

Treating Adolescents with Adoption and Attachment Issues in Wilderness Therapy Settings

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Abstract

Using therapeutic and educational activities, wilderness therapy programs provide therapeutic care within remote outdoor settings. This treatment modality has become increasingly common for adolescents facing behavioral issues, yet different programs use different theories to conceptualize treatment and intervention. The authors present John Bowlby's attachment theory as a lens for re-conceptualizing adolescent behavior in wilderness treatment, particularly with the application of attachment theory to adopted adolescents. The authors present specific recommendations for programmatic changes to accommodate adolescents' attachment needs.

Attachment in Wilderness Therapy: Treating Adolescents with Adoption and Attachment Issues

Beginning around 1920, Sigmund Freud began to acknowledge a type of separation anxiety experienced by infants upon separation from their mothers. Freud believed this reaction was motivated by basic instinctual drives. In contrast to Freud, (Bowlby, 1958) saw humans motivated not just by instinctual drives but also by relationships, particularly by the need in infants to attach to a primary caregiver. Borrowing heavily from animal biologists while breaking

from traditional psychoanalytic thinking, Bowlby defined human's "instinctual responses" toward attachment as including "sucking, clinging, following, crying, and smiling" (p. 362). Rather than explaining such behavior as drive impulses, he believed these were attachment behaviors and essential to survival. Bowlby understood the nature of the relationship between mother and child as crucial to the child's development (Bowlby, 1958). He viewed attachment as a fundamental behavioral system grounded in relational needs and separate from the instinctual drive for food (Bowlby, 1958, 1988). This assertion was later supported by Harry Harlow's research with rhesus monkeys, concluding that comfort through physical contact was imperative in the development of attachment bonds and that actual nursing for nutrition alone played a very minor role in the development of these bonds (Harlow & Zimmermann, 1959)

Bowlby (1958) described attachment as an evolutionary system emerging out of the biological desire for proximity, responsible for regulating infant security and survival in the environment (Bowlby, 1958). This ethologically-based perspective held that infants are born with instinctive proximity-seeking behaviors. Over time, these behaviors become organized into internal structures as the child interacts with the environment (Bowlby, 1958, 1988).

Since Bowlby's development of this theory, most attachment researchers have defined attachment as a relatively stable concept (Bowlby, 1988; Daniel, 2006; Hamilton, 2000; Shorey & Snyder, 2006). Through repeated interactions, the child develops internal representations of self and caregiver (Bowlby, 1988; Sable, 2004), enabling the child to anticipate behaviors of attachment figures (Shilkret, 2005). For example, securely attached children learn that when in distress, caregivers will be responsive to their needs, yet allow them to successfully explore their environment and negotiate fearful situations. With each successful interaction, children begin to internalize a sense of personal security, eventually learning that they are able to deal with small adventures on their own. In contrast, insecure attachment patterns with caregivers force children to develop alternative strategies in order to navigate their environment. These strategies include maintaining contact with a needy parent, even when the child wants to adventure or avoid contact with a parent who is

unable to tolerate closeness. At the time these strategies are adaptive, allowing children to maintain necessary contact with parents for survival. However, children internalize these strategies and continue to use them even when they have become maladaptive.

During infancy, this internal blueprint of relational strategies (also termed the “internal working model”) is established and the child’s patterns for future relationships become relatively fixed (Bowlby, 1988). The developing child assimilates other relationship experiences into existing internal working models. As a result, the child perceives other attachment figures as similarly attentive, sympathetic, helpful, or unhelpful (Bowlby, 1988; Daniel, 2006; Mickelson, Kessler, & Shaver, 1997).

Bowlby (1969/1982; 1988) described several fundamental beliefs concerning attachment. First, children are born with a predisposition to develop an attachment to their caregivers. Second, children will organize behavior and thinking in order to maintain those attachment relationships believed to be key to psychological and physical survival. Third, they will often maintain such relationships at great cost to their own functioning. Finally, the distortions in feeling and thinking that stem from early disturbances in attachment strategies and continue to use them even when they occur most often in response to the parents’ inability to meet the child’s needs for comfort, security, and emotional reassurance (Bowlby, 1969/1982, 1973; Slade, 1999).

Based on these beliefs, Bowlby (1969/1982; 1973) established four basic principles of attachment relationships. The first is proximity maintenance. This principle involves the infant seeking physical closeness with the caregiver and finding security in this closeness. The second principle is separation distress. When separation from the attachment figure is involuntary, the infant will protest. The third principle is safe haven. This principle describes the child using the caregiver as a safe base, returning for comfort when faced with a threat. The fourth principle is the concept of secure base. This principle illustrates the sense of safety that the child experiences when in the presence of an attachment figure. The child displays a greater ability to explore their environment when in the presence of the attachment figure (Bowlby, 1969/1982, 1973; Cassidy, 1999; Slade, 1999).

Beginning in the 1960's, Mary Ainsworth created the research foundation from which social scientists view attachment theory today (Davies, 2004; Shilkret, 2005). Developing a research protocol termed the "Strange Situation," Ainsworth studied the behaviors of infants temporarily separated from their mothers (Ainsworth, 1979; Ainsworth & Bell, 1970; Davies, 2004; Main, Kaplan, & Cassidy, 1985; Shorey & Snyder, 2006; Westen, Nakash, Thomas, & Bradley, 2006). Based on the results of these studies, Ainsworth discovered variations in the quality of maternal responsiveness and sensitivity during the first years of infant's lives that led to demonstrable differences in their patterns of comfort-seeking. These empirical findings confirmed Bowlby's central hypothesis: patterns of seeking care and nurturance and expressing affect emerge as a function of the parent's response to them (Bowlby, 1988). A child learns from an early age which responses will elicit care from the parent and which ones will not. Those responses that elicit at least some elements of attentive parenting become chosen ways of interacting with caregivers (Slade, 1999).

From her research, Ainsworth also developed a clearer understanding of the dynamics of attachment. This understanding resulted in the identification of three distinct patterns of attachment styles: secure, anxious-ambivalent, and avoidant (Ainsworth, 1979). Several years later Main and Solomon (1986) identified a fourth attachment category: disorganized/disoriented/unresolved. During the "Strange Situation" protocol, children were rated as "secure" if they approached their mothers for nurturance if upset during her absence. These "secure" children greeted their mothers with warmth and wanted to interact. Conversely, children rated as "avoidant" avoided their mothers at her return. Children rated as "anxious-ambivalent" mixed anger toward their mother with proximity-seeking behaviors. Children in the "disorganized/disoriented/unresolved" category were a small group of infants who adopted a range of attachment strategies from the other categories without using one central organizing strategy (Ainsworth, 1979; Hesse & Main, 2000; Main & Solomon, 1986).

Adolescent Attachment

During infancy and into becoming a toddler, children primarily seek out their caregivers, need enduring physical and emotional nurturance from them, and rely entirely on caregivers.

During a child's development into adolescence, attachment needs shift and they no longer depend entirely on caregivers. Although they still need relationships with caregivers, adolescents increasingly turn to peers for support (Freeman & Brown, 2001; Keiley & Seery, 2001). They often resist physical comfort from parents, looking instead to a boyfriend or girlfriend. They begin actively shifting attention from family of origin to peer relationships outside of the family (Freeman & Brown, 2001).

Developmentally, adolescence is a stage in life defined by acute emotional, cognitive, and behavioral transformations (Allen & Land, 1999; Burrow, Tubman, & Finley, 2004; Feigelman, 2001). Within Western cultures, there is substantial emphasis placed on adolescents developing a sense of independence, psychological individuation, and necessary skills to function apart from the family (Freeman & Brown, 2001; Kenny, 1994; Kuperminc, Allen, & Arthur, 1996; Pavlidis & McCauley, 2001). Culturally, completion of these tasks are very important and central features of adolescent development (Kuperminc et al., 1996; Markiewicz, Lawford, Doyle, & Haggart, 2006; D. Moore, 1987).

Behaviors that differentiate adolescents from others (e.g., independent thought and self-determination in social settings) are critical indicators of adolescents striving for autonomy (Allen & Hauser, 1996). There is increasing evidence that the balance between individuality and connectedness, also termed "autonomous-relatedness," is important for adaptive functioning and serves as a favorable source for supporting functional adolescent-parent relationships (Allen, Aber, & Leadbeater, 1990; Allen, Hauser, Bell, & O'Connor, 1994; Kenny, 1994; D. Moore, 1987).

Adolescents who are comfortable with closeness (which is an indicator of secure attachment) generally display trust, relationship satisfaction, interdependence, and self-disclosure in relationships (Allen, Hauser, O'Connor, Bell, & Eickholt, 1996; Grotevant & Cooper, 1985; Kuperminc et al., 1996; Lamborn & Steinberg, 1993). Adolescents who are anxious in relationships (which is an indicator of insecure attachment) tend to lack trust, display relationship dissatisfaction, jealousy, and lack of compromise. They typically

engage in high levels of interpersonal conflict and coercion, and display significant distress (Allen et al., 1990; Feeney & Cassidy, 2003; Keiley & Seery, 2001).

Attachment Issues in Adopted Adolescents

There are a number of factors faced by children placing them at risk for developing insecure attachment (Gray, 2002). These risks are particularly salient in adopted children. As adopted children move toward adolescence, they often begin to have questions about their birthparents' motives. They begin to assess their feelings of belonging in their current family situation. They also may develop a sense of abandonment or feelings of isolation, which form additional obstacles at this already turbulent developmental stage.

The process of identity formation (e.g., defining oneself while individuating from family) is particularly prominent during adolescence, strongly affecting adolescent attachment relationships (Gray, 2002; Grotevant, 1997; Kohler, Grotevant, & McRoy, 2002). Adopted children often experience increased difficulty during this developmental stage (Grotevant, 1997). The developmental process can reawaken feelings of loss, loneliness, and abandonment by biological parents (Riley & Meeks, 2005). Further complicating this process for adopted individuals can be a heightened sense of missing personal history based on a lack of knowledge about birthparents (Grotevant, 1997; Riley & Meeks, 2005). All of these factors can impact adopted adolescents' attachment relationships with their adoptive parents.

Adopted adolescents are also at a heightened level of risk for insecure attachment relationships with caregivers if they were adopted after attachment to a different primary parental figure, experienced prenatal exposure to drugs and alcohol, were exposed to severe trauma, abuse, or neglect, or spent time in foster care (Gray, 2002). The single most critical factor predicting adoption adjustment, however, is age of placement (Riley & Meeks, 2005). There is a growing body of research analyzing the effect of severed attachments on the adjustment of children adopted after their first year of life (Riley & Meeks, 2005). Parental awareness of the effect of such circumstances can help families deal with the behavioral and emotional difficulties faced by these children. Being aware of their own and their children's

attachment needs places parents in a healthy position to strengthen family relations and address these challenges (Gray, 2002).

Awareness of differences from other family members emerges with increased consciousness for adopted adolescents. This is particularly true for children adopted across racial and/or cultural lines. With these children there often are social pressures to categorize oneself by group identification or affiliation during adolescence, as well as personal awareness of differences and internal struggle to find one's place and identity (Grotevant, 1997; Riley & Meeks, 2005). It is important to note that being able to speak openly to parents about these issues is linked to higher functioning in adopted adolescents (Riley & Meeks, 2005).

As indicated earlier, peer attachment relationships become a central issue during adolescence. Peers are increasingly used for companionship while parents continue to be a source of comfort during times of distress (Furman & Buhrmester, 1985). By the end of high school, the transition from parents to peers as principle attachment figures should be well-established (Freeman & Brown, 2001; Hunter & Youniss, 1982). Adopted adolescents may experience this connection as somewhat compromised. Many adopted adolescents believe that they are “different,” which can interfere with the sense of comfort and similarity obtained by belonging to a peer group (Riley & Meeks, 2005). If this common bonding element is less available, adopted adolescents may experience increased isolation in their search for independence (Riley & Meeks, 2005) This can make this life stage particularly tumultuous and further compromise attachment relationships.

Adopted Adolescents in Treatment

Adopted adolescents tend to be over-represented in clinical settings (Brinich, 1980; Brodzinsky, Radice, Huffman, & Merkle, 1987; Miller et al., 2000; Warren, 1992; Wierzbicki, 1993). In fact, some studies have shown that one-third of adolescents referred for treatment are adopted (Miller et al., 2000; Riley & Meeks, 2005). By contrast, recent U.S. Census data show that only 2.5% of all children in U.S. households are adopted (U.S. Census Bureau, 2003). A meta-analysis of 66 published studies found that while adopted

individuals possessed a significantly higher level of maladjustment than non-adopted peers, research is not conclusive regarding whether this is indicative of environmental or genetic influences (Wierzbicki, 1993).

Research considering adopted adolescents' mental health is mixed. Some studies have identified increased emotional and behavioral problems for this group (Brodzinsky et al., 1987; Hoksbergen, 1997; Rhodes & Copeland, 1993), while others have found that emotional health is comparable between adopted and non-adopted adolescents (Feigelman, 2001; Marquis & Detweiler, 1985). Marquis and Detweiler (1985) found adopted children compared favorably to non-adopted individuals when both groups came from a community sample. Other research, however, found that adopted adolescents were more likely than their non-adopted peers to experience difficulties in school, display acting out behavior, drug use, and other complaints common to this developmental period (Brinich, 1980; Brodzinsky et al., 1987; Miller et al., 2000; Riley & Meeks, 2005; Wierzbicki, 1993). Even with these divergent findings, it is clear that adoption can be an issue of great emotional importance to adolescents.

Studies looking at why there are disproportionate numbers of adopted adolescents in treatment have varied conclusions (Ingersoll, 1997; Warren, 1992). The higher socio-economic status of many adoptive families may make them more inclined to seek mental health treatment for mild problems. Alternatively, adoptive parents may be more likely to obtain professional services (Feigelman, 2001; Warren, 1992). Parents who are more highly educated tend to use therapy more often. On average adoptive parents have higher levels of education, and therefore may be more likely to utilize mental health services (Ingersoll, 1997; Miller et al., 2000). The more difficulties experienced by an adoptee, the more likely those difficulties will be attributed to adoption than to other sources or typical developmental issues (Kaye & Warren, 1988). Adoptive parents may be more anxious about the health and welfare of their children and may be more likely to seek mental health services (Ingersoll, 1997). Warren's 1992 empirical analysis, replicated by Miller et al. (2000), found a lower parental threshold for referral combined with increased problems linked to a heightened representation of adopted children in treatment. The exploration of various hypotheses persists.

Wilderness Therapy as Treatment for Attachment Issues

Wilderness treatment programs can create an environment conducive to the disruption of insecure attachment cycles. Similar to residential treatment programs, wilderness therapy programs typically provide 24-hour care away from the home environment in a therapeutic community. Wilderness therapy programs, however, provide therapeutic care entirely within a remote outdoor setting.

Russell (2003) defines wilderness therapy as a “type of program that works to address problem behaviors...through a variety of therapeutic and educational curricula in outdoor environments.” (p. 3). Among other therapeutic activities, clients often participate in individual and group psychotherapy with psychotherapists several days a week. These therapists typically create individualized treatment plans for each client and work with each client’s family to provide appropriate aftercare planning.

Wilderness therapy is one type of program among a variety of wilderness experience programs (WEPs) differentiated by the provision of therapy (Russell, 2001). WEPs are typically designed around the general purposes of helping individuals to develop their human potential (Friese, Hendee, & Kinziger, 1998). Their focuses vary around issues of personal growth, therapy, rehabilitation, education, or leadership/organizational development (Friese et al., 1998; Russell, 2001). Wilderness therapy programs have a specific therapeutic focus, addressing problem behaviors and inadequate social functioning. Often misconstrued with other types of WEPs, wilderness therapy are not challenge courses, adventure-based therapy, or boot camps (Russell, 2001).

During wilderness therapy programming, clients live in the wilderness with groups of peers and several staff, hike most days to primitive campsites, and participate in other outdoor activities. Clients work together to accomplish daily living tasks. They typically learn skills such as pack building, shelter construction, primitive fire making, and meal preparation. Therapeutic assignments initially focus on effective communication, individual responsibility, and accountability. Tasks assigned later on in wilderness therapy treatment focus on developing emotional competencies, appropriate leadership,

and group contribution.

The setting of wilderness therapy programs provides clients with a space away from family, friends, and the comforts of modern technology. Contact with the outside world is typically limited to letters exchanged several times a week. In wilderness programs, there are no electronic means of communication or comfort. Clients spend their days engaged in activities focused on developing basic living skills and therapeutic activities (e.g., one-on-one time with staff or group therapy sessions) (Bettmann & Jasperson, 2008).

Wilderness therapy programs incorporate numerous elements of family treatment throughout the treatment period. Designed to improve familial relationships, treatment usually incorporates weekly update phone calls between the family and program therapist, families' participation in weekly family therapy at their home location, regular phone contact between the family's home therapist and the client's program therapist, weekly written therapeutic assignments sent from client to parent, and regular written therapeutic assignments sent from parent to client (Bettmann & Jasperson, 2008).

Attachment Styles in Wilderness Treatment

It is essential for wilderness therapy programs to recognize general adolescent attachment patterns and specific adopted adolescent attachment patterns. Typical clients will likely have insecure attachment patterns as well as possess a strong sense of mistrust for authority figures (Cunningham & Page, 2001; Zegers, Schuengel, van Ijzendoorn, & Janssens, 2006). While some therapists utilize behavioral treatment paradigms in these settings, this focus does not address the internal representations of adults as being rejecting and untrustworthy (Cunningham & Page, 2001; K. Moore, Moretti, & Holland, 1998). An awareness of clients' internal working models and attachment styles becomes an important aspect in understanding clients' troubled behaviors (K. Moore et al., 1998).

Similar to “Strange Situation” dynamics, wilderness “therapy concerns itself over and over again with loss, separation, and reunion – both in its consideration of such events in patients' lives, and in the constant separations and reunions that are intrinsic to the therapeutic

process” (Slade, 1999, p. 589). The treatment staff and therapists often serve as models of attachment figures for adolescents, utilizing this unique therapeutic relationship to explore the functional reshaping of internal working models.

Attachment theory holds that successful treatment includes the client’s ability to utilize therapy and the therapist as a secure base (Bowlby, 1988). This utilization involves addressing past and present relational experiences, abstracting meaning and applying it in a way that facilitates the healing process (Slade, 1999). Even if the therapist provides a secure base, clients whose attachment organizations are insecure are likely to initially respond in ways consistent with their established patterns of defense and affect regulation (Slade, 1999). Bowlby (1988) believed, however, that therapists’ behavior could re-shape clients’ healing processes, allowing clients to improve understanding of experiences and develop positive relational growth in treatment.

Strategies for Treating Adolescents in Wilderness

Wilderness therapists are strongly encouraged to openly address adoption issues with adopted adolescents in the field. For the wilderness therapist, however, the first step in discussing adoption is communicating a comfort level discussing adoption issues. Displaying openness to talking about adoption issues can have the immediate therapeutic effect of lowering a client’s feelings of shame and secrecy about adoption. Observing the therapist’s comfort level with this topic is essential for the adolescent to feel comfortable exploring adoption issues. The adolescent needs to sense the therapist’s competency with adoption issues.

During the initial interview, it is important to be aware of body language and voice tone while addressing adoption. Adopted children can be sensitive to questions surrounding their parental histories. Often they do not know much detail, and may experience fear and anxiety around questions regarding health history. A comprehensive clinical assessment for adopted clients should involve their adoptive parents. Not only do many adolescents fail to disclose important information, they are generally not aware that information surrounding adoption issues is essential for treatment planning. It is important to obtain

information regarding relationship history during infancy, pre and post-natal development, the familial comfort level communicating about adoption, the adoptive parent's attitude toward birth parents, and the dynamics of the adoptive family (Riley & Meeks, 2005). In cases when the adolescent participates in psychological testing during wilderness treatment, it is important for the wilderness therapist and the testing psychologist to share information gathered about adoption issues and ensure that it is passed on to the next treatment provider.

Therapists should keep in mind that out-of-home treatment can be particularly unsettling for adopted adolescents. Often the decision for the child to be in wilderness is the parents' decision, not the adolescents', and the experience of separation anxiety and relational rejection can be highly disorganizing. Being sent away to be cared for by somebody else can mirror the original adoption dynamic, which the adolescent may or may not consciously acknowledge. Having knowledge of these relational dynamics can help the therapist and treatment staff put into context adolescents' feelings of desperation.

Wilderness programs often create the feeling of an isolated environment. While this can serve as a powerful element in this form of treatment, it is essential to pay particular care to clients' previous attachment relationships. Exploring all clients' feelings and meanings around relationships, as well as exploring feelings of grief and loss related to the interruption of these home attachment relationships, is an important part of the treatment plan. Therapists must emphasize to parents the importance of consistently writing letters, sending pictures, and being fully involved in family treatment meetings. Therapists may encourage letter writing with other important attachment figures, including previous therapists, close family members, siblings, and even peers. Although family therapy phone calls may not be a regular intervention in all wilderness treatment programs, the therapist may consider facilitating a family call in order to support familial attachment relationships during this time of separation and stress. Transitional objects, such as a stuffed animal or piece of jewelry that connects clients to family members, can also help decrease clients' anxiety during separation and support healthy attachment relationships (Bettmann & Jasperson, 2008).

For all adolescents in wilderness treatment, it is important to intentionally process relationship losses and transitions. In wilderness, clients often spend a week at a time with the same staff. When these staff members depart, clients often experience a great deal of emotional distress and may act out. For example, a client during staff change might project anger toward a staff member with whom he/she has become close. Such a response is indicative of insecure attachment strategies, and treatment staff must be trained to recognize these strategies.

Interventions should balance behavioral and relational interventions. For example, a student may need to be separated from the group for several hours after she has spoken aggressively to a staff member. During this time, the staff member may work one-on-one with the student to develop a behavioral contract regarding healthy communication. During this time, it is also essential that staff members process underlying emotions. For example, the staff member may have a conversation with the client about what it is like to grow close to someone and have them leave. The client may or may not demonstrate insight into her/his behavioral patterns around relational transitions. However, when staff members stay attuned to the attachment behaviors of clients, and respond by being consistent, display healthy boundaries, and serve as nurturing attachment figures, they create an environment where clients' maladaptive attachment patterns can begin to shift.

Peer relationships are particularly important to adolescents and it is critical for the therapist to recognize this when treatment planning. While a primary treatment goal for adolescent clients is to strengthen parent-child attachment relationships, addressing peer attachment relationships can help improve clients' attachment strategies. Maintaining a connection with healthy peers (e.g., via letters or photos) may help adolescents ease feelings of separation anxiety. Emphasizing the development of healthy peer relationships in the treatment environment is also important. Peer relationships are central attachment relationships for adolescents and can provide a sense of security and connectedness which serves as a foundation for client growth.

Although adolescent clients often present as having little interest in relationships with adults, these relationships are essential.

Adolescents want and need attachment relationships with adults. A central focus of treatment should be the development of healthy relationships between client and therapist, and client and treatment staff. When the clients begin to develop positive relationships with adults in treatment, their ability to transfer those positive relational experiences to familial relationships can grow. Interventions aimed at supporting this goal include: (a) talking openly with the client about how practicing healthy interactions with adult treatment staff is important practice for family relationships, (b) exploring transference issues with the client, and (c) facilitating role plays using clients' family relationships.

Given the short duration of most wilderness treatments, only initial progress may be made on adoption and attachment issues. While it is important for therapists and treatment staff to create openings for conversations about adoption and attachment issues, it may not be appropriate to push these issues unless the client presents as being motivated to address adoption and relational issues. This is because wilderness treatment may be too short-term in treatment length to adequately address this issue. It may be more appropriate for relational issues to be explored in long-term treatment, in the context of longer-term therapeutic relationships. Even when adoption or attachment issues are not addressed directly in wilderness, attachment interventions during this phase of treatment can have a powerful effect on establishing an appropriate base for clients to explore these issues in depth during the next phase of treatment.

Working with Parents of Adopted Adolescents

It is also essential for therapists to be aware of common emotional experiences of adoptive parents. An adoption in a family can affect parenting styles, shape family dynamics, and influence parents' self concept. Adoptive parents often express feelings of uncertainty, anger, shame, guilt, (Riley & Meeks, 2005) and face unique parental identity issues. Some adoptive parents feel uncertain about their adopted child, feeling as if they do not have full right to the child (Riley & Meeks, 2005). Adoptive parents may feel that their status as parents comes from luck and they are not fully parents. Parents often adopt because they are unable to have children of their own. When the adopted child struggles or acts out, parents might question whether

they should be parents, viewing their child's difficulties as evidence to support this doubt. Disavowal is also a common parental response, with parents keeping their children at arm's length. Parents may experience grief and loss associated with the fantasy that a biological child may have been more compatible in the family (Riley & Meeks, 2005).

Many adoptive parents harbor feelings of anger toward their children and then feel shame regarding this anger. Anger may also surface in the form of blame. Adoptive parents may harbor thoughts such as, "Look at all I've done for you – I gave you this chance for a good life. You're not even my kid, and now you are treating me like this?" This is a common defense for parents who may be feeling guilt for sending the child away or shame in experiencing themselves as inadequate parents (Riley & Meeks, 2005).

Frequently expressed by adoptive parents, guilt manifests itself in various ways. Adoptive parents often feel guilty about the adopted status of their child, and feel as if the child started life at a disadvantage. Some adoptive parents may respond to this dynamic by having difficulty setting limits or boundaries for their child. Facing out-of-home treatment can bring up unique feelings of guilt for adoptive parents. Sending their child to wilderness or other out-of-home care can mirror the original adoption dynamic (i.e., sending the child away to receive adequate care in another environment). This evoked dynamic may elicit complex feelings of guilt or shame in adoptive parents (Riley & Meeks, 2005). Adoptive parents may also be defensive in discussing the impact of adoption. They may want to deny that adoption is an issue. If they are willing to entertain the possibility of adoption's significance in the child's clinical picture, they may be ambivalent about its importance (Riley & Meeks, 2005). Many parents seem to be fearful of putting too much weight in this area. Within society and sometimes the family itself, the status of adoptive parents as "real" parents is often challenged (Riley & Meeks, 2005). These dynamics can make it difficult to openly address adoption issues with adoptive parents.

Many parents find it helpful when a therapist educates them about adoption dynamics. One study showed that parents found this to be the most helpful element of therapy (Riley & Meeks, 2005). Even

if adoption is not the wilderness therapist's primary area of expertise, the therapist can provide education in various ways. For example, a clinician can direct parents to educational resources, encourage family therapy with a therapist who has expertise with adoption issues, and encourage parents to attend specialized parent support groups. Therapists should have awareness of the feelings commonly experienced by adoptive parents in order to work effectively and sensitively with this population.

Conclusion

Wilderness therapy is becoming an increasingly common treatment for adolescents (Werhan & Groff, 2005). Adolescents with insecure attachments often lack trust and typically engage in high levels of conflict. While some programs utilize primarily behavioral interventions, this limited focus ignores insecure adolescents' internal representations of adults as rejecting and untrustworthy. Attachment-oriented wilderness therapy programs create an environment conducive to the disruption of insecure attachment cycles by challenging clients' long-held relational beliefs. Although clients' internal working models are long-lasting and hard to change, wilderness treatment programs can facilitate change, beginning to disrupt the influence of early negative relational experiences (Bettmann, 2007). The introduction of different relational experiences, in addition to the continuous exposure to evidence that contradicts existing relational representations, creates an opportunity for personal re-evaluation.

Family involvement is a key element in this attachment-focused therapeutic process for adolescents. Making parents aware of their own and their children's attachment needs places them in the best position to strengthen family relations. This is particularly true for families with an adopted child. Not all wilderness programs, however, incorporate family treatment into the client's treatment plan. With all clients, addressing family dynamics is a critical component to successful treatment outcome. Wilderness therapy programs could greatly benefit from developing more fully this critical therapeutic element.

In addition to family involvement, staff members are

important components in attachment-focused wilderness treatment. Unfortunately, many programs do not adequately educate staff on attachment strategies and clients' attachment needs. Staff should be trained to re-conceptualize specific acting out behaviors as adolescents acting out of attachment needs. Attachment-focused treatment is most successful when a consistent staff team, enabling clients to experience a secure base in the treatment milieu, regularly applies such interventions. Thorough and regular training on the relational needs of children and their attachment strategies is recommended.

Wilderness therapy programs historically have based treatment on cognitive and behavioral interventions rooted in social learning theory (Cunningham & Page, 2001). These interventions typically use reward and consequence to reinforce pro-social behaviors and to discourage undesired behaviors. However, this approach can lack emphasis on the relationship between client and staff (Cunningham & Page, 2001). The incorporation of attachment-focused interventions that consider the critical impact of relationships and relational strategies for all clients is highly recommended. Such focuses further enhance and strengthen the wilderness therapy treatment milieu.

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