

Participant Number 5 explained:

What I will do in tough situations is I will go and consult with the field staff and bounce ideas off of them because they are the only ones out there. I ask them what they have been noticing about the students. If transference is coming up in middle of the session to where it is effecting treatment I will end the session because I have eight weeks to work this them.

Participant Number 6 discussed:

We need to be able to walk away from kids and allow them to struggle at times through the process. I think there is a lot of parents out there that have adopted the idea that they are responsible for their child's self esteem and can not let them struggle. Especially in regards to transference and counter transference we need to give the kids the knowledge and awareness, but we need them to figure it out and struggle with it on their own.

Participant Number 7 stated:

As a therapist I have to work a lot harder in the office, I really have to use my brain because I am not able to use the wilderness to help in the therapeutic process. All I have in the office is transference and counter transference, but when I am in the wilderness I have many tools in helping the therapy to progress forward...There are times when you need to confront transference and other times when you need to ignore it...One of the programs I worked at talked about counter transference and how kids would "piss you off" on a 28 day course and how you could have another instructor interact with the student to avoid the counter transference. When I was an instructor, I was very conscious of counter transference always thinking about how to interact with kids, should I pass them off to another instructor, how can I help this student, and how that student was making me feel. I think relationships that a student has with an instructor is the most

valuable part of the whole intervention. I don't know if I would call it transference or just relationships.

Thus, clinical and supervisory staff appears to recognize the clinical importance of transference and counter transference and therefore attempted to address it in a variety of ways.

Theme: Boundaries

This study explored ways in which boundaries are established and maintained while working in WT. Additionally, there was a discussion about the ways the participants go about educating and training their field staff on this issue. Only one participant described in detail some of the policies and procedures in place in order to maintain boundaries; this participant described that “ staff should never be alone with students, never out of earshot from other staff” and what is appropriate conversation with clients. However, at no time during the interview process did the other participants clearly state what the boundaries of their organization are as related to client-to-client and staff-to-client relationships. Boundaries were a commonly discussed ethical concern in regards to WT by all participants, due to WT intimate settings. With treatment provider's living with the patient population, day in and day out, boundaries can become blurred quickly. With trained clinical staff only spending a small portion of time each week with the students, the majority of face-to-face time is spent with the non-clinical paraprofessional staffers. The participants all responded regarding ways in which they train their clinical and non-clinical staff to maintain and hold boundaries. However, few mentioned exactly how program policies helped to establish clearly delineated boundaries in order to protect staff and help in establishing effective treatment. Three of the seven participants used the term “internal boundaries” to describe how ones own moral boundaries takes precedence over that of

the program and the ways individuals work to maintain them. One participant reported, “I have gone to a boundary training before.”

Participant Number 1 stated:

Holding boundaries is such a huge topic...The boundary line becomes less clear in the WT setting when you are working day in and day out with the same clients...So much of this is done through the program’s policies and procedures.

Participant Number 2 explained:

In the WT setting it is different and so you need to have much stronger internal boundaries. I think boundaries need to be clear, but they are your boundaries as a human being. Not necessarily the boundaries an agency places on you.

Participant Number 3 discussed:

There is a fine balance because we often ask field staff to be more open to disclosing information about themselves with a client if they feel comfortable. This sometimes makes space for boundaries to get crossed that as a therapist I would not necessarily cross myself.

Participant Number 4 explained:

Folks in WT have to be extremely conscious of their own self-experience and boundaries even more so than in traditional therapy. We are literally delving into a relationship on a much deeper level. We have a holistic understanding of our clients because we meet and interact with their families, and not just the student in a vacuum.

Participant Number 5 described:

I have to be careful...you have to set your boundaries...there is defiantly space for the relationship to get to an un-ethical place. You have to walk the line of forming that

relationship and setting those boundaries at the same time. Yes I can be a role model, but yes I am still your therapist and there are still boundaries associated with that. That can be a delicate tightrope to walk sometimes...I feel to facilitate therapy I am going to have to go to that point to make that connection and I feel that if I did not make that connection I would not be effective...students want to latch onto someone, but they also have to trust you. After you establish trust you still need to be careful about maintaining the therapist student relationship, not friends or buddies...Supervision about boundaries happens in a more informal process.

All of the female participants (n=4) reported that from their observations, WT attracts employees that are insightful, interested in connecting with clients, and want to be included in the treatment process. This heightened level of commitment by the field staff helps to contribute to the treatment. One participant reported, "I think WT field staff are more self-aware, insightful and are actually seeking this".

Participant Number 1 explained:

I think that being vulnerable is common for field staff...We joke that the field of WT attracts fairly rugged women and pretty sensitive guys who both love the out of doors. You have this group of people that like to talk about their feelings and like to hear other people talk about their feelings.

Participant Number 2 stated:

I think the kind of people that are attracted to WT are looking for something more deep and meaningful, the proximity and closeness they create with clients. So, I think that the folks attracted to WT are more aware of transference because this group of people chose to be in this setting and are aware of their own stuff...I feel like there are so many

different ways that are put into place in order to “otherize” clients from therapist. I think a lot of therapists in this field choose not to create false dichotomies. I think this actually creates a greater awareness, but I don’t think that the work itself does that, but rather the people that come to it.

It seems as though the topic of boundaries was not only an important issue among clinicians, but that this is part of the constant dialogue that all participants take part in at their individual programs. Participants did not discuss in detail the ins and outs of their programs protocol as it relates to this issue. One of the common themes between all the participants was connected to self-disclosure and the ways in which that is handled in the field with clients. Though respondents discussed different meanings of boundaries such as either internal boundaries or programmatic boundaries, there was no clear understanding of which takes precedence.

Theme: Supervision

As a keystone to clinical practice, supervision is recognized as a central component for establishing clinical standards in treatment and as such is a major area of examination in this study. All participants discussed the value of supervision consistently throughout the interview process. This is consistent with general findings from the literature review that expresses the importance of the supervisory process. The supervisory process they commented on not only included the clinical team, but also addressed the ways in which the clinical team trains the para professional field staff on topics ranging from transference/counter transference to ways in which to manage behaviors. However, the specifics of the supervisory process were never touched on during the interview process. The participants did allude to the fact that the para professional staff receives clinical trainings once a week prior to their departure on course. Four participants

explained that supervision happens both through formal and informal channels in part due to the nature of the work. Since much of the programming takes place outside of the office, formal supervision is there for limited. Two participants reported that their programs provide outside supervision options for their licensure. Four participants stated that if clinical supervision is needed for a therapist working towards licensure, the clinical director at their program is the one who provides the supervision.

All participants (n=7) report that the supervision process is a tiered system with clinicians helping to train para professionals, but with field director's helping to also facilitate this process. Field directors are staff that have worked in the field for many years and now hold an administrative role providing logistics and support to the courses in the field. The field director usually has no clinical background other than what they have learned through their of experience in WT. The courses in the field usually consist of team leaders that have a range of experience. The field directors and the team leaders help to oversee and provide field support for the junior instructors while in the field. All of these different supervisory processes are in place in order to provide a tiered system of support.

Participant Number 1 stated:

The program does a really good job emphasizing feedback as well as setting aside time for the group twice a week and every night giving each other feedback. I think the whole WT culture values feedback as a piece to supporting the field team.

Participant Number 2 addresses:

The discussion about boundaries is always going on. It is water cooler talk about kids, what the processes is, the approach, how is that working out for you. This can happen wherever. It happens in a structured and non-structured way.

Participant Number 3 provided:

I try to train staff in supervision to differentiate between what is going on with the client and what is going on for them...Again this is like the tiers of supervision we talked about earlier, that is where education comes into place. We have four staff out there at one time and they are all observing one another and give feedback to each other daily.

Participant Number 4 addressed:

I think that some of the younger field staff are hesitant to bring up issues of transference and counter transference in part because it is difficult for them to understand what they are experiencing and partly because they get intimidated by their treatment team leader. They don't want to look like they don't have it all together... guides receive specific training on this on a regular basis. This issue is covered in the field staff initial hiring seminar as well as their written guide handbook.

Participant Number 5 stated:

A lot of the supervision in the field is done on the fly and occasionally we have gone in and asked field staff what questions they might have...Often field staff is younger and they have issues going on maybe they have been in treatment themselves and they are still sorting through a lot of life's things. So, a lot of the time field staff will bring up specific issues they have when working with clients.

Participant Number 6 noted:

We have a section in our manual discussing transference and counter transference. We even use those specific words. When we discuss this topic with field staff we use more practical scenarios to explain exactly what transference and counter transference is... Just this week I led a presentation for the clinical team on how to intervene and build

relationships with students. We spend a lot of time discussing transference and counter transference... There is a lot of personal staff development feedback. It is common for a staff to get feedback 3-4 times a week about their involvement with kids.

All participants (n=7) reported the supervisory processes as being an important component to the clinical treatment. It is not only seen as a value for the clinical staff, but is also important for the field staffers as well. This is common to what is found in the literature review.

Theme: Theoretical Orientation

As a key clinical focus the study was interested in learning about the range of clinical approaches utilized to engage adolescent clients. No participants reported operating from the same singular theoretical background. Participants reported many overlapping theoretical orientations and there were many commonalities in participant responses. Participants often used theory terms such as “eclectic”, “a mash up”, “strength based” and “humanistic” to describe theoretical orientation. Cognitive Behavioral Therapy or CBT was also commonly referred to as a theoretical approach used by participants. Many respondents talked about the need for a diverse theoretical approach due to the fact that they are working with such a diverse patient population. Additionally, one group may contain many students who each have their own individual treatment plan that might need varying approaches.

Participant Number 3:

I combine many theories because we get such a range of clients here. I think it is hard to come from one theoretical orientation because not every foot fits the same shoes. We do a bit of assessment because we have students who have had a lot of therapy and many diagnosis and we have students who have not had any therapy at all and they come in and their life is a train wreck. I think so much of the process is assessment.

Participant Number 6:

I used to be more eclectic, but it all depends. I have to switch gears often because it is such an individualized process for each kid. I might have a theory I am using in session or an overall idea of where I want to go, but I might give students different assignments through the week that might not necessarily be connected to one specific theoretical model.

Summary

All of the information in this chapter is a direct reflection of clinician's own experiences working in WT and the ways transference and counter transference is addressed and worked through. Participants hold uniquely different roles within their programs and view clinical encounters from different theoretical backgrounds. Despite the participant's varying roles and orientations, many of their answers were similar in the ways they address transference, the supervisory processes, and importance of boundaries for all staff members working within the industry. Once the information was obtained and analyzed, the information was put into four thematic groups based on their importance.

Only one respondent was critical of WT. Coincidentally, this is also the participant who has been working within the industry the longest and talks openly about how the industry has changed for both the good and the bad over the years. Participant Number 7 stated,

If you make the WT trip just walking around in the woods you lose all dimensionality of where the change happens. I think you need to allow for the guide to really participate in the process not have the guides hike the kids for a week then send in the masters level therapist to come out and talk to the kids and do the therapy part. This is crap. What is the therapist suppose to do, this is the weakest part of the program. The most effective

part of the program is the experiential part when the kids are in the field having problems and the field staff can handle it. The wilderness program is not suppose to be a therapy program anymore. It is suppose to be for containment, assessment, and pulling it together before going to a therapeutic boarding school.

This same respondent also went on to discuss how they believe that the field therapist provides very little therapeutics to the group since they are only visiting kids once a week for just a few hours.

Field staff know in their hearts that meeting up with the therapist is “bullshit”. They know they are going to be stuck with that kid and have to deal with their behavior issues and emotional problems after the therapist leaves. The kids know this too. The kids know the therapy game and know what to talk about with the therapist. The kids forget the act when they are in the field everyday with the field staff.

This is similar to Keith Russell and Dianne Phillips-Miller’s (2002) idea that wilderness program clients are “therapeutically savvy” (p. 422) and are familiar with the therapy game.

Chapter V

Discussion/Conclusion

The purpose of this qualitative study was to examine how WT clinicians manage and address issues of transference and counter transference while working in an outdoor setting. Each therapist was asked questions about how they understand the phenomena of transference and counter transference. Participants were asked how transference and counter transference impacts their relationship with clients and the clinical work they do; Secondly, ways clinicians set boundaries and maintain them while working in such an intimate environment with clients day in and day out; Thirdly, about the supervisory process in place to educate both clinical and field staff. Additionally, each therapist indicated that they believe transference happens more readily in a wilderness setting when compared to the therapeutic process in more traditional settings. This chapter discusses the findings in four sections: key findings discussed in terms of previous literature and findings and those unique to this study; this studies research and implications, implications for the field of social work, and the limitations of this study. A conclusion follows that will synthesize this study

Major Findings

The results from the findings show that all seven interviewees reported finding value in the transference and counter transference processes allowing greater insight into their own therapeutic practice. This supports Irvin Yalom's (1995) perspective that if transference is not addressed or avoided, the therapeutic process is thwarted. Respondents discussed how each of

their organizations provide not only clinical training for the therapist, but also provide weekly clinical training for the para professional staff. This allows for the para professional staff to become increasingly competent and confident implementing the treatment plans the clinical teams develops. Authors Gass and Gillis (2010) along with others describe how the supervision process is crucial to establishing the highest quality standards in any clinical practice. The supervisory process not only happens in a formal setting, but also through an informal process. This informal processing occurs in large part because of the unconventional settings in which WT takes place. Since field staffers spend more time in the field than in the office, programs use a tiered system of supervision that helps to support staff even when they are away from the clinical team. Programs send para professional Leadership Teams out into the field that are comprised of team members with varied experience in wilderness therapy so as to provide guidance and mentorship to less experienced field staff while in the backcountry. Clinical team provides on sight direct counseling support weekly. One participant number six said, “It is not uncommon for field staff to receive feedback 3-4 times a week” while in the field. Additionally, field staff at every program are equipped with a satellite phone which enables them to contact the clinical team at any time if they are in need of extra support or supervision.

As Williams (2000) suggests, transference issues arise at a more rapid and intense pace due to the close proximity of staff and clients and extended time in treatment. Additionally, Marx (1988) also discusses how transference happened at a much faster rate when working in the field of WT. Many participants (n=5) reflected on similar experiences and strongly supported these author’s points. Participant number seven stated, “Transference arises quicker in WT because there is a much stronger dependency; the student is relying on the instructors”. Author Keith Russell (2001) wrote because of WT’s uniqueness, the philosophy allows for therapists to step

back from troublesome clinical encounters and gives the client autonomy and time to deescalate the situation. By being able to step away in moments of tension, clinicians and field staffers are viewed as less authoritative therefore helping to build the therapeutic alliance. Four of the seven respondents reflected how they themselves use the natural surrounding to help redirect sessions when appropriate.

The subject of 'boundaries' came up in discussion with each participant throughout the interview process, but there were some differences in responses from participants. Three of the seven respondents reported that the most important first step in establishing boundaries is creating and identifying one's own internal boundaries and establishing what is appropriate or inappropriate for themselves personally when working with young adult clients; They went on to say that these internal boundaries take precedence for them over the program's established boundaries. No discussion was had on what happens when internal boundaries and programmatic boundaries are at odds. The rest of the clinicians (n=4) reported that protocol is in place within the programs in order to insure the highest level of ethical and professional boundaries. Some of these rules are as simple as no hugging or never interacting alone with any student under any circumstance, and go so far as to explicitly articulate what defines an appropriate relationship with students after they graduate the program. Participants often discussed how they encourage para professional field staff to self-disclose appropriate information with client. It is in the fluidity that allows for rapport to be made through the use of self-disclosure. As Russell and Phillips-Millers' (2002) study shows, one contributing factor to WT's effectiveness lays in the relationships that are established between staff and adolescent clients. However, this study has found that the topic of boundaries seems to be inconsistent throughout the industry from program to program and individual to individual. The topic of

specific boundaries is outside the scope of this paper and would benefit from further research. This brings into question what happens when individual's boundaries are in contradiction to program boundaries and how that effects the quality of care.

All participants reported operating from a diverse theoretical orientation with a few (n=2) reporting "eclectic" orientation. This is common in both the literature as well as the way in which programs describe themselves. Since WT works with such a wide variety of students in a experiential setting, the discussion revolved around how participants needed to have a theoretical orientation that is flexible.

Only participant number seven provided constructive criticism about WT and the evolution necessary to become legitimized as a mainstream treatment modality. This participant reported that as the industry has worked to become more legitimate, it has also become safer, but at the same time, the participant noted a shift from an experiential therapy model to that of a more business-oriented model. Today, WT is used as a mandatory precursor to most therapeutic residential programs. The Wilderness Therapy industry as a whole is striving for legitimacy through best practices and accreditation, but at a cost. The organic, 'in the moment', experiential component that is so effective, is being pushed to the wayside. Participant number seven questioned the efficacy of a clinician coming into the field once a week to meet with a client for only an hour or two each week. Most of the therapy happens day in and day out, in the moment. Para professional field staff are able to address negative or dysfunctional behavior immediately. It seems as though we have gotten to a point much more focused on outcome, but yet still have every little understanding of how WT works as an intervention.

Research and Implications

This study aimed to explore how issues of transference and counter transference are managed while in the field of WT. The hope is that this work will contribute to the small, but growing body of research focused on the field of wilderness therapy. Future research could benefit from having a larger pool of research participants. With only seven research participants, it is difficult to glean what is happening in the industry as a whole with such low participation. In this study with seven participants, there are only five programs represented there by limiting the diversity of the sample. Additionally, para professional field staffers should also be included in any further study, as they are the primary person implementing treatment and maintaining both the physical and psychological safety of clients. Since the field staffers spend significantly more time with students, it is this author's observation, based on time spent in the field, that transference and counter transference is more intense among field staff and clients than with clinical staff and clients. This may be because the field staff is there in the moment with the client when challenges arise. Many of the respondents alluded to this fact as well during the interview process and even provided personal anecdotes from when they were field staff themselves and encountered a difficult situation where transference and counter transference played a part. Finally, it would be crucial to compare the responses of the field staff with their clinical counterparts in regard to transference, supervision, and boundaries. No studies have yet to examine the continuing supervision process among WT clinicians (Becker, 2010). It would be productive to explore if para professional staff did, in fact, feel as though their pre-course trainings actually focused on topics of transference and counter transference, providing them with a true understanding of the phenomena and other clinical topics.

Social Work Implications

Of the seven interviewees, four are MSW. Of these four, one participant is an LCSW, two participants have completed their clinical hours and are now preparing for their licensure test, and one is not working towards licensure because they are research focused. Of the four MSWs, two had worked in the field for years before attending graduate school. The sizable proportion of MSWs is common throughout the industry and therefore makes WT a field that should receive more attention by social workers. It is this researcher's opinion that because of the large make up of social workers in the field, the profession should undertake research and clinical education with regard to WT. The absence of a clear academic discipline contributes to a misunderstanding of WT and the lack of research, prolonging the industry's legitimization among traditional practitioners.

Limitations

Limitations of this study are the small sample size, low response rate, and the fact that participants did not include para professional field staff. It is difficult to speculate why many of the clinicians contacted through email and phone declined participation. A wilderness therapy clinician's schedule is as untraditional and emergent as WT is as a treatment modality. Most clinicians spend one or two days in the field a week, depending on their program. Some therapists might have to hike in to meet groups or spend time in transit to meet groups, all of which take time. When therapists return from the field, often they are busy making calls to their client's parents, education consultants, and the client's therapist from home. All of this contributes to their hectic schedule. It is my belief that the low participation rate was due in part to this untraditional schedule that a field therapist works within. As stated in the findings chapter, all seven of the participants hold different jobs within their organization; this could have contributed to different responses or ways in which they perceived the interview questions.

Another limitation to this study is the researcher's analysis and interpretation of the information gained through the interview process. Having worked in WT for many years as a field staffer, I tried to be as neutral as possible when analyzing the data. Thus, researcher bias was a real challenge in this study. This was mitigated to some degree by the use of keeping a journal log, allowing me to write down subjective impressions and notes about where bias might affect the analysis process. Another limitation was the fact that, because of the small sample size, little attention was paid to issues of diversity in terms of clinicians attitudes towards the youth served. A final limitation was the limited amount of time for conducting the study.

Implications for Future Study

Having worked for so many years in WT, I was disappointed with the limited number of participants. WT is still a fairly new treatment modality with a limited, but growing body of research and a common consensus among practitioners about the importance of the need for more in-depth research. It was astonishing to the researcher that so few individuals in the industry showed any interest in participating in a study focused on WT. Literature on WT clearly documents the lack of research and the need for continued analysis. It is alarming that most programs are uninterested in contributing to this anemic body of work. Programs that fit criteria for this study were contacted via phone and email to gauge their interest in participating in this study. Approximately forty phone calls were made to varying clinicians within programs throughout the field. A similar number of emails were also sent out during the recruitment process and followed up with phone calls. Snowball sampling provided very few participants.

I was surprised to find that six of the seven participants reported that there is an ongoing discussion about transference and counter transference at their program. This is very different from my own personal experience and contradicts many informal discussions I have had with

other field staff that report being unaware of these terms or the ways this phenomena plays out while leading courses in the backcountry. This reflects my initial hope for this study to include the para professional staff in addition to the clinical staff to gain a more well rounded understanding of how clinical information is disseminated and the ways in which field staffers receive support. Further study is indicated with a broader sample size of clinicians and field staff. A quantitative study using a survey method might help to improve respondent pool in any future research.

Conclusion

Though this study was brief and respondents were few, there is need to further examine the clinical aspects of WT in order to establish it efficacy within traditional treatment models. This study provides additional knowledge to the field of WT with regard to transference and counter transference, and confirms some of the previous literature on this subject. Because all clinicians in this study report finding value in transference and counter transference, it is clear the field could benefit from more in-depth research with more practitioners. Many commonalties arose between the interviewee's responses and the literature that is published on the topic of WT. Though small, this was certainly a productive study and opens up other aspects, demonstrating the need for further research. Because of WT's limited body of research, many options are available for future study in terms of the clinical aspects of these programs. In regards to this study, a future study would benefit from a larger participant pool and the inclusion of para professional field staffers. Social workers make up a large part of the treatment providers within the field of WT, therefore it is important that the social work profession support education, professional guidelines, accreditation, and further research to establish the efficacy of WT. Just as we look at ethical issues and how they arise in front country clinical settings, it is imperative

to look at how these ethical dilemmas effect treatment in WT. Only once WT starts to address these vital questions will it able to be accepted by mainstream treatment providers.

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Appendix A

HSRC Approval Letter

School for Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 1, 2012

Jon Dukes

Dear Jon,

Your project is now officially approved by the Human Subjects Review Committee. This area is so understudied, and I think important for many clients. I hope you find interesting results and consider publication.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Take care and good luck!

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Elaine Kersten, Research Advisor

Appendix B

Informed Consent Form

Dear Participant,

My name is Jon Dukes, I am a second year graduate student at Smith College in Northampton, Massachusetts studying clinical social work. Having worked in wilderness therapy for many years prior to returning to school, I have great interest in studying clinical aspects of WT. I am now writing my thesis, which will involve interviewing both clinical staff and field staff to gain a greater understanding about their knowledge of transference and counter transference* as it occurs in the field of wilderness therapy. The purpose of this research is to learn how different organizations and staff attend to transference during the course of the WT therapeutic intervention. All information gained in this study will be used in my master's thesis, subsequent presentations and possible publication.

I will be interviewing participants who hold a masters degree or above (in social work or allied mental health) or are currently working towards their masters in a related field and who work directly with youth in some clinical and/or wilderness activity capacity and provide clinical oversight in the program. Additionally, all clinical participants will have had to have been working in the field of WT for at least 3 years in either a para-professional or clinical capacity. Each interview will be conducted via phone calls and if possible, utilizing Skype video conferencing technology. The researcher will contact participants via phone in order to schedule a mutually convenient interview date and time. Each interview will last approximately 30-40 minutes in duration. All interviews will be recorded using a digital voice recorder in order to up hold the highest level of accuracy as well as to help transcribe the complete interview. Interview questions will be sent to participants via email prior to the interview to allow time to review interview topics and become familiar with the content of each question. If participant do not have email capability or would prefer to have a hard copy sent via the post office these arrangements will be made. Additionally, personal information will also be gained by asking such question as to what geographic region they work, age, gender, educational and clinical backgrounds. Upon completion of the interviews, the researcher will be solely responsible for transcribing the conversation.

The benefit of participating in this study is that your involvement will contribute to a deeper understanding of the therapeutic process in a wilderness therapy setting. Personally you might gain a new perspective of viewing

the concept of transference and counter transference and how it is managed in WT. Though there are no serious risks associated with participation, it is recognized that revealing personal thoughts about the work you do might be challenging.

All information from the study is completely confidential; however your anonymity cannot be maintained because the research entails video conferencing and/or phone calls. I will be the only individual with access to the research data, which will ensure the confidentiality of the interviews. My research advisor will only see data after all of the identifying information has been removed to help maintain the highest level of confidentiality. When the report is written, personal information will be disguised in order to ensure maximum confidentiality before compilation or presentation. The data gathered through this empirical study will be kept for three years, which is required by federal guidelines. Not only will personal information be confidential, but also any information about the agencies you might work for.

After the three-year period, all information will be destroyed. If however material is needed longer than the three year period it will continue to be kept in a secure location and when finished with the material it will all be disposed of properly.

Participation in the study is voluntary and participants are able to withdraw at any point during the duration of the research study before April 1, 2012 at which time the data analysis will be completed. If you do decide to withdraw at any point prior to April 1, 2012, all of your information gathered up to that point will be destroyed and will not be incorporated into the thesis. If you have any concerns about your rights as a participant or the study itself, you are encouraged to contact either myself via email, via phone or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

*Transference is when an individual will unconsciously re-direct their feelings onto other people without being aware of its occurrence. Counter transference is when a therapist unconsciously re-direct feelings towards individuals they are working with.

Participant's Signature
Date_____

Researcher's Signature
Date_____

Jon Dukes