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ORIGINAL PAPER

Adults in Wilderness Treatment: A Unique Application of Attachment Theory and Research

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Abstract Research shows how an understanding of adult attachment applies to clinical treatment, such as outpatient therapy, but no literature explores the application of adult attachment to wilderness therapy, a distinct type of residential treatment. This paper explores how an understanding of adult attachment applies to wilderness therapy clients, as the nature of wilderness therapy involves losses, separations, and reunions, all of which evoke attachment needs. Adult wilderness treatment exemplifies an effective method of treatment that provides a secure base and supports healthy attachment relationships.

Keywords Adult attachment · Residential treatment · Wilderness therapy

Attachment theory hypothesizes that our experiences of early relationships frame our later understanding and use of important relationships. During development, humans assimilate new experiences into "internal working models" (Daniel 2006; Shorey and Snyder 2006). As we mature into adulthood, these internal representations of relational experience serve as road maps for interpreting and responding to others, resulting in self-perpetuating interactional behaviors (Bowlby 1988; Daniel 2006; Mickelson et al. 1997; Rothbard and Shaver 1994).

These attachment patterns, however, are not fixed. Changes in attachment patterns can result from a multitude of factors, in a positive or negative direction. One such factor is repeated evidence or experience that positively or negatively challenges existing representations (Hamilton 2000; Rothbard and Shaver 1994; Shorey and Snyder 2006; Simpson and Rholes 2004). For example, elevated life stressors or changes in family circumstances may disrupt the relationship between child and caregiver. Caregivers' experiences with their own negative affect states may reduce their availability to attune to and regulate their children's negative arousal.

Effective psychotherapeutic treatment can work to heal early attachment failures, providing "earned security" (Roisman et al. 2002) in attachment relationships. The concept of "earned security" means that treatment or other positive life experiences can facilitate an individual's ability to overcome negative childhood histories, leading them to use more secure attachment strategies. Earned security is demonstrated in clinical settings when insecurely attached clients become able to recount life experiences from a coherent perspective, breaking negative intergeneration relationship cycles (Paley et al. 1999; Phelps et al. 1998; Roisman et al. 2002). Successful treatment can provide corrective emotional experiences, enabling clients to regain trust in a relationship's ability to provide support, containment, and regulation.

Wilderness treatment programs create an environment conducive to the disruption of insecure attachment cycles, opening the way for the development of earned security as positive therapeutic relationships are established and insecure attachment patterns are challenged. Although working models created within early attachment relationships are expected to have far reaching effects, wilderness treatment programs facilitate changes in working models, disrupting the influence of early experiences. The introduction of new life experiences, in addition to the continuous exposure to evidence that contradicts existing relational representations,

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creates an opportunity for the client to develop "earned security."

This paper explores residential wilderness treatment as an attachment-based intervention in the treatment of adults. It suggests that wilderness therapy provides an avenue for the successful treatment of insecure attachment wounds. At this time, there is little research investigating adults in wilderness programs, and existing literature on adults in wilderness focuses on psychological gains through non-clinical programs such as Outward Bound (Asher et al. 1994; Goldenberg et al. 2005; Hyer et al. 1996; Kelly 2006; Paxton and McAvoy 2000). While adventure-based therapy programs continue to grow in popularity and size (Kelly 2006), no significant research has investigated the therapeutic processes of wilderness programs for adult clients. Further, no research has explored the application of adult attachment to wilderness therapy.

Nevertheless, attachment theory is pertinent to wilderness therapy programs due to the particular type of residential treatment that it offers. Similar to typical residential treatment programs, wilderness therapy programs provide 24-h care away from the home environment in a therapeutic community. However, wilderness therapy programs provide therapeutic care entirely within a wilderness 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. [This] process is facilitated by licensed professionals" (p. 3). The wilderness setting also provides clients with a space away from all family and friends. Typically, clients' only contact with friends and family is through letters exchanged several times a week. In the program, there are no landlines or cell phones, computers or emails, televisions or electronics, buildings or lights. Clients spend each day engaged in activities for daily living, such as cooking, getting water, and making fire, or therapeutic activities.

The wilderness environment allows clients to focus on what is present, taking care of daily life, and thinking about what one feels now in the moment. Clients report feeling slowed down, calmer, and more focused in the wilderness milieu. In other words, the extreme novelty of the wilderness program experience, in combination with separation from loved ones and familiar surroundings, intensifies the likelihood that the participant's attachment system will become activated. Such activation, especially in the presence of new secure attachment figures, offers participants the possibility of creating new, healing relationships, which may serve to alter previous attachment patterns.

This article will begin with a literature review on adult attachment strategies and adult attachment in clinical settings. Adult attachment patterns present distinctly in adult treatment programs, and these patterns in treatment will be explored. Next, this paper will explore adult attachment themes in residential wilderness treatment and will consider how this therapeutic context allows for the disruption of disturbed attachment patterns while providing a secure base. Finally, this article will present a case example, which illustrates how attachment style serves as a foundation for interpersonal relationships in a wilderness treatment program.

Literature Review

Adult Attachment Strategies

Optimally during childhood, children receive primary support and care from parents. When conditions are suboptimal in childhood or adolescence, disturbed attachment patterns can develop. Children look to their caregivers to provide a sense of safety and security. From this safe base, children explore their worlds and form relationships. Bowlby (1969, 1973) hypothesized that children use caregivers protectively to help mediate threat and loss. He believed that, in times of stress, children rely on attachment relationships by maintaining proximity to nurturing adults who help to manage distress and maintain a sense of safety. He noted that in times of threat or loss, the attachment system is activated.

When caregivers are abusive or neglectful, children develop problematic strategies to maintain connection with their caregivers. When caregivers are abusive, "at once the source and the solution" (Main and Hesse 1990, p. 163) to children's attachment dilemmas, children's needs for connection and security are activated, but they are unable to receive soothing. Liotti (2004) notes, "[this] leads to fright without solution... There is no single, coherent behavioral or attentional strategy able to interrupt the loop of increasing fear and contradictory intentions (approach and avoidance) in the infant's experience" (p. 477). Insecure, even disorganized, attachment strategies can result from such dilemmas.

Adult attachment styles, also termed "states of mind" in the Adult Attachment Interview, develop from these early experiences of relationship (Shaver and Mikulincer 2002). Adults with secure/autonomous attachment style are comfortable depending on others and find it easy to get close to others. These individuals likely experienced empathic and secure relationships with their caregivers. By contrast, clients in wilderness programs are more likely to have insecure attachment styles. For example, individuals with dismissing attachment style are uncomfortable being close to others and find it difficult to trust people. They often utilize deactivating strategies to cope. These strategies involve the appraisal of proximity seeking as being

unlikely to alleviate distress. Therefore, the pursuit of support is minimal and the individual is likely to attempt the handle the distress alone (Mikulincer et al. 2003). Dismissing attachment strategies consist of behaviors that maximize distance from attachment figures, assert independence, and demonstrate striving for self-reliance and control (Shaver and Mikulincer, 2002). These individuals use deactivating strategies, denying attachment needs, avoiding intimacy and close relationships (Mikulincer et al. 2003). In wilderness programs, these behaviors are often displayed through isolating, excessive demonstrations of independence, superficial interpersonal connections, and extreme acting out behaviors in order to keep others at a comfortable emotional distance.

Adults with preoccupied attachment style see others as reluctant to get close, fear that others do not really care about them, and are often viewed by others as clingy (Mickelson et al. 1997). These individuals often utilize hyperactivating coping strategies. This hyperactivation requires constant vigilance until an attachment figure is perceived as available and a sense of security is attained (Cassidy and Kobak 1988). According to Shaver and Mikulincer (2002), clinging and controlling behaviors which attempt to minimize distance from attachment figures are indicative of this strategy. Clients in wilderness programs that utilize these strategies often display behaviors associated with low self-esteem. They are clingy, particularly with staff, and mirror others' behaviors in an attempt to fit in. Preoccupied clients in wilderness programs often identify people that they believe to be well-liked and try to replicate their behaviors. Believing that their own personality is not as likable as the identified well-liked individual, they often monitor others' idiosyncratic behaviors and attempt to mirror them. In addition, they display hyperactivating strategies which can include excessively energetic behaviors and physical aggressiveness.

Those labeled as cannot classify/disorganized demonstrate high levels of both dismissing and preoccupied strategies or appear globally incoherent (Daniel 2006; Main 1996). These individuals will often resort to "strategies of desperation" including "dependent or childlike behavior... rages and aggression... or frozen withdrawal" (Solomon and George 1999, p. 27). They typically lack self-soothing skills and become unsteady in difficult or frightening circumstances (Cassidy and Mohr 2001).

Young adults in wilderness programs are especially challenged by difficulties with self-soothing. Over 90% of clients have substance abuse or dependence diagnoses; most also have co-morbid mood or anxiety diagnoses (Pam Parsons, personal communication, March 15, 2007). Clients are commonly diagnosed with Axis II traits, as well, and nearly all have histories of either suicide attempts, assaultive behaviors, or both. All have experienced significant trauma or disruption, such as loss of a parent through suicide or illness, divorce of parents, survival of sexual assault, adoption in infancy, school and vocational problems, or legal troubles. Nearly all have been through multiple inpatient and outpatient treatments prior to entering the wilderness therapy program. As there is research linking insecure and disorganized attachment styles with Axis II disorders, trauma and loss (Cassidy and Mohr 2001; Fonagy et al. 1996; Westen et al. 2006), it is likely that participants in wilderness programs experience difficulty with self-soothing and have insecure attachment organization.

Adult Attachment in Clinical Settings

Recent adult attachment literature has focused on clinical applicability (Daniel 2006; Eagle 2006; Shilkret 2005; Shorey and Snyder 2006). In *A Secure Base*, Bowlby (1988) wrote, "In providing his patient with a secure base from which to explore and express his thoughts and feelings, the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world" (p. 140). One of the most fundamental contributions of attachment theory to clinical work within a wilderness treatment program is the framework it provides for understanding the developmental history and internal working models of clients (Daniel 2006). Whatever the goals of treatment, attachment-oriented therapists focus on altering clients' existing working models (Daniel 2006).

As clients reenact attachment patterns in clinical settings, therapists gain insight into clients' working models (Mallinckrodt et al. 1995; Slade 1999). These mental representations, whether reflected in narrative or affect, affect therapists' responses (Meyer and Pilkonis 2002) and the development of the therapeutic alliance. In treatment, attachment-oriented therapists focus on creating conditions through which clients can explore current and past attachment experiences (Sable 1992). Adult clients clearly demonstrate their attachment styles in the therapeutic relationship. This allows therapists to use observations of transference to further treatment (Shilkret 2005). In wilderness treatment programs, therapists and staff spend extended periods of time with clients. This creates an opportunity to observe attachment behaviors under various circumstances that most treatment settings would not accommodate. Thus, therapists can utilize these observations, challenging clients' internal working models and furthering their treatment.

Attachment-oriented therapists also consider what therapeutic approach the client can tolerate (Shilkret 2005). For example, a client who demonstrates a dismissing pattern of

attachment may be unable to respond to a therapist's inquiries about the interpersonal impact of a cancelled session. However, a client with a preoccupied attachment style may interpret a lack of inquiry about the cancellation as a therapist's dislike for him (Shilkret 2005). Client responses to interpersonal interventions provide knowledge to therapists helping to determine the therapeutic approach most conducive to clients' attachment styles.

Attachment in Residential Treatment

Most clients in residential treatment have insecure attachment styles and possess a strong sense of mistrust (Cunningham and Page 2001; Zegers et al. 2006). Research supports the link between insecure attachment and the psychological disturbances of residential treatment clients (Dozier 1990; Fonagy et al. 1996; Meyer et al. 2001; Wallis and Steele 2001). In their study of adolescents in a psychiatric residential unit, Wallis and Steele (2001) found most clients had insecure attachment type, particularly dismissive type, as measured by the AAI. Fonagy et al. (1996) concluded that non-psychotic psychiatric inpatient adults were most often preoccupied or unresolved/disorganized type.

The behavioral focus of most residential treatments is based on the assumption that client behaviors, often difficult and threatening, need to be contained and controlled (Cunningham and Page 2001; Moore et al. 1998). Individuals in residential care typically appear to be beyond control, feel unloved or unlovable, are aggressive or frequently in a state of crisis (Schofield and Brown 1999). These clients can be so damaging to themselves and others that they often seem beyond help and desperate for containment (Schofield and Brown 1999).

Residential programs generally provide a feedback system to clients concerning appropriate social behaviors. This feedback is generated through fairly rigid, institutionalized systems of rules and consequences. However, within this treatment environment, clients are likely to develop external locus of control (Cunningham and Page 2001). In an environment where clients perceive their behaviors as controlled by others with externally imposed rewards and consequences, clients are unlikely to develop internal controls, acceptance of personal accountability, or other characteristics associated with long-term pro-social behavior change (Cunningham and Page 2001; Moore et al. 1998).

In contrast to the behavioral approach of most residential treatments, attachment-oriented approaches encourage understanding the meaning of behaviors rather than simply attempting to control them (Moore et al. 1998). It is best to view client behaviors as resulting from a compilation of years of conclusions about themselves in relation to others (Zegers et al. 2006). Therefore, understanding the troubled behaviors of clients in residential programs requires an awareness of their internal working models (Moore et al. 1998). Behavioral programs in most residential treatments do not directly address clients' internal representations of caregivers as being rejecting and untrustworthy (Cunningham and Page 2001; Moore et al. 1998) or focus on repairing dysfunctional family relationships.

In residential treatment centers (RTCs), focus on relationships is critical. Treatment outcome is impacted by relationships formed with staff or other patients and through the isolation of the client from previous attachment figures (Schuengel and van Ijzendoorn 2001). Research into RTCs has shown the need for staff and therapists to provide a secure base for clients (Moses 2000). If the environment is safe and consistent and quality relationships are established, clients' interpersonal patterns can be explored and possibly reshaped (Moses 2000).

In contrast to behavioral treatment approaches which focus on behavior provocation and control, attachment-oriented therapies consider affect arousal and regulation. RTCs aim to help clients develop an awareness of their emotional and behavioral activation. For example, treatment staff might assist avoidant/dismissing individuals in identifying inhibited emotional states such as anger, and might help anxiously attached/preoccupied individuals manage their intense, negative emotional experiences through emotion regulation interventions. In RTCs, staff not only model healthy ways to address such emotions, but also create a secure base environment for addressing problematic affective strategies.

Ultimately, the goal of RTCs is improved client self-regulation. For most RTC clients, distress-regulation is not the main regulatory achievement of the attachment system. Instead, hyperactivation or deactivation of the attachment system is the achievement. Hyperactivating strategies keep the attachment system chronically activated while deactivating strategies keep the attachment system in check (Mikulincer et al. 2003). In RTCs, attachment-oriented treatment focuses on helping clients to understand their various states of affect arousal and assists them in recognizing their unhealthy relational patterns and self-regulation strategies.

The therapeutic communities in residential treatment serve various functions. Frequent interactions with the therapist helps the client to maintain therapeutic continuity (Tolmacz 2003). This sense of continuity increases the likelihood of establishing a solid therapeutic alliance, secure-base relationships, and positive treatment outcome. In addition, these frequent encounters enable the therapist to witness the client in different interactions and relational contexts (Tolmacz 2003). These everyday encounters provide the therapist with deeper insight into clients' attachment strategies.

Wilderness Treatment

Wilderness therapy programs are a type of residential treatment. Licensed by state agencies, wilderness treatment programs are staffed by clinical therapists and field guides who are specially trained in areas such as substance abuse and de-escalation skills and work with clients in a group wilderness setting. Clients have regular contact with licensed, masters-level mental health practitioners who also work with clients' families to help them to understand the nature of client behaviors and to enhance treatment objectives. Clients have personalized treatment plans and receive formal evaluations of treatment effectiveness. In addition, therapists provide aftercare planning to each client's family to ensure that progress made during the program will be maintained. In this treatment approach, the outdoor environment is used to assist clients in leaving behind their familiar maladaptive culture and creating a unique experience that will facilitate specific learning and therapeutic objectives (Russell 2001).

The 7-week residential wilderness therapy program presented in this paper works to provide a secure base for clients through its base camp model. This program serves both adolescent clients, aged 14–17, and young adult clients, aged 18–28, in separate groups. Clients live in the wilderness with primary care staff and participate daily in group and milieu treatment with Masters-level psychotherapists. Psychotherapists spend 2 days each week in the field with clients providing individual and group psychotherapy.

Prospective clients typically referred by their parents for treatment. Clients often hear from their parents that they will be financially cut off or receive other consequences if they do not attend some kind of treatment. Prospective clients are screened medically and clinically by program staff prior to admission. Typical presenting problems include low self-esteem, oppositional defiance, drug abuse, alcohol abuse, depression, Attention-Deficit Hyperactivity Disorder, grief and loss, promiscuity, relationship problems, manipulation, entitlement, adjustment issues, anxiety, anger management, learning disabilities, social skills deficits, family problems, school problems, self-destructive behavior, and identity issues. Issues that are not well served by this program are psychosis, patterns of violent behavior, sexual perpetration, patterns of severe suicidal behavior, serious eating disorders, diabetes, severe conduct disorder/antisocial behavior, severe borderline personality traits, IQ below 90, and medical conditions deemed unsafe for a wilderness setting.

This program combines traditional therapeutic approaches with naturopathic medicine, innovative substance abuse treatment, organic whole-foods nutrition and healthy outdoor living to facilitate an optimal healing environment. Therapists create individualized treatment plans for each client and work with each client's family to provide appropriate aftercare planning. These treatment plans consist of developing short-term objectives and long-term goals, making sure to address both challenges and strengths. Therapists refer clients for psychiatric consultations as needed during the program.

During the program, adult clients live in the wilderness with groups of seven peers and two or three staff, hiking most days to primitive campsites. Clients work together to accomplish daily living tasks such as pack-building, shelter-construction, primitive fire-making, and meal preparation. Clients also work through a level system with therapeutic assignments appropriate to each level. Program groups expedition for 5 or 6 days, hiking from primitive campsite to campsite and setting up temporary shelter at each place. On the sixth day, groups return to the program base camp where each group has a canvas teepee and fire-pit established. During base camp time, clients meet with their individual therapists, receive mail from home, get a new supply of food, and welcome a new staff team. Clients state that they feel reassured when they return to base camp after some days away, explaining that the familiar sites and activities provide soothing familiarity. Clients report that the emotional and physical activation, which occurs when they are in strange places, in urban environments or wilderness, does not occur at base camp. Clients are in a familiar place at base camp, feel calmer, and act accordingly. Similar to the soothing familiarity provided by a safe attachment figure, the base camp provides clients with a safe haven, a calming space in which safety is predominant and deactivation can occur.

Attachment in Wilderness Treatment

The nature of wilderness therapy programs involves losses, separations and reunions, all of which evoke deeply-embedded attachment needs. Adult clients entering wilderness therapy programs leave all of their family and friends at home and enter their treatment group without a single attachment figure. This provides significant strain on clients' already-taxed attachment systems. Leaving all of one's attachment relationships at home causes significant upheaval for adult clients suffering from drug dependence, mood disorders, and occupational failure and other strains. The stress of leaving existing attachment figures and the novelty of the wilderness experience serve to activate the attachment system, creating the need for a sensitively attuned figure who can regulate the activated affect and serve as a secure base. Staff often become this figure for clients.

Further, clients in wilderness therapy often recognize the impact of negative affiliative relationships at home such

as drug-abusing friends and problematic attachment relationships such as abusive partners. These clients often use the time in wilderness to gain insight into, begin to let go of, and grieve these destructive relationships. Thus, clients suffer not just the loss of important attachment figures at home but the reevaluation of those relationships which also involves loss.

For participants in this program, this loss of attachment figures is a profoundly distressing event. Intense emotions typically do not persist following loss. Life eventually regains normalcy, painful feelings lessen, and thoughts of the lost relationship cease to dominate thought content (Shear and Shair 2005). For some, this favorable outcome does not occur. For example, Wayment and Vierthaler (2002) found that following the loss of a loved one, individuals with anxious-ambivalent attachment reported higher levels of grief and depression. Fraley and Bonanno (2004) found that fearfully-avoidant individuals, who demonstrated hyperactivation of the attachment system like preoccupied individuals and also avoidance of closeness like dismissing individuals, struggled unsuccessfully to adapt to the loss of a loved one. The authors also found that dismissingly-avoidant adults demonstrated resilience to loss using deactivation strategies. Particularly for fearfully-avoidant individuals, the stress of grief can inhibit motivation and interfere with long-term goal development. This decrease in motivation creates new stresses, further triggering the attachment system and inhibiting engagement in group activities (Shear and Shair 2005). Wilderness programs can provide adequate support and resources to clients struggling with the stress of loss, allowing space for temporary withdrawal and the development of new secure-base relationships.

Without easy access to attachment figures from home, clients in wilderness therapy necessarily form new attachment relationships, most often with paraprofessional staff members. The two or three staff in each group camp out with clients, lead hikes, facilitate groups, teach outdoor cooking skills, and provide one-on-one mentorship and guidance. Clients often become close with staff, who work 8-day shifts in the program followed by 6 days off. On staff change days, during which one staff team leaves the group and a new staff team comes in, clients experience emotional disruption. Staff live 24-h a day with clients for 8 days at a time; clients often become attached and are hurt by staff departures. While separations from staff members last only 6 days, clients often experience these separations negatively. Some clients express their worries to staff by making statements such as, “you’re happy to leave me and have your time off.” This response illustrates the frightened response and insecure attachment fears of many clients.

This response further suggests that insecure clients typically view staff departures as abandonment. Many react with a mixture of resentment, hostility, anger, self-criticism, fear, sadness, and depression. Clients with preoccupied attachment often utilize hyperactivating strategies, demonstrating anxious, hypervigilant attention to the staff relationship and looking for possible signs of disapproval, waning interest, or impending abandonment. Individuals with dismissing attachment utilize deactivating strategies to cope. They distance themselves from staff in anticipation of staff departures and rarely seek support in addressing the loss. Clients with disorganized attachment often react with a combination of rage and anxiety to staff departures. Such clients typically act out their attachment distress by breaking program rules in the day prior to staff departures or by withdrawing entirely, stating that they cannot talk to staff.

Clients report feeling calmer and better in the presence of staff with whom they are attached, showing the beginning of “earned secure” attachment relationships. That is, these individuals, despite a history of insecure attachment patterns, are learning to function competently in close relationship in adulthood (Paley et al. 1999). Clients often say to returning staff members, “look at what I’ve been doing this week. I’ve been doing so well. You would have been proud if you had seen me do this!” Such statements demonstrate the need to be seen and understood by attachment figures, as well as the desire for recognition and support from such important figures. These statements also show the beginning of a therapeutic attachment bond that has some security and trust.

Reunions during wilderness therapy programs occur not only with program staff, but also with clients’ families at the end of the program. These reunions commonly reveal insecure attachment patterns between parents and their adult children. Some clients demonstrate elements of dismissive attachment style, acting blasé when their family members come to wilderness base camp at the end of the program. Even after nearly 2 months apart, some clients barely smile at their family members and look away often. In such behavior, clients display their best attempts at protecting against relational harm using dismissive attachment strategies.

Other clients demonstrate preoccupied attachment strategies during family reunions, becoming dysregulated at the idea of seeing family and demonstrating clinging and highly emotional responses to families’ presence. Such clients often find it difficult to separate from family members and express extreme upset at the idea of further separation. In preoccupied clients, such separation heightens fears of abandonment and evokes long-held beliefs about their unlovability. Disorganized clients demonstrate elevated levels of both dismissing and preoccupied behaviors. Their inability to self-regulate effectively makes reunions stressful and often frightening. Such clients often

respond to family reunions with frozen withdrawal or explosive rage.

Securely attached clients typically reunite with family or staff with excitement and warmth, seeking connection. By contrast, insecurely attached clients demonstrate avoidant and often contradicting behaviors. These adult behaviors commonly parallel the Strange Situation responses of toddlers. The departure and return of staff and family is similar to the departure and return of caregivers during the Strange Situation. Similar to toddlers in the Strange Situation, adult clients in wilderness demonstrate emotional reactivity to separation from family and important staff. Clients often demonstrate this reactivity through aggressive acting out, tearful clinging behaviors, and anger at family or staff. For example, toddlers labeled as insecure-ambivalent in the Strange Situation typically demonstrate elevated distress at separation and concurrent seeking and resistance to contact at reunion (Main and Solomon 1986). Similarly, preoccupied adults in wilderness reunited with family or staff exhibit these same behaviors. Dismissing adults, like avoidant toddlers, typically maintain distance from returning staff for several days, ignore family members when reunited, or struggle with the desire to reconnect and resistance to those feelings.

Transitional objects play an important role for adult clients in wilderness treatment. Transitional objects, such as photos and letters from important attachment figures at home, remind clients of attachment relationships and the feelings of safety which emerge from those relationships. Transitional objects from staff also are important for clients. Staff often write short notes in clients' level workbooks expressing support and belief in the client. Such notes serve to anchor clients in the developing attachment ties with staff, providing reminders of clients' capabilities and sense of worth. Such notes may give clients a sense of safety and stability, even in the context of changing staff teams and the resultant departures and reunions.

Attachment-oriented Family Treatment

Research has shown significant intergenerational transmission of attachment style (Fish and Dudas 1999; Fraiberg et al. 2003; Main 2000; Shilkret 2005). On the Adult Attachment Interview (AAI), caregivers typically provide responses linking them to the parallel attachment category of their child (Fish and Dudas 1999). Researchers find high correlation between attachment patterns of parents with those of their children. Secure parents are likely to have secure children, dismissing parents to have avoidant children, preoccupied parents to have resistant children, and unresolved/disorganized parents to have disorganized children (Shilkret 2005). The AAI narratives of preoccupied parents typically display confusion and preoccupation with their own attachment figures. When discussing unresolved trauma, parents of disorganized/disoriented infants demonstrate lapses in the monitoring of their reasoning and lose track of their narrative flow.

Parents of adult clients in wilderness therapy often reenact insecure attachment dynamics from their families of origin. Many parents of adult clients in wilderness describe relationships with their own families of origin as tentative, highly conflicted or distant. Parents of adult clients often describe wanting to be close with their children, but feeling unsure how to do this. Adult clients in wilderness treatment sometimes state that they have never heard either parent express feelings or cry. Such statements are perhaps indicative of their parents' discomfort with closeness and caregiving, and insecurity in the attachment relationship with their children.

In an effort to improve relationships between parents and clients in treatment, the wilderness therapy program incorporates numerous elements of family treatment throughout the 7-week treatment period. These family treatment elements are designed to improve familial communication through weekly treatment update phone calls from the client's program therapist, weekly family therapy at their family member's 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. The program also provides parents of adult clients with a workbook of therapeutic assignments to encourage a reflective process and strongly recommends all parents enter weekly family therapy in order to aid in this work.

For example, therapists working with parents of adult clients in wilderness encourage parents to reflect on their needs for closeness and connection in order to separate their own attachment needs from those of their children. Therapeutic intervention with these parents involves affective identification of past childhood experiences. When parents are able to retrace their feelings of ambivalence and rejection of their children to their own childhood experiences, therapeutic success is more likely (Lieberman et al. 1999). Facilitating parents' access to their childhood pain effectively deters the repetition of troubled relationship patterns while continued repression of childhood relational experiences reinforces their continued existence (Fraiberg et al. 2003).

Wilderness therapy can also serve to enhance positive affect between parent and adult child. Mikulincer and Sheffi (2000) assert, "...interactions with significant others who are responsive to one's attachment needs may lead to the experience of more and longer episodes of positive affect, the development of positive feelings towards these

persons, and the reliance on support-seeking as a mood-repair device" (p. 150). This suggests that wilderness therapy programs enhance positive affect between parent and adult child by implementing interventions which improve emotional attunement. These interventions include therapeutic letters in which parent and child share emotions or reflect each others' experiences. Such interventions serve to improve emotional exchanges and heighten attunement, thereby increasing possibilities for fun, joy and other positive affective exchanges. Mikulincer and Sheffi state, "[t]he more positive the interactions with significant others in times of need, the more secure a person will be in others' availability, and the more relaxed he/she will be when no threat is present" (p. 152).

In sum, wilderness therapy interventions provide opportunities for the enhancement of the parent-child relationship, increasing the likelihood of positive affective exchange. The nature of wilderness treatment clearly evokes attachment themes of separation, loss and transition, while it also treats attachment disturbances through careful attention to therapeutic relationships in treatment and supportive and modifying work with families. Attachment dynamics in a wilderness therapy setting are illustrated most clearly through the following case example.

Case Example

Doug was a 20-year-old client at a wilderness therapy program who entered treatment at his adoptive mother's urging. She reported that he had been "acting out" for years, not following rules, getting into minor troubles with the law, being disrespectful at home and having angry outbursts at home and elsewhere. Doug reported that he frequently screamed at his mother, threatened his girlfriend physically, and once slammed his cousin against the wall, fracturing his cousin's shoulder. Doug also reported drinking daily, typically 14 to 18 beers throughout the day.

Doug was adopted at 1-year-old, following abandonment by his biological mother and extreme mistreatment by his biological father, who cut Doug's legs repeatedly. Following multiple hospital visits and an anonymous report of abuse to Child Protective Services, Doug was removed from his biological father's care to a foster home. His foster mother, a single parent with two other foster children, adopted Doug after 5 years. His adoptive mother reports a warm relationship with Doug when he was young, but noted that he often became extremely agitated by her departures or absences. She also noted that, when upset, he took a long time to settle down.

Doug reported that he was suspended and expelled from school numerous times, typically for disrespect to teachers combined with physical aggression toward his peers. He reported that he never graduated from high school, even though he received good grades when he tried. He stated that school made him angry. Similarly, he reported that he could not keep a job for more than a few weeks, and he lived at home because he could not afford to pay rent. Doug reported a high level of conflict in his relationships with his single-parent mother and his girlfriend of eight months, describing both relationships as "angry all the time." He reported significant losses in his life: his biological parents with whom he had no contact, his adoptive grandparents who died when he was a child, and his mother's boyfriends, several of whom spent years living in the home.

At the beginning of treatment, Doug exhibited numerous symptoms of Post-Traumatic Stress Disorder and Generalized Anxiety Disorder, as well as some depressive symptoms. He also reported symptoms of Alcohol Dependence and Cannabis Abuse. His adjustment into the program was rough, as he argued constantly with staff and expressed repeatedly his desire to leave the program. He stated that the only reason he stayed in the program is "my mom will kick me out of the house if I don't finish the program."

Doug displayed many attachment strategies indicative of a disorganized attachment style. A style common to severe trauma survivors, Doug lacked resolution concerning areas of loss and trauma in his life. His dysregulation in the context of close relationships, extreme acting out behaviors, frequent lapses in the monitoring of reasoning, inability to emotionally regulate, contradictory coping behaviors, his inability to self sooth in stressful situations, and his competing approach/avoidance cognitive processes place him in the disorganized attachment category.

Doug began to engage in the program when he met with his individual therapist, Eric. He expressed interest in Eric and immediately began to do things which might please him. He promptly completed written therapeutic assignments given to him by Eric, and often asked for more time in individual therapy. He became sad when Eric left the group each week following their sessions, although he typically expressed his sadness through rage. He continued to argue with staff and to debate any direction they gave him rather than follow it.

Doug's treatment advanced significantly when Eric gave him an assignment to build a willow bench for the group. Doug described how he avoided tasks at home that might frustrate him, and he similarly avoided finding materials for the bench or investigating how to build it. He knew that he would need assistance from staff in order to complete the task, yet he described resistance to asking for any help from anyone. Doug became angry when Eric returned to the group 6 days later and Doug had made no progress on the bench. In individual therapy, Doug said, "this is too

hard! You can't ask me to do this!" Eric processed with Doug what was difficult for him about completing this task and explored how his difficulty with the bench related to his difficulties at home: problems with emotion regulation, disorganized attachment strategies, difficulty asking others for help, and difficulty engaging others in relationship without rage.

Doug displayed in treatment the same troubled attachment behaviors from home, but these were processed in a safe environment, with support provided to him so that he could make different relational choices. After Eric facilitated a group therapy session in which Doug was encouraged to ask staff and peers for their support to complete the project, Doug was able to complete the bench. In group, Doug stated that if the bench construction task had been given to him at home, he would have experienced the same frustration, but would have hit others or damaged property. He explored how his beliefs that others would not be able to help him often led to his rage and rejection of relationships.

In an individual session, Eric encouraged Doug to explore how his early experiences with abandoning, rejecting, and traumatizing caregivers contributed to his current beliefs about relationships. Eric asked Doug to complete a written therapeutic assignment, a letter to his mother in which he shared with her some of his beliefs and worries about his relationship with her. During a weekly treatment update phone call with Doug's mother, Eric asked her to respond carefully to the letter, affirming to Doug that she heard him and explaining concretely her hopes for their relationship in the future.

Family treatment was critically important in this case in addressing and modifying attachment dynamics between mother and son. Specifically, Eric worked with Doug's mother to address her responses to his rages. Previously, she had shut down when Doug raged, going to her room and shutting the door because she found his anger frightening. It seems likely that his mother's fear of his anger and departure to her room escalated Doug's dysregulation by replaying dynamics of abandonment by attachment figures. Thus, Eric encouraged Doug's mother to consider the emotion behind his rages and to think carefully about the emotional and relational needs he was expressing in his rages. Eric encouraged her to consider Doug's anger as a bid for containment, acceptance, and holding, and a signal that he needed her help with affect regulation. Eric assisted Doug's mother in exploring actions she could take which would communicate support and containment, rather than leaving which suggested rejection and abandonment.

As his wilderness treatment progressed, Doug described pride in his bench. He often sat proudly on it when the group was in base camp and sometimes invited others to join him on the bench. These invitations exemplified a small shift in Doug's internal working model. In treatment, Doug received a positive and disconfirming relational experience, one of asking for support from available others and receiving it. His achievement of working through the difficult task of building the bench and maintaining emotional regulation throughout is significant. Further, he learned that others were available to help him manage his emotions and would be attentive when he expressed distress. While still insecurely attached, Doug made his first steps towards more secure attachment relationships because he learned what they look like and what they can be relied upon to provide.

Discussion

Doug's case shows how his attachment style served as a foundation for his interpersonal relationships in a wilderness treatment program. His case illustrates how a therapist in residential treatment can work effectively towards establishing a secure base for clients. Doug's transference to Eric and the staff provided a clear window into his attachment style, while it also provided information about what he could tolerate relationally. His idealizing transference of Eric and rageful transference to staff illustrate his desire to be close, but also his strong mistrust of others. His therapist recognized his disorganized attachment style and assigned appropriate therapeutic tasks to begin to modify Doug's attachment strategies.

Doug's therapist carefully considered what early behavior and relationships of this client helped to determine his attachment style and thus what interventions would be most appropriate.

His interventions included strengthening the security of the attachment relationship between Doug and his mother by assisting them in voicing relational worries, having these heard, and then making clear commitments to strengthen their relationship. Further, Eric worked with Doug's family to recognize the relational needs behind his acting out. Assisting clients and families to recognize each other's attachment needs is a critical task of treatment. Helping adult clients and their attachment figures to see each other more clearly for their relational worries, hopes, and fears sets the groundwork for building towards secure attachment relationships.

Understanding clients' developmental histories and internal working models provides a clear view into their relational worlds and attachment patterns. Wilderness therapy provides a unique holding environment for clients with troubled attachment. This treatment provides the time and distance for critical evaluation of attachment strategies and careful application of relational interventions in the holding environment of wilderness.

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