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ORIGINAL PAPER

Into the Wilderness—A Case Study: The Psychodynamics of Adolescent Depression and the Need for a Holistic Intervention

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Abstract Adolescent depression has become epidemic in the United States, with statistics showing that one in five adolescents may suffer from depression (Brent and Birmaher in N Engl J Med 347(9), 2002). This article examines adolescent depression from a psychodynamic perspective, and identifies the psychodynamics of adolescent depression as the affective correlates that stem from unresolved developmental conflicts, issues of separation/individuation, the search for identity and the development of the true self. This article presents wilderness therapy as a holistic intervention which can be used to address the intrapsychic, developmental and relational factors that give rise to adolescent depression. Wilderness therapy is a modality of mental health treatment that takes place outdoors and utilizes challenge and adventure, group work and other structured clinical interventions. A clinical case study presents wilderness therapy as an effective intervention for adolescent depression that can promote positive self-image and enhanced coping skills, and discusses limitations and implications for social work practice.

Keywords Adolescent depression · Wilderness therapy · Psychodynamic theory · Ego psychology · Object relations · Case study

> "Depression is the inability to construct a future."
> Rollo May (1909–1994)

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For thousands of adolescents, this quote is a reality. Adolescent depression has become epidemic in the United States, with statistics showing that one in five may suffer from depression (Brent and Birmaher 2002). According to the World Health Organization, depression is the second leading cause of disability for people ages 15–44 (World Health Organization 2009). Despite the prevalence of adolescent depression, there is an acknowledged shortage of treatment options and providers in the field of child and adolescent mental health (Koplewicz 2002).

The reality of this treatment gap for adolescents can be devastating. The consequences of untreated depression can lead to serious problems later in life, or in some cases, suicide. For adolescents who have depressive illnesses, the rates of suicidal thinking and behavior are alarmingly high. Recent statistics revealed that approximately three million youth, aged 12–17, either thought seriously about suicide or attempted suicide in 2000, and the actual suicide rate for all adolescents has increased more than 200% over the last decade (Borowsky et al. 2001). Many teens who commit suicide suffer from undiagnosed or untreated clinical depression, and have experienced serious difficulties in school, work and personal relationships (Weersing et al. 2008).

Because of these alarming statistics, adolescent depression has finally been recognized as a serious mood disorder that affects the functioning of millions of adolescents (Koplewicz 2002). Most agree, however, that the majority of adolescent depression can be treated; yet there is debate about which type of therapeutic intervention can target adolescent depression most effectively. Clearly integration of theory is needed in contemporary social work treatment of adolescent depression. As Allen-Meares (1987) said: "Social workers need to expand their knowledge about risk factors and unique characteristics associated with

depression in this population to refine the different schools of thought and to design prevention and treatment interventions" (p. 515).

In order to address the psychosocial, developmental and relational factors that give rise to adolescent depression, this case study presents adolescent depression through a psychodynamic lens. This lens allows for the consideration of the multiple etiologies of adolescent depression, and supports the choice of an intervention that can address these various domains. This case study also introduces wilderness therapy as a holistic intervention that may address the various factors of human development and pathology related to adolescent depression (Amesberger 1998).

While people have long been aware of the increase in general well-being that being outdoors can have on a person (Miles 1987), wilderness therapy seeks to harness the power of the outdoors in combination with structured clinical interventions in a way that promotes healing and personal growth. This approach seeks to create a context of hope that may positively affect a client's emotional state, and is based on the paradigm that "a primary cause of emotional and behavioral disturbances in youth is the lack of significant relationship with the social and natural worlds" (Gass 1993, p. 24). In particular, Kimball and Bacon (1993) provide a rationale for the application of wilderness therapy to the treatment of adolescent depression in their explanation of wilderness therapy as a "frontal assault on learned helplessness, dependency and feelings of low self-worth" (p. 20).

Although wilderness therapy has been recognized as a powerful intervention that promotes cognitive, affective and behavioral change (Gillis 1992), leaders in the field admit that more research is needed to understand the impact of wilderness therapy on specific emotional and psychological issues (Berman and Davis-Berman 1994; Russell 2001). Further explanation of the wilderness therapy intervention will be provided later in this paper.

The Problem: Adolescent Depression

Definition and Prior Research

Adolescent depression has been defined as a recurrent, chronic and familial mood disorder; however, in adolescents, depression can look quite different (Brent and Birmaher 2002). It is not always characterized by feeling sad, but rather by boredom, irritability, or difficulty experiencing pleasure. Depression is distinguishable from sadness because it is evidenced by a persistent drop in mood, combined with difficulties in functioning.

Clinical diagnosis of adolescent depression is most commonly diagnosed as major depressive disorder, in which depressive episodes can last up to 8 months if left untreated (Brent and Birmaher 2002). According to the American Academy of Child and Adolescent Psychiatry (2007), adolescent depression is often accompanied by other psychiatric and medical conditions. While there are other mood disorders that affect adolescent mental health, adolescent depression in this case study refers to major depressive disorder. However, the applicability of wilderness therapy in the treatment of other adolescent mood disorders merits further inquiry.

In trying to decide how best to treat adolescent depression, it is important to acknowledge its complexity and multiple epigenetic pathways (Eaves et al. 2003; Lewis and Lewis 1985). Research shows various factors related to the onset of adolescent depression. Environmental risk factors such as poverty, deprivation and violence (Fleming and Offord 1990; Simons and Miller 1987), as well as systemic familial issues (Allen et al. 1994), including divorce (Lewinsohn et al. 1998), being raised by depressed caretakers (Beardslee et al. 1998; Lau and Kwok 2000) or experiencing other relational losses (Monroe et al. 1999) contribute to the problem of adolescent depression. Adolescent depression includes cognitive and affective (Ryan et al. 1987), interpersonal (Davila et al. 1995), neurological (Cozolino 2002) and physical (Foreman 1993; Oler 1994) components. The etiology of adolescent depression can be referred to as a truly biopsychosocial phenomenon (Lewis and Lewis 1985). Siefert and Bowman (2000) found that depression was the cumulative effect of having multiple internal and external risk factors, which seems to confirm the abundance of varied research on the etiology of adolescent depression.

Recent meta-analyses related to the treatment of adolescent depression have highlighted the efficacy of interpersonal therapy, family therapy, and most commonly, cognitive-behavioral treatment (CBT) in conjunction with anti-depressant medication (AACAP 2007; March et al. 2003; Weersing et al. 2008). The application of CBT and medication is based on the paradigm that "thinking determines mood;" and seeks to address an adolescent's cognitive distortions "before they become embedded in the brain" (Koplewicz 2002, p. 37).

Current brain research shows that teenagers may be particularly vulnerable to mood disorders because of the overproduction of synapses and the subsequent pruning that is occurring in their brains. While this pruning is a time of opportunity, it is also a time of risk (Koplewicz 2002). Changes in the adolescent brain, as well as the release of hormones at this time, can increase levels of aggression and irritation, and should be acknowledged as a part of the complex problem of adolescent depression (Koplewicz 2002).

It seems clear that adolescent depression is a serious illness; however, to view depression solely as a biological disease oversimplifies the problem and fools us into thinking we can treat it by relying only on a medical model of intervention. Cognition and neurobiology may indeed affect mood, but may not be the sole determinants. Current relational theory reminds us that our "selves" are "much more than (cognitive) representations of self; rather, they are each versions, complete functional units with a belief system, affective organization, agentic intentionality, and developmental history" (Mitchell 2000, p. 63). Adolescence, in particular, is an important time in one's developmental history, in which the formation of one's identity and the development of one's true self take center stage (Erikson 1968; Winnicott 1965). For this reason, this author has chosen to explore adolescent depression within the dual framework of ego psychology and object relations theories.

Ego psychology and object relations have long differed on whether or not humans were seeking drive satisfaction or the satisfaction that comes in relation to real others. For this reason, psychodynamic scholars have differed regarding their compatibility; however, ego psychology and object relations theories seem to fit together in explaining the psychodynamics of adolescent depression as the affective correlates that stem from unresolved developmental conflicts, issues of separation/individuation, the search for identity and the development of the true self. These factors can be referred to as *the psychodynamics of adolescent depression*, and may give us deeper insight into the problem than focusing solely on cognition and biology.

Adolescent depression involves cognitive, affective and physical components; yet, there are also intrapsychic, existential and spiritual components that need to be addressed in the treatment of adolescent depression. Teenagers are living in an unpredictable world in which they struggle to define their importance and purpose. They often feel overwhelmed and unable to cope with the challenges they face. Laufer (1975) refers to adolescent depression as characterized by the feeling that the possibility of something changing for the better is impossible. This is the epitome of hopelessness because it implies that depressed adolescents cannot see themselves in any other state of being than the one they are in. Saari refers to this as an "inability to imagine…a future in which personal goals have been achieved" (Saari 1991, p. 174). The ability to do so is known as transcontextualization, and is an essential component in creating a context of hope for depressed adolescents (Saari 1991).

Viewing Adolescent Depression Through a Psychodynamic Lens

While many theories can be used to understand adolescent depression, a psychodynamic framework can provide a useful template for exploring the intrapsychic, developmental and relational aspects of adolescent depression. Ego psychologist Peter Blos (1979) believed that the affects of anxiety, depression and irritability often associated with adolescence are correlates of developmental conflicts which arise in adolescence begging for resolution. He expressed this eloquently by saying,

> Every adolescent child is, so to speak, expectantly waiting to come to terms with the unfinished business of childhood when he enters the widened social stage. It is my contention that adolescent phase-specific regression, should it find no adequate societal support or reasonable opportunity for sustained developmental progression, will lead the adolescent to adopt a raison d'etre by way of polarization with the world that preceded his own budding selfhood. (Blos 1979, p. 34)

What is this "reasonable opportunity for sustained developmental progression" of which Blos writes? This is the therapeutic environment or "care-taking surround" in which an adolescent can learn the skills needed to cope with and process the affective correlates of unresolved developmental conflicts. This is similar to object relations psychologist D. W. Winnicott's (1965) holding environment, and is a necessary factor not only in regulating these affects, but in reworking earlier object relations failures. In this type of environment, the needs of the infant (and the client) are met sequentially and in a way that is developmentally appropriate.

Adolescence is a time of psychic restructuring in which the need for a holding environment is especially critical. Blos (1962) believed that adolescence is a time of a second individuation phase, and thought that much like in the infancy stage of individuation, this stage is complete with vulnerabilities to the process of personality organization which can lead to adolescent depression. Blos felt that most adolescents have a lack of tolerance and a lack of coping skills for managing the painful affects associated with this phase. He pointed out the need for the development of these skills, as well as the need for extra-familial object finding in adolescence.

Without these skills or relationships, adolescents may attempt to separate from their families without ever really achieving a sense of ego identity that results from healthy individuation. Blos (1979) referred to this as side-stepping the process by replacing internal objects through polarization, which can lead to isolation and depression. Polarization occurs when an adolescent rejects forming identification with the object, in most cases, the parent. This becomes problematic to true separation and individuation because, as Freud believed, one cannot fully let go of the object until he has identified with it (Bergmann 1971).

While many of these intrapsychic conflicts are normative, they can become pathological if an adolescent does not possess the coping skills necessary to carry herself forward developmentally. Blos (1979) believed that these skills should be developed during the latency phase, but he recognized that due to developmental fixations, many adolescents have not yet developed them. By exploring wilderness therapy as a treatment for adolescent depression, this case study seeks to address how these skills can be developed in the unique therapeutic setting of the wilderness.

In understanding the process of separation and individuation in adolescent development, not only are coping skills important, but so is the adolescent's ability to develop his or her true self. The development of the true self is related to Winnicott's (1965) ideas about illusion and disillusion. Winnicott believed that if a child has only been given an illusion of omnipotence, without the corresponding disillusion of real limitations, the child will become frustrated and even depressed upon encountering the responsibilities of adolescence. Blos (1979) reaffirmed this when he wrote:

> Tension, failure, and disappointment, which no child can be spared, become readily neutralized by a constant flow of stimulation and encouragement…often, at adolescence this illusory self, nurtured by the parents up through the latency years, is finally rejected in the efforts at more adequate self-definition. (p. 18)

In rejecting the illusory self, the adolescent experiences a loss and an uncertainty, both of which may give rise to feelings of depression. As Winnicott (1965) believed, the false self may take over, and although the true self is hidden within, adolescents can develop a sense of futility and feel that life is not worth living.

When adolescents have not developed coping skills in the latency stage for dealing with these issues, they must find a way to develop them in adolescence or risk adaptive failures. As Blos (1962) said, "without having passed through the latency period, the child will be defeated by puberty" (p. 5).

The Intervention: Wilderness Therapy

Definition and Prior Research

For the purpose of providing a general theoretical definition of wilderness therapy, Kimball and Bacon's (1993) foundational definition is all encompassing. For Kimball and Bacon, wilderness therapy employs: (1) a group process, (2) a series of challenges in a wilderness setting, (3) structured clinical interventions and therapeutic techniques such as reflection and journal writing, individual counseling, and self-disclosure, and (4) varied length. While the definition of wilderness therapy has evolved from this definition to specify more clinical approaches, this definition serves as a good umbrella.

Wilderness therapy is not talk therapy; it is experiential therapy with an outdoor component, and it has its deepest historical roots in the tent therapy programs for mental health patients in the early 1900s (Berman and Davis-Berman 1994). Likewise, the early history of group work in the social work profession contributed to the development of wilderness therapy in its use of camping for therapeutic purposes (Schwartz 1960).

Wilderness therapy seeks to provide adolescents with the opportunity for developmental progression by helping them build coping skills through challenge and adventure in a wilderness setting, using activities such as mountaineering, backpacking, rock climbing, paddling, high ropes courses, etc. Alvarez and Welsh (1990) wrote a seminal article about adventure as a model of experiential learning and its role in therapeutic change. Furthermore, the rationale for using adventure for therapeutic purposes has been well documented in the literature (e.g., Gillis and Bonney 1986; Kimball 1983; Kirkpatrick 1983; Mason 1987).

Though few studies have been done in regards to the effectiveness of wilderness therapy in dealing with adolescent depression, several outcome studies have been done on the efficacy of wilderness therapy and mood disorders. Russell (2001) conducted research in which he looked at pre- and post-test outcomes of wilderness therapy participants' scores on the Youth Outcome Questionnaire (Y-OQ). In this study, participants with mood disorders scored the highest (78.59) on the initial Y-OQ, and lowest on the post-test (45.99) at discharge. This may be evidence that wilderness therapy is most effective at treating mood disorders; however, conclusive theory in this area cannot fully be derived from this study alone.

Continuing his research on mood disorders and wilderness therapy, Russell's (2002) longitudinal study found that 22.4% of adolescents participating in wilderness therapy programs were diagnosed with mood disorders. While his study did not solely address the effectiveness of wilderness therapy on mood disorders, his findings did report clinically significant improvement in clients' depressive symptoms. This was based on clients' self-reports and parent feedback. Client levels of functioning were found to be similar to a non-clinical adolescent population (Russell 2002). These studies analyzing mood disorders, including adolescent depression, have focused on the general intervention of wilderness therapy, and have not fully examined the individual components of the intervention to really understand what aspects of the intervention specifically

benefit depressed adolescents. For this reason, a case study approach to exploring wilderness therapy is highly relevant.

Viewing Wilderness Therapy through a Psychodynamic Lens

While many theories have been used to explain wilderness therapy (Berman and Davis-Berman 1994), psychodynamic theory attends to the psychosocial, developmental and relational aspects of the intervention. According to Crisp and O'Donnell (1998) wilderness therapy may involve an experiential reconstruction of developmental foundations as the individual corrects fundamental assumptions about him/herself and others. Put another way, delayed, incomplete or unmastered developmental tasks can be addressed by tangible corrective experiences (Crisp and O'Donnell 1998). For example, in combating adolescent depression, there is a paradox between feelings of hopelessness and the need and will to survive as the adolescent faces the realities associated with wilderness travel and other adventure-based activities (Handley 1998). Lightfoot (1997) went so far as to say that "simply trying something new has its own rewards; regardless of outcome, it convinces him (the adolescent) of his own active participation, agency" and movement towards the future (p. 97–98).

Wilderness therapy also combats the polarization and isolation that Blos spoke of by helping the adolescent build relationships with the self, others and the natural world. As Saari (1991) pointed out, there is a universal need for participation in the human community. Wilderness therapy takes place in the context of a peer group, and may provide participants with opportunities for corrective relationships and social learning.

Several authors have framed wilderness therapy from an object relations perspective. For example, Gass (1993) believes that the metaphorical role of the wilderness trip leader as the good rapprochement mother can help adolescents deal with unresolved developmental issues as they take on developmentally appropriate tasks and challenges. In Gass's experience, both the trip leader and the group act as a safe base for the adolescent to come back to in between active phases of self and other exploration, similar to the rapprochement mother in Mahler's (1967) developmental theories.

In the wilderness therapy milieu, the role of the trip leader is an essential component of the healing process. Similar to the relational paradigm in social work treatment, the wilderness therapist functions as a participant-observer and provides opportunities for experiential learning and correction of negative relational patterns (Borden 2000). The role of the therapeutic relationship in the context of wilderness therapy cannot be underemphasized for it is this adult that provides the adolescent with an extra familial object with whom to work through past conflicts.

Much like the trip leader and the group help to create a safe space, it is also important to note that the wilderness itself may act as a holding environment for the adolescent, one that involves both illusion and disillusion, and helps the adolescent balance her internal mood with the external reality. While there is not much in the literature about the unique therapeutic context of the wilderness, participants in wilderness therapy programs have reported that simply being in nature was one of the most important components of the wilderness therapy experience (Norton 2007).

Lastly, wilderness therapy creates a context of hope as it provides depressed adolescents with what Erikson (1959) referred to as real accomplishments. As adolescents confront opportunities in the face of uncertain outcomes they build a sense of mastery which helps them create an identity through the reconstruction of the story or dominant narrative they hold about themselves (Stoltz 1998). In essence, the challenges they overcome provide them with new evidence about themselves. The creation of a new narrative may increase the depressed adolescent's ability to envision themselves in a new place emotionally, creating a deeper sense of future. This process of transcontextualization (Saari 1991) is a critical factor in the treatment of adolescent depression. For the adolescent client who is trying to resolve earlier developmental crises, this new narrative may be part of what impels them forward in their psychosocial development.

Wilderness therapy embodies the goals of treatment set forth in the relational paradigm of social work treatment in that it "seeks to help persons strengthen their ability to process subjective experience, deepen awareness of their own and other's behavior, develop problem-solving skills and coping capacities, and enlarge understanding of self, others, and life experience" (Borden 2000, p. 156). In this way, wilderness therapy is a holistic intervention that may begin to address the intrapsychic, interpersonal, and existential aspects of adolescent depression by experientially increasing an adolescent's capacity for relatedness.

Case Study

Lisa was a 16 year old, Caucasian girl of French and German descent who was raised, along with her older brother, in an affluent home in suburban Colorado. Her father was an oil executive and her mother a socialite. Her family was very close, though her father was often absent from the home for work. Lisa was given everything she wanted, and her parents routinely tried to placate her by ignoring her acting out behaviors. However, after one particular incident involving drugs and alcohol that Lisa's

parents described as "scary," Lisa's parents decided they needed help. After talking with administrators at her school, they realized they could no longer ignore Lisa's behaviors and decided to send Lisa to participate in wilderness therapy because of her substance abuse, school failure and truancy issues.

Lisa reluctantly agreed to participate in a 28-day therapeutic wilderness program that involved camping, canoeing, and rock climbing. At the end of the program, Lisa and other group members participated in an urban community service project and a parent/guardian seminar in order to begin to transfer the learning from the wilderness experience back into their daily lives.

When Lisa first came to the wilderness program her entire identity was centered on being a "pot-smoking snowboarder." She was physically very capable and acted aloof and unphased by the challenges of the program. She made everything look easy, but only connected with other participants through surface conversations about drugs, boys and snowboarding. Only when Lisa would talk one-on-one with the instructors did she allow her more vulnerable side to be exposed.

Lisa described herself to her peers as "spoiled" and almost seemed to take pride in this. She would roll her eyes and tell stories about how she was able to "get away" with so much with her parents. In discussions with the staff, Lisa admitted that she used to feel very close to her family, but that she no longer did. She said they used to "do anything for me," but that lately, they seemed to "not care" about her anymore.

After talking with Lisa, it became clear that her parents had overindulged her at times, and that they would often step in and rescue her by keeping her from experiencing the consequences of her failures. In Lisa's case, her parents' overindulgence took on the form of excessive gratification and a lack of parental control (Campis et al. 1986). Much like Blos's (1979) assessment of a child who is spared failure and disappointment, Lisa's family tried to do so for her. This created an illusory self for Lisa in which she felt as if she was omnipotent.

However, upon entering high school, Lisa was diagnosed with a learning disability and began to struggle in school. Though her parents tried, they could not protect her from the struggles she faced. According to Lisa, she had struggled in school her whole life, but it wasn't until high school that she was no longer able to compensate. She was failing classes and said she felt very stupid. Lisa became depressed, and her parents sent her to counseling where she was prescribed anti-depressant medication. For almost the first time in her life, Lisa experienced failure and disappointment; however, she had not developed the coping skills during the latency phase needed to handle this disappointment.

Instead of facing her struggles, Lisa's depression worsened and she started smoking marijuana everyday. She began failing her classes, and eventually started avoiding school altogether, skipping classes and going snowboarding instead. During this time, she would spend time with an older crowd that also used drugs. Lisa joined in until smoking marijuana was a daily occurrence. Because of her drug use, Lisa refused to take anti-depressant medication. Aware of the dangers of combining the two, she chose to smoke pot instead. Lisa began spending more and more time "on the mountain," dressing differently, listening to different music, and calling her snowboarding friends her "family." Sometimes, after a day of snowboarding on a school day, she wouldn't even come home.

As Blos (1979) theorized, Lisa replaced her early object representations with polarization from her family and her school. Like most developmentally regressed adolescents, Lisa was trying to separate from her family without having a solid ego identity. Lisa's new identity was created in polarization to her parents' perceptions of her, rather than an adequate self-definition that integrated her early object ties. Through the intervention of wilderness therapy, the goal was to help Lisa individuate by facing her overreliance on her false self and rediscovering her true self.

Lisa had a turning point 1 day when she was rock climbing as she faced her fear of failure as well as her fear of heights. On her first climb, Lisa slipped and fell. Although she was anchored on a belay safety system, she became very upset and afraid and was yelling that she couldn't go on. "I suck at this!" "I can't do this!" These and other expletives were flowing from her mouth.

Yet, her belayer, the holder of her safety system, remained calm and encouraged her to simply breathe deeply and listen to her body. As she began to calm herself, she was reminded that she may or may not be able to complete the climb (illusion and disillusion); but that it didn't matter. What mattered was the present moment of anxiety, and whether or not she could move past it—because if she could move past that moment, she could move past other moments.

At that moment, Lisa started to cry, "This is exactly what happened to me when I first started snowboarding. I sucked at it, and I kept falling, but it didn't scare me. I just kept trying because it made me feel so alive, and now I don't feel alive at all. I do it to get away, to get high. Those people aren't even my friends. They don't even know the real me. No one knows the real me. I just want to finish school, but I can't. I'm stupid. I need help." Lisa was at a moment of crisis in which she faced the realization that her true self had been hidden by an overreliance on her false self. Winnicott (1965) believed that the false self hides the true self in an adaptive or protective manner, and yet if the true self is not utilized it suffers from what he referred to as a lack of experience.

All this time, Lisa was standing on a ledge about 30 feet up in the air; however, her belayer did not offer to lower her immediately, which would have mimicked the rescuing behaviors of Lisa's parents. Instead, her belayer asked her what she needed right then. Was she feeling okay being up there after such a long time? Did she want to come down and talk more about things? Did she want to keep climbing? Her belayer reassured her that she was still okay holding her there, that it wasn't too much weight, and that she (the belayer) was fine. Eventually, Lisa wiped off her face, and looked up. "No, I want to go on. I just need to go slowly." Lisa proceeded to ascend the cliff, and made it to the top where she turned around to relish the view. As Lisa faced her limitations in that moment, and still made a decision to keep going, she experienced her true self. She was able to do so by expressing her emotions, and utilizing her relationship with her belayer as she needed.

Discussion

The psychodynamics of adolescent depression involve unresolved developmental conflicts, issues of separation/individuation, the search for identity and the development of the true self. All of these things are deep aspects of the self structure and require a powerful intervention in which healing can occur. Wilderness therapy is not a panacea, yet it does provide a holistic approach that can begin to address the psychodynamics of adolescent depression experientially through challenge and adventure in a unique therapeutic setting.

Research indicates the increased risks for severe depression and suicide for many adolescents who have been diagnosed with a learning disability (Huntington and Bender 1993). Some believe this is related to a limited range of coping skills which leave many youth like Lisa vulnerable to psychiatric illness (Bernal and Hollins 1995). While Lisa's depression was largely related to her learning disability diagnosis, the situation was made worse by an overreliance on her false self. In Lisa's case, the coping skills that she employed in grade school, no longer worked in high school, and her parents were no longer able to protect her from these failures. This changed Lisa's entire self-concept, and she began to feel so inadequate after entering high school that she avoided failure by avoiding school, and was unable to ask for help. Over time, Lisa's feelings of helplessness and dependency led to extremely negative feelings about herself, key issues that have been identified in depression (Blatt et al. 1982; Seligman 1975).

Here, Erikson's psychosocial stages of development are very helpful in providing a framework for Lisa's struggle. As Erikson (1959) says, issues of industry versus inferiority are often related to an insufficient resolution of the earlier conflict of initiative versus guilt. This was true for Lisa in that her identity was still fused with the illusion of perfection she had been given by her parents. To engage in the learning context fully would mean relinquishing that illusion, which would produce both guilt and grief. Instead of facing up to failure in the school environment, Lisa immersed herself in snowboarding, at which she eventually excelled. Although the negative peer culture that accompanied snowboarding contributed to her false self, as Erikson (1959) says, this was Lisa's attempt at mastery of her situation. However, these unresolved conflicts contributed to Lisa's feelings of hopeless because she felt that she could not move past her inadequacies and had little to no vision for her future. This inability to transcontextualize further contributed to her depression.

While the whole of Lisa's experience in the wilderness therapy program was very influential, it is important to consider what it was that made Lisa's rock climbing experience such a turning point for her. In many ways Lisa's belayer provided her with a rapprochement mother figure (Mahler 1967), but unlike her parents, her belayer tailored her interactions to include both illusion and disillusion so Lisa could begin to uncover and develop her true self. This support, along with the actual activity of rock climbing, provided Lisa with a holding environment, a form of ego support necessary in helping her separate and individuate in an integrated way. Winnicott (1974) wrote about the primary anxiety of falling forever. In that moment on the rock, Lisa may have been able to recover this primary anxiety in a very concrete way, experience it in a holding environment, and deal with it realistically.

During Lisa's participation in the wilderness therapy program, she began to face her illusory self by confronting opportunities to attempt and complete tasks that were difficult for her. Whether it was learning how to build a fire in the rain or rock climbing, Lisa was supported in not giving up even when things were hard and failure seemed imminent to her. Each time Lisa mastered something real, she experienced a new context of hope for her future.

At the end of the wilderness therapy program, Lisa felt very proud of her accomplishments. She began to share other parts of herself more authentically with the group, and she was able to start talking about what she wanted from her life in the future. Lisa was able to begin a dialogue about her true self, and continued to use snowboarding as a healthy metaphor for dealing with failure, anxiety and depression. She reflected on her strengths in learning how to snowboard, as well as everything she accomplished on the wilderness therapy program. She began to say things like, "If I can do that, I can do anything!" Much like Winnicott's (1971) ideas about imaginative play, Lisa was able to utilize symbols that were already in her outer life to help further develop her inner life with personal meaning.

Upon returning home, Lisa transferred to a boarding school that specialized in working with students with learning disabilities. This school also had an outdoor adventure program in which Lisa hoped to participate. Lisa made a commitment to lessen her marijuana usage and started taking anti-depressant medication. She engaged in family meetings with the administration of her new school, and was able to communicate her struggles to her parents without feeling ashamed. During her climb and in her life, Lisa decided to go on; she just had to go slowly, making sure to ask for what she needed along the way.

Implications for Clinical Social Work Practice

This case study points out the relationship between the psychodynamics of adolescent depression and the need for healthy coping skills in adolescence. Without these skills, adolescents like Lisa who have unresolved developmental crises may be even more vulnerable to depression (Highland 1979). In this case, Lisa was faced with stress from having to face role changes for which she was not ready. For this reason, Highland believed that in order to reduce adolescent depression, an intervention should promote coping skills to help the adolescent cope with the stress that accompanies psychosocial development. This case study reaffirms current social work research calling for appropriate interventions that promote coping skills to deal with the stress of socio-environmental variables that adolescents have to negotiate during development (Simons and Miller 1987).

In this case study, however, clinical social workers are also reminded of the psychodynamic variables that also need to be addressed in a clinical intervention. Unresolved developmental conflicts, issues of separation/individuation (Blos 1962, 1979), a lack of coping skills in response to the stresses of adolescent development (Blos 1962, 1979; Galaif et al. 2003; Highland 1979), and the search for identity and the development of the true self (Erikson 1968; Winnicott 1965) may all be factors which contribute to adolescent depression. Based on this case study and other research, clinical social workers have more of a rationale for referring clients to wilderness therapy programs in order to treat these aspects of adolescent depression.

However, it is important to note that the effects of wilderness therapy may be short lived if they occur without follow up or ongoing treatment. Though Russell (2001) found that there were long term gains even when wilderness therapy was an isolated intervention, some wilderness therapy practitioners and researchers have emphasized the importance of follow-up procedures in ensuring the continual benefits of participation (Berman and Davis-Berman 1994; Hutton 1988; Marsh et al. 1986). For this reason, the intervention of wilderness therapy may best serve as an adjunct modality to other forms of treatment for adolescent depression.

Kaplan (1979) asserted that social workers could help maintain the positive impact of therapeutic wilderness experiences by establishing community-based follow-up programs that would "reinforce and sustain the positive attitudes and behaviors developed," (p. 37). She believed that a community-based program for youth who completed wilderness programs should include the following four components: ongoing outdoor programming, community service placements, alternative education programs, and counseling (p. 44–45). This researcher agrees with Kaplan and believes that the power of the wilderness therapy intervention and its influence on lasting change may be helped by this type of intensive follow-up. This could be an exciting prospect for clinical social workers who are interested in using wilderness therapy with their clients while embedding this type of experience in the context of an on-going therapeutic relationship.

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