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ORIGINAL PAPER

# Wilderness Therapy: Ethical Considerations for Mental Health Professionals

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**Abstract** Wilderness therapy is a growing treatment modality for adolescents presenting with a variety of clinical concerns, and wilderness therapy clinicians and referring mental health professionals must carefully consider the ethical issues that are unique to this modality. Following an overview of wilderness therapy as a mental health treatment, relevant ethical issues for mental health professionals are described and discussed, including the distinction between therapy and therapeutic experiences, the use of efficacious treatment, consent and confidentiality, therapeutic boundaries, a continuum of care and family involvement, and aftercare. A thorough reflection of the unique ethical issues faced by wilderness therapists is not only necessary, but will also assist in moving the field of wilderness therapy and outdoor behavioral healthcare forward in its establishment as both a recognizable and ethical treatment option.

**Keywords** Wilderness therapy · Outdoor behavioral healthcare (OBH) · Ethics · Adolescents

Melanie, 15-years-old, opens up the pasta and takes the lid off the pot of boiling water. She leans over, puts her brown hair behind the ears, and tosses the noodles into the bubbles. She then picks up the long-handled spoon and begins to stir. Over the next 10 minutes, Melanie continues preparing the dinner with Katie and Megan. As the sun begins to set behind the trees, the discussion moves away from casual conversation with increasing intimacy. Megan, a licensed therapist, prompts a discussion that continues a conversation that began the day before. Melanie, staring into the churning water, begins to describe the way she felt the first time she made herself throw up after a school picnic 3 years ago. Although she has not purged in over 4 months, each meal confronts Melanie with renewed confusion, fear, and, at times, disgust. Megan offers comfort and support, as Katie reaches over and rubs Melanie's back. After several more minutes, the meal is ready and the others are called

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over to eat. Melanie stands up, and before she begins to serve the spaghetti, walks over to Megan and gives her a hug. Later that night, Melanie lays inside her tent and tries to count the stars that she can see through the thin fabric. She thinks back to the earlier conversation, and a slight smile stretches across her face. Her body aches and she knows it will be cold in the morning, but she is distinctly aware of being surprisingly content.

Melanie is halfway through a 10-week wilderness therapy trip in western Colorado with eight other adolescents. Melanie lives with her parents in Virginia and has been seeing a counselor for the last year in order to address challenges associated with eating, self-image, and overall adjustment to high school. Initially resistant to the idea of spending ten of her long summer weeks backpacking through Colorado, she opened up to the idea after several conversations with her parents and therapist. Melanie is just one of many adolescents who participate in wilderness therapy expeditions each year, and although she is excited to return home and spend the rest of her summer relaxing with her friends, she is glad she pushed herself to do something she thought was beyond the realm of possibility. She wonders how—and if—this new experience will impact her life back home.

Melanie's wilderness therapy experience highlights several important ethical questions relevant to wilderness therapy. Melanie talks about her issues related to food and eating while stirring a pot of boiling water, and it is important to consider how physical and psychological safety are both established and maintained over the course of a wilderness therapy expedition. Who monitors Melanie's eating while she is backpacking for several hours each day? Is the conversation that occurred over dinner preparation considered to be actual therapy or is it more appropriately thought of as a casual conversation? How is Melanie's confidentiality protected, and how is information shared with other group members as well as other staff leading the trip? Melanie and Megan's hug represents a crucial component of wilderness therapy—the unique relationship between therapist and client—but how are professional and personal boundaries addressed with youth who present with a wide variety of clinical concerns?

Psychotherapy practice is laden with ethical dilemmas that require careful thought and attention. These dilemmas frequently arise when therapy takes place within the four walls of a clinician's office, but when the office becomes a forest, lake, or mountain—or all three—unique ethical quandaries are sure to follow. Following an overview of wilderness therapy as a mental health treatment modality, ethical issues are described and discussed as they relate to the practicing wilderness therapist or the mental health professional interested in referring clients to wilderness therapy programs. As a specialized field that draws from the skills of diverse professionals, it is believed that a thorough reflection of the unique ethical issues is not only necessary, but will also assist in moving the field of wilderness therapy forward in its establishment as an increasingly viable and ethical treatment option. This article is specifically directed to mental health professionals as opposed to wilderness guides or wilderness therapy programs, and although ethical aspects related to programmatic policy (including issues around the use of educational consultants, the use of escorts to transport youth to wilderness programs, third party payments, and assessment/diagnostic procedures related to program admissions) warrant examination as well, these programmatic issues are beyond the scope of this article.

## An Overview of Wilderness Therapy

Primarily geared toward adolescents, wilderness therapy broadly refers to various interventions that focus on using nature and the wilderness as a prominent aspect of treatment.

Foundational tenants to the wilderness therapy approach are the use of outdoor living, wilderness skills, and group dynamics to not only address personal problems and destructive behaviors, but also cultivate a sense of personal and social responsibility (Davis-Berman and Berman 2008; Kimball and Bacon 1993; Russell 2001).

Wilderness therapy traces its roots to "tent therapy" in the early twentieth century, where various hospital patients experienced greater improvement after being moved outside, and wilderness therapy has a clear predecessor in Outward Bound programs (Gillis et al. 2008; Williams 2000). Yet whereas Outward Bound programs are primarily used with participants who are high functioning, wilderness therapy is used for adolescents who need treatment and are likely to have participated in other types of therapy or treatment (Berman and Davis-Berman 1989; Clark et al. 2004; Russell and Phillips-Miller 2002).

### Theoretical Integration

Currently, wilderness therapy is one of several terms, including adventure therapy, wilderness adventure therapy, and outdoor behavioral healthcare (OBH), that are often used interchangeably. Additionally, programs vary widely in their structures and foci, and Gass (1993) has acknowledged that "there is such a wide variety of organizations and programs employing some form of wilderness therapy that it is difficult to define the process precisely" (p. 14). In order for the many programmatic, practical, and clinical needs to be effectively addressed, both creativity in theoretical integration and diversity in clinical utility are necessary (Becker and Conway 2009).

Hoyer (2004), in describing one possible theoretical framework from which wilderness therapy may operate, appropriately states that "theory and practice are entwined in a reciprocal, symbiotic relationship" (p. 56). In discussing the need for theory-informed practice in wilderness therapy specifically, he concludes: "To reap the full benefit of the experience, we must understand what is occurring so that we can use the tool efficiently" (p. 57). In addition to efficiency, theory-informed practice has implications for the way in which treatment may be used efficaciously and ethically. It is proposed in this article that if wilderness therapy starts with the unpredictability and novelty of the wilderness before considering appropriate theoretical foundations, the treatment will lose not only part of its efficiency and efficacy, but also be at greater risk for ethical problems and potential malpractice.

## Ethical Considerations

### The Distinction Between Therapy and Therapeutic

It seems clear that the role of the wilderness is crucial in conceptualizing the various components that are important to wilderness therapy (Miles 1993; Russell and Phillips-Miller 2002). Williams (2000) importantly notes that "though the wilderness setting is recognized…as being highly therapeutic, these therapeutic processes do not occur automatically with any group that ventures into the woods" (p. 54; see also Levine 1994). There are clear psychological benefits to spending time in the outdoors and wilderness (Louv 2005), but spending time outside does not in and of itself mean that therapy is occurring. The distinction between *therapy* and *therapeutic* is particularly relevant to any discussion of ethics, as certain ethical guidelines are pertinent and necessary when therapy is a distinct component of the approach.

As the field of wilderness therapy has evolved, several authors (Davis-Berman and Berman 1994, 2008; Itin 1993; Russell 2001; Williams 2004) have given particular attention to the distinction between experiences that might be considered therapy and those that might be considered therapeutic. Williams (2004) argued that there are four reasons why the field must distinguish between "adventure therapy" and "therapeutic adventure." Williams proposes that a clear distinction will allow for programs to use terms that accurately reflect their practice, will assist in informing clients about the offered services, will aid in the development of the field's professional identity, and will contribute to ethically-informed service. Particularly, programs and practitioners must understand the differences between experiences that are therapy and experiences that are therapeutic, and they must also be sure to represent their services as such.

Although one is not inherently greater or more important than the other, distinct differences between *therapy* and *therapeutic* can and must be made. Russell (2001) examined various programs and provided a helpful distinction between wilderness therapy and wilderness experience programs (WEPs; see Table 1). Particularly, he emphasizes that wilderness therapy programs are supervised by a licensed mental health practitioner, have trained clinical staff, develop individualized treatment plans monitored by licensed clinical staff, and conduct formal evaluations of treatment effectiveness. Highlighting some of the differences between various programs, Davis-Berman and Berman (2008) emphasize that "while there are a host of programs that use the wilderness to help people as an adjunct to traditional therapy or in lieu of therapy…we view wilderness therapy as a behavioral health care service" (p. vii).

As a type of behavioral healthcare, an important development occurred in the field of wilderness therapy in 1997, when the Outdoor Behavioral Healthcare Industry Council (OBHIC) was established as a coalition of wilderness therapy programs committed to sharing and cultivating best practices within the profession (OBHIC 2009). OBHIC, which began with five founding programs, currently consists of 16 programs that specifically focus on wilderness-related interventions for youth. These programs are committed to 18 philosophical and ethical standards and allow for some programmatic regulation. And although OBHIC's standards are quite broad in scope and do not apply to the many operating programs who are not OBHIC members, these standards constitute a needed addition to the profession. In addition, OBHIC has established the Outdoor Behavioral Healthcare Research Cooperative (OBHRC), and this organization has played a vital role in the design, implementation, and dissemination of research related to wilderness therapy.

Despite advances in the organization of wilderness therapy programs and researchers through OBHIC and OBHRC, wilderness therapy is frequently seen as an illegitimate form of therapy (Friedman et al. 2006; Thomas 2008), and it is unclear why so many wilderness programs are not members of OBHIC. Koocher (2003) provides a case example of the negative light that often accompanies wilderness therapy:

> Tommy's parents believe that he is 'out of control.' He has been expelled from two private boarding schools in the last three years for a myriad of behavior problems…At their wits' end, his parents have decided to send him on a 'therapeutic wilderness retreat.' They know that Tommy will be unenthusiastic about this plan, so they do not tell him about it until two large 'counselors' arrive at the Wilder home to escort Tommy to his therapeutic encounter with nature. For some adolescents, specialized programs of this 'tough love' variety may facilitate positive changes; however, *many such programs have little content that can legitimately be termed psychotherapeutic*. (p. 1250; italics added)

**Table 1** Unique and common characteristics of wilderness therapy programs and wilderness experience programs (WEPs)

| Unique to wilderness therapy | Common to other WEPs |
|---|---|
| Program is licensed by a stage agency or moving toward licensure where appropriate | Use of outdoor and unfamiliar environments to help the client leave their family culture behind and have a unique experience |
| Program is supervised by a licensed mental health practitioner and client has periodic contact with licensed therapist either in individual or group therapy sessions | The use of adventure activities and wilderness living to challenge the client to have an experience that will facilitate meeting specified learning objectives |
| Program works with the family to help them understand the nature of the client's problem behaviors and enhance treatment objectives | Takes place in a group setting where group development processes facilitate learning |
| Program has trained clinical staff in the area of specialty (drug and alcohol treatment, family therapy, etc.) | Use reflective-activities to help the client process what it is that they have learned from the experience |
| Primary-care staff has training in specialty areas appropriate for the population of clientele (therapeutic holds, de-escalation, etc.) | Facilitated by qualified professionals meeting a standard set of requirements |
| Clients have individualized treatment plans that are monitored by licensed clinical staff | A formal assessment procedure is used at intake with all new clientele |
| Client has routine medical check-ups to monitor well-being | |
| A formal evaluation of treatment effectiveness is conducted to determine treatment effectiveness | |
| Clinical staff work with aftercare services and the family ensure that any progress made by the client can be maintained | |

*Note* Adapted from "What is wilderness therapy?" by Russell 2001. Copyright 2001 by the Association of Experiential Education. Adapted with permission from the publisher

Although this description is an inaccurate representation of many wilderness programs and the current OBHIC guidelines, such programs do exist. As a result, wilderness therapy programs—particularly those which are unlicensed or unregulated—have recently come under intense scrutiny in media (Krakauer 1995; "When 'tough love'" 2007), academic (Behar et al. 2007; Friedman et al. 2006; Meyer 2007), and political (Government Accountability Office [GAO] 2007, 2008; "Stop Child Abuse" 2008) forums. Importantly, Koocher's (2003) sentiment that wilderness programs are void of therapeutic content highlights several of the challenges that currently face the field, and the onus is on the wilderness therapy programs and practitioners to provide high-quality professional and ethical treatment that counters this view.

## Is Wilderness Therapy Effective?

Although the research is limited, promising support does exist for wilderness therapy as an effective treatment with a diverse range of adolescent populations. The modality is not a manualized, *empirically-based* treatment (EBT), but it may be considered to be *evidence-informed* (Bohart 2005), and potential clients and families should receive a balanced review of the available empirical research as a part of the informed consent process. The research available suggests that wilderness therapy may be an effective treatment option

for a wide range of adolescents, including youth with substance abuse problems, adolescent sex offenders, and adolescents suffering from depression and various other clinical disorders or involved with the juvenile justice system (Brand 2001; Clark et al. 2004; Jones et al. 2004; Lambie et al. 2000; Levine 1994; Russell 2003a, 2006a). Components such as spending time in the wilderness, unique staff-client relationships, group dynamics, removal from the adolescent's primary living situation, and success at outdoor challenges have all been cited as contributing to the success of wilderness therapy (Davis-Berman and Berman 1994, 2008; Gass 1993; Glass and Myers 2001; Lambie et al. 2000; Newes and Bandoroff 2004; Russell 2003b; Russell and Phillips-Miller 2002).

The vast majority of the empirical examination of wilderness therapy has been conducted by OBHRC. Several studies warrant attention, as they point to both preliminary support for the modality as well as some of the ongoing challenges. An initial outcome study consisted of 1,600 parents and youth from seven OBHIC member programs (Russell 2003a). A longitudinal repeated measures design was used to examine a variety of outcomes based on admission, discharge, and 12-month follow-up data. Both parents and youth reported statistically significant reductions in behavioral and emotional symptoms immediately following treatment, and the 12-month follow-up with a subsample of the participating youth showed an overall maintenance of treatment gains. However, subscales related to the ability to organize tasks, complete assignments, handle frustration in different settings, obsessive–compulsive behavior, suicide, and eating disorders showed some deterioration.

A qualitative study examining alcohol and substance use at a 2-year follow-up also found mixed results (Russell 2005). Participants reported doing well in school and appropriate leisure activities, although the youth's ability to make friends was a reported concern among approximately half of participants. Perhaps more disconcerting is the 60% of respondents who reported having had some trouble with the law or were continuing to use substances. Of those youth for whom substance use was a primary focus of treatment, over 70% were still using substances, and another study (Russell 2006a) found that approximately half of the participants were still using substances at a 6-month follow-up. Russell (2007) appropriately concluded that "the perception that [outdoor behavioral healthcare] treatment 'fixes adolescents' and delivers…a youth who is ready to return to peer, family and school or work environments…was simply not supported" (p. 28).

Although many participants had not obtained complete sobriety, Russell's (2006a) 6-month follow-up revealed that wilderness therapy reduced the frequency of substance use for many youth, particularly those who used more serious substances prior to wilderness therapy treatment. Additionally, the study found that 91% of surveyed participants stated that their problems were either a great deal or somewhat better. Particularly, the wilderness therapy treatment was instrumental in motivating clients toward a place where they were ready and able to participate in treatment. Also, depression, anxiety, and stress were significantly improved for those youth who had mild to severe classifications in these areas at admission. Although males showed a significant decrease in stress immediately following treatment, they had deteriorated in this area at the follow-up but remained below clinically-elevated levels. For females, all treatment gains in the domains of stress, anxiety, and depression were maintained, and males maintained treatment gains in the domains of depression and anxiety.

Russell's (2007) review of recent research concluded that "programs practicing wilderness therapy have the potential to generate positive outcomes for adolescent participants" (p. 18), although it is also acknowledged that wilderness therapy is a "misunderstood, and relatively untested, treatment approach" (p. 51). There is a crucial need for rigorous research studies that utilize control groups and, despite methodological

complexities, randomized controlled trials. Additionally, it is problematic that the majority of the existing research has been conducted with OBHIC member programs. Although this research is important and worthwhile, concerns are raised when a range of five to nine programs participate in outcome studies despite the fact that approximately 65 programs identify themselves as providing outdoor behavioral healthcare (Russell et al. 2008). As a subsample of all operating wilderness therapy programs, programs which are members of OBHIC align themselves to best-practice industry standards and are also the programs likely to have the administrative, financial, and personnel capabilities necessary to participate in large-scale research studies. Very little is known about those programs that are OBHIC members and have not participated in OBHRC research, and practically no recent empirical evidence exists for the many programs who are not OBHIC members (e.g., Cason and Gillis 1993; Gillis and Thomsen 1996). Taken together, the dearth of empirical—particularly controlled—research, the absence of research undertaken by professionals from varied perspectives, and the relatively few programs which have participated in published research all contribute to the criticisms placed on the field of wilderness therapy by other mental health professionals.

## Consent and Confidentiality

Ethical issues related to informed consent and confidentiality are particularly relevant for adolescent clients (Koocher 2003). Although parents may legally commit children and adolescents to residential treatments, there are clear ethical challenges that arise when this occurs. Many youth are less-than-excited about the opportunity to participate in a wilderness therapy expedition, and passive resistance or active refusal are common. Russell (2006b) analyzed interviews with various wilderness therapy stakeholders, and found that "staff perceived the typical adolescent entering wilderness therapy feeling frightened and angry, with a deeply rooted resistance to authority" (p. 55). This sentiment is shared by professionals who work in other residential programs or facilities, and mental health practitioners must be aware of the increased potential for coercion as youth are placed in increasingly restrictive treatment environments (Koocher 2003).

Wilderness therapy practitioners should be cognizant of an adolescent's individual development, and each client should play an active role in the development of treatment goals and the direction of therapy (Koocher 2008). Unfortunately, this is not always the case, and many view wilderness therapy as analogous to a military boot camp (Krakauer 1995; Russell 2006a). Engaging clients in the development of treatment goals is not only ethically warranted, but also contributes to both the establishment of a therapy alliance (Koocher 2003) and the client's safety while on a wilderness therapy expedition. Mental health professionals have a "critical role" in providing recommendations based on the goals and data obtained from parents, youth, and other invested parties (Koocher 2008, p. 604). One may wonder how effective wilderness therapy programs are in their delivery of individualized treatment plans when outdoor behavioral healthcare programs report that they employ a median of three clinical staff (Russell 2007). The ratio of field (wilderness) staff to clinical staff is 6:1, and this raises concerns regarding the overall clinical focus of wilderness therapy trips. Particularly given that clinicians may be responsible for many youth on the same trip, the incorporation of individualized treatment plans becomes increasingly complex. For example, do programs that employ multiple clinicians ensure that one clinician is responsible for the implementation and modification of a specific youth's treatment plan? If treatment plans and goals are implemented haphazardly, there is little oversight to the particular needs of individual clients, and it is quite possible that

some participating youth may receive less-than-adequate care or be neglected in their care as staff focus on youth who display more externalizing or disruptive behaviors.

From a developmental perspective, issues related to consent and confidentiality are important aspects related to an individual's autonomy (Tan et al. 2007). To what extent is an adolescent's confidentiality maintained over the course of wilderness therapy? This question needs careful consideration by practitioners, as it relates to the communication of privileged information to parents, other youth participants, and trip staff and practitioners. There is a danger that practitioners will feel less bound by ethical and legal aspects of confidentiality when outside the formal walls of the therapy office, but breaches in client confidentiality constitute negligent and unethical treatment regardless of the therapy setting.

In addition to the expected challenges associated with the sharing of information with parents of child and adolescent clients (Kaczmarek 2000; Prout et al. 1999), wilderness therapists are presented with additional challenges related to client confidentiality. As information is often shared across teams of professionals (Strein and Hershenson 1991), how does confidentiality apply to other trip staff (e.g., wilderness guides, administrative personnel)? Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not have explicit guidelines for wilderness therapy programs, it is clear that HIPAA applies to all programs which are health care providers, and wilderness therapy programs must carefully consider how to incorporate HIPAA into their practice. Relatedly, wilderness therapists must be prepared for significant personal disclosures while a youth is participating in wilderness therapy. Disclosures of abuse or neglect can be particularly challenging when they occur in a wilderness context, and practitioners and programs must have the ability to quickly notify requisite authorities related to such disclosures. Ultimately, HIPAA allows parents legal authority over their child's records in almost all cases, and exceptions to confidentiality, the role of third parties, issues related to mandated reporting, and the way private information will be transferred for aftercare should be clearly explained to all clients, including minors, before treatment commences.

For example, does confidentiality apply only when "formal" therapy happens (i.e., group or individual therapy), or do less formal conversations (e.g., conversations while hiking or over a shared meal) also warrant confidentiality? This question highlights the differences in confidentiality for group therapists and wilderness therapists, as groups operate under clear schedules and session timeframes. However, there are clear similarities between group and wilderness therapies (Gillen and Balkin 2006; Williams 2000), and wilderness therapy draws much of its theoretical foundation from group therapy theory and process (Davis-Berman and Berman 1994; Russell 2001). In examining the differences between wilderness therapy, traditional residential treatment, and group counseling, Williams (2000) proposed that wilderness experiences allow for greater transference due to the length, duration, and intensity of the modality. Because of this, wilderness therapists must be highly attuned to both the state of the individual and the group, and when this is coupled with the logistical and pragmatic concerns related to a wilderness environment, clinical sophistication and competence is absolutely essential. Many wilderness therapy providers are young and lack lengthy experience, and no studies exist that examine the ongoing supervision of clinical staff while facilitating wilderness treatment.

The wilderness therapy approach cannot easily be dichotomized between moments of "therapy" and moments of "non-therapy," nor should this be attempted as a goal given the unique theoretical approach of the modality. Indeed, mental health professionals ought to maintain high levels of confidentiality over the course of the entire wilderness therapy

experience. Again, because the wilderness is such a unique setting, it may be easy and tempting for trip staff to loosen their expectations of confidentiality, and this temptation must be both acknowledged and addressed. Clinical staff may need to share appropriate information amongst themselves and with other trip staff (e.g., field guides), and this should be done with a consistent clinical focus in the forefront. Information that is irrelevant to either the client or group's treatment goals, progress, or safety should not be shared, and relevant information should be discussed in a professional manner at all times.

Additionally, caution should be taken to ensure that all conversations pertaining to confidential information are not heard by any participants. For this reason, clinical conversations should, whenever possible, occur in open areas that allow for monitoring the presence of participants. Although confidentiality can be maintained while a client is participating in a wilderness therapy expedition, mental health practitioners need to consider the relevant issues associated with confidentiality and safeguard against potential or clear unethical practices.

## Boundaries and the Role of the Therapist

Many authors have noted the unique relationships that develop between clients and staff in the context of wilderness therapy experiences (Newes and Bandoroff 2004; Russell 2003a, 2005, 2006a; Russell and Hendee 1999; Russell and Phillips-Miller 2002). Wilderness therapy allows adolescents to experience therapists and other adults in ways that are very different from what is normally experienced in more traditional therapies. Clients often view wilderness therapists as more human and trustworthy than the authority figures encountered in schools, juvenile justice systems, or traditional outpatient therapies. The definition of "therapy" itself is challenged and expanded, as "individual counseling sessions can take place on the trail, in a client's shelter area, or while whittling sticks when making a bow-drill fire set" (Russell and Hendee 1999, p. 15). As a result, the client's perception of therapy—and the therapist—is disrupted, as the "neutral environment and unorthodox approach eliminates many of the barriers associated with traditional therapeutic counseling, such as intimidation by the therapist or the stigma of going to a 'hospital' because they are 'sick'" (Russell and Hendee 1999, p. 15). Research suggests that wilderness therapy participants experience high levels of therapeutic alliance and view the wilderness staff as helpful (Russell 2006b), although it is unclear if this research has specifically addressed the clinician–client relationships or the relationships between the client and the entire wilderness staff (including wilderness guides). Additionally, programs widely differ in the structure and amount of time therapists spend with clients in the field, and research is needed to examine how the therapist–client relationship is impacted by the amount of time the therapist spends as a part of the wilderness expedition.

In addition to the potential for wilderness therapy to cultivate unique client–therapist relationships, the wilderness therapist is also able to adjust therapy to meet some unique developmental considerations. Kiselica (2003) provides five strategies that are likely to aid in the development and maintenance of rapport and the therapeutic alliance, particularly with male adolescents. These strategies include the use of flexible time limits and informal therapy settings, the use of expressing humor and self-disclosure, using a variety of rapport building tactics, working in groups, and reexamining professional constraints and inaccurate stereotypes. Indeed, each of these strategies are present and maximized in wilderness therapy.

However, the unique therapist–client relationship present in wilderness therapy may be ethically problematic, particularly as it relates to the establishment and maintenance of

professional boundaries for the wilderness therapist. Professional boundaries are considered essential to all mental health professions, although the standards among different professional groups (e.g., social workers, psychologists) may differ. Therapeutic boundaries separate the personal from the professional and are intended to prevent harm to clients that may come from exploitative or unsafe therapy (Borys 1994; Smith and Fitzpatrick 1995).

The current professional climate emphasizes a movement toward more clearly delineated boundaries (Lazarus 1994; Williams 1997). Although there are certainly times when clearly defined boundaries are appropriate and essential, Lazarus (1994) suggests that this trend parallels professional anxiety around the fear of malpractice suits and may undermine clinical effectiveness. In addition to Lazarus, Williams (1997) emphasizes the unique ways in which less-strict boundaries—particularly as it relates to self-disclosure—might actually be beneficial to the therapeutic process. Appropriate self-disclosure may allow the client to see the therapist as more fully human, as "it allows the patient to see that all people have failures and other unresolved matters in their lives" (Williams 1997, p. 242).

Wilderness therapists are likely to maintain less rigid boundaries than many traditional practitioners due to the nature of the treatment structure and modality approach. As the boundaries are already less distinct and clear in wilderness therapy, practitioners must be particularly mindful of professional and personal boundaries and the potential to cause harm to both an individual client and the entire group. It is of high importance that trip supervisors and staff have discussions regarding boundaries prior to any wilderness therapy expedition and commit to regular dialogue about boundaries as the trip commences and progresses. Discussions around boundaries should contain several different components, including different interpersonal styles, gender, physical touch, theoretical approach, the length and intensity of the wilderness trip, the role of the therapy staff alongside other trip staff (e.g., wilderness guides), and, certainly, the clinical focus of the wilderness trip and the composite of individual clients. Through careful supervision, ongoing consultation and accountability, and an emphasis on self-care, boundaries may be stretched and shifted, but not to the detriment of the overarching clinical focus.

## A Continuum of Care and Family Involvement

Interestingly, wilderness therapy has positioned itself as filling a void in the continuum of care, despite the fact that the majority of youth who participate in wilderness therapy enroll in programs that are out of their state (Russell 2007). As emphasized in both clinical and educational practice, it is ethically imperative that youth be served in treatment settings that are as minimally restrictive as necessary given a client's clinical needs (Taylor 2004/1988). It is evident that over three-quarters of youth who participate in wilderness therapy have been in previous treatment, and it has been noted that parents and various stakeholders (e.g., therapists, school personnel) often utilize wilderness therapy when other treatment options appear to have been exhausted (Russell 2007). And yet, where does wilderness therapy fit along the continuum of care, particularly given the high cost to parents? Why are wilderness therapy programs chosen over other residential placements that may be closer in physical proximity?

Russell (2007) emphasized that the notion of an existing continuum of care for severely troubled adolescents is a myth, and other researchers have acknowledged the discontinuity between theory, practice, and treatment outcomes (Bickman 1996). Many communities do not have the capacity to provide outpatient, day treatment, partial hospitalization, and inpatient treatments, and schools often fall short of adequately addressing the mental health

needs of their students. Nonetheless, parents should be encouraged to think carefully about their decision to place their son or daughter in a highly restrictive placement, and local community resources should be prioritized. Although parents and clinicians may see wilderness therapy as an ideal treatment option, highly restrictive treatments should be carefully evaluated before placing an adolescent in a program, particularly against his or her will.

As with hospitalization and other treatments that remove a child from their residence and community, wilderness therapy may reinforce the notion that the child is the identified patient and remove responsibility for change away from the broader family system (Robinson et al. 1999). Additionally, research suggests that it can be counterproductive to remove an adolescent from his or her daily environment, as treatment gains are lost once the youth returns to their home, school, and community environments (Bettmann and Jasperson 2009; Frensch and Cameron 2002). In their review of residential placements for children and adolescents, Frensch and Cameron (2002) emphasized the role of family involvement throughout treatment: "Parental involvement and family support during treatment is consistently and significantly related to children and youth's within treatment progress and the ability to successfully adapt to the community following discharge" (p. 334).

Russell (2007) examined the amount of family involvement in wilderness therapy programs and found that the majority of programs were utilizing a variety of family involvement strategies, including family sessions, parent sessions, and psychoeducational family groups. Approximately 50% of programs reported that they had less than 15 h of contact time with parents, and only 20% of programs reported having more than 30 h of contact time. However, programs reported a wide range of family contact hours (0–124), and the overall percentage of time a family was involved in treatment compared to the overall time the client was in treatment was quite small (median length of treatment stay was 56 days), despite the significant family issues present in the majority of families who elect to utilize wilderness therapy (Russell 2007). These initial results need to be examined in regard to the different wilderness therapy models, and research must also examine the extent to which parents are involved continuously throughout treatment or if the sole family involvement occurs immediately prior and following the wilderness trip. In examining different programs, referring mental health professionals should assist parents in considering the different approaches to family involvement before, during, and after treatment, and this is clearly an area for future research as well.

## The Role of Aftercare

Given the empirical findings that suggest some deterioration following wilderness therapy treatment completion, aftercare is considered to be essential to any long-term change, and may thus be considered ethically in best-practice. Russell and Hendee (1999) emphasize that "while providing for effective intervention, diagnosis and initial treatment, wilderness therapy is not a stand alone cure" (p. 12). In a study that examined youth functioning 2 years after a wilderness therapy experience, Russell (2005) found that 95% of youth considered their wilderness therapy experience to be effective, and 80% of parents thought the same. Importantly, between 80 and 85% of youth who participate in wilderness therapy programs go on to participate in some type of aftercare, including outpatient treatment (27%), therapeutic boarding school (26%), residential treatment (11%), Alcoholic's Anonymous (2%), or inpatient hospitalization (1%; Russell 2005; Russell and Hendee 1999).

However, discrepancies exist in how well wilderness therapy programs and practitioners prepare youth for aftercare. 78% of surveyed wilderness therapy programs stated that

clients leave their programs with a clear aftercare plan (Russell 2007), and this is very close to the 80% of youth who recalled staff assistance in developing an aftercare plan (Russell 2006b). However, a qualitative study found that "many parents cited the lack or absence of any plans and felt the programs had more of a responsibility to prepare their families for transition and posttreatment care" (Russell 2007, p. 28). This is a clear area for future research, given that parents, compared with programs and youth, appear to perceive the planning of aftercare services to be less than adequate. It is possible that aftercare plans are developed while youth participate in a wilderness trip but lack the necessary linkage of this information to parents at the conclusion the wilderness therapy experience.

It is evident that aftercare is almost always essential in order for treatment gains to be maintained, and parents must be aware that wilderness therapy is not the quick and easy "fix" that they may be hoping for. Indeed, further treatment—and any associated costs—should be a part of the decision-making long before the youth embarks on a wilderness therapy experience. Wilderness therapy clinicians must be realistic when describing the intervention to parents, acknowledge the potential benefits and limitations, and work to maintain knowledge of the research base related to their work.

## Conclusion

As the field of wilderness therapy continues to grow and evolve as a treatment modality, it is important for mental health professionals to consider the unique ethical issues that may arise when therapy moves far beyond the four walls of a therapist's office. This article raises several relevant ethical issues, including the distinction between therapy and therapeutic experiences, the use of efficacious treatment and aftercare, a continuum of care and family involvement, consent and confidentiality, and therapeutic boundaries. None of the ethical issues discussed have been systematically evaluated in current wilderness therapy research, and so it is currently unclear how programs are—or are not—addressing these ethical challenges. It is the aim of this article to serve as a starting point for wilderness therapists to consider their professional roles and the intersection of ethics and mental health services that occur in the wilderness.

Additionally, this article has been written with a variety of mental health professions in mind, for wilderness therapy encompasses a diverse population of many different professionals and paraprofessionals. Master's level counselors, social workers, psychologists, and family and group therapists have different ethical codes that often represent different standards between professional groups. For wilderness therapists to move forward in their development and work, it is of necessity and mutual benefit for these groups to dialogue together about the ethical issues described here and other issues that are certain to arise. Through respectful conversation—as opposed to territorial combat—mental health professionals will be positioned to work together effectively and serve clients with a thoughtful understanding of diverse ethical and professional issues.

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