THE PARTS I'VE LOST: AN AUTOETHNOGRAPHIC STUDY OF A TRANSITION PROGRAM DESIGNED TO AID FORMER WILDERNESS THERAPY FIELD INSTRUCTORS

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Connor Mathias

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Director: Dr. Callie Spencer Schultz

Associate Professor, Experiential & Outdoor Education

Committee Members:

Russ Curtis, Ph.D., LCMHC, Clinical Mental Health Counseling Program, WCU

Jeremy Schultz, Ph.D., Parks and Recreation Management, WCU

David Wynn, M.S., LCMHC, Parks and Recreation Management, WCU

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ABSTRACT

Wilderness therapy (WT) and other outdoor behavioral healthcare (OBH) programs remain a popular treatment modality for youth facing emotional, behavioral, psychological, and substance abuse disorders (Berman & Davis-Berman, 2008; Cramer & Wanner, 2022). The field instructor's (FI) role is critical in maintaining the client's emotional and physical safety and well-being within the programs. FI face numerous stressors due to the nature of therapeutic work, including long workdays, a constant state of hypervigilance, and potential exposure to violent and traumatic events (Kirby, 2006; Kirk & O'Connell, 2012). As instructors transition out of the field, these stressors can compound, causing emotional anxiety and other physical and mental challenges (Bunce, 1998; Marchand et al., 2009). Few programs exist that seek to aid FI during this transitional period. This three-part autoethnographic study aimed to design, implement, and examine a multi-day backpacking trip for current or former FI. I examined my perceptions and observations through journals, photographs, discussions, and participation in cognitive behavioral therapy (CBT) to create this autoethnography. Examining the results, I found the group setting to be a crucial component as it provided the opportunity to be surrounded by individuals with similar shared experiences. The use of CBT throughout the research process allowed for constant reflexivity while adding clarity to the written material and discussions throughout the course. I struggled with turning off the constant state of hypervigilance required by FI to operate (Marchand & Russell, 2013) and continuously found it difficult to find comfort in outdoor spaces. While a course of this nature can potentially aid in the processing of past traumatic events, it is not designed to replace the use of a licensed clinician but rather for individuals to participate in CBT concurrently. An industry-wide landscape analysis of the well-being of former FI can be crucial in illuminating the issues these individuals have or are experiencing due to their employment in WT.

Keywords: Wilderness therapy, field instructor, autoethnography, transition program

CHAPTER 1

I'm sitting on the ground, preparing to dispense a nighttime medication to a student sitting in front of me. Our breaths were visible as we sat there. I was hunched over a large Tupperware container, attempting to cut a pill in half. I'm leaning over, cutting this pill, and out of my peripheral, I see a hand, and I see the bottle of pills move. The student had taken the bottle and swallowed every single pill in a desperate attempt to commit suicide.

I shove my fingers down the student's throat to expel the pills, being covered with water and vomit in the process. I radioed a nearby group to send one of their staff to help watch my group. I had my personal phone in one hand and my work phone in the other, contacting the appropriate medical and management personnel. I created a grid system, and with my headlamp and the light from my phone, I walked back and forth, to find any loose pills on the ground. My fear increased as I found none. I took off my outer layers and checked every single crevice in a desperate attempt to find any pill. I even combed my hair in case one somehow landed there. It became evident that the student swallowed every single pill in the bottle.

The student and I sat together as we waited for help to arrive. Through tears, they asked me, "Am I going to be ok?". I looked up at their face and saw something I had not seen before; a scared, confused young child. The anger and fear I felt were suddenly replaced by shame and guilt. "I don't know." Was all I managed to say—a brutally honest answer to a scared child who needed reassurance when I had none. We sat there in silence. One of us terrified, and the other trying not to be. Help arrived soon after, and the student was taken to the hospital, where they were given the proper treatment and rejoined the group later the next day.

While I had a few sleepless nights immediately following this incident, it was not until a year later, after I had left the field of wilderness therapy, that the anger and fear that I had so

recklessly suppressed revealed itself. It was early morning, my nose stuffy, and my head hurting from allergies. As I grabbed a bottle of Claritin, a pill slipped through my fingers and fell onto my bathroom floor. I bent down to pick up this tiny white pill and suddenly felt a massive surge of anger. How easy it was for me to find this pill, but not the others. How close I was to causing the death of a child. I think about that child and those pills every day and how one decision entangled our lives in ways both of us will never fully understand.

INTRODUCTION

I share my stories to bring to light what I believe to be a significant pitfall of Outdoor Behavioral Healthcare (OBH) and Wilderness Therapy (WT) programs: a lack of support for field instructors transitioning out of the field of wilderness therapy. There is currently a substantial amount of literature exploring these types of programs and the positive and negative impacts they generate on the participants and the instructors (Berman & Davis-Berman, 2008; Fernee et al., 2017; Marchand, 2008; Russell et al., 2008). Outdoor Behavioral Healthcare programs often fall under names such as Wilderness Therapy, nature-based therapy, or adventure therapy. Because of this, it is often hard to distinguish between programs that are accredited as "Wilderness Therapy programs" and other organizations that simply self-identify as WT programs. In the twenty years since Russell and Hendee (2000) published their categorization of OBH and Wilderness Therapy programs, many other scholars have proposed their own definitions. Dawson & Russell (2012) state that OBH programs use primitive living and natural consequences to treat adolescent behavioral issues. For the sake of this research proposal, I will use Cramer & Wanner's (2022) definition of wilderness therapy as the combination of "therapeutic elements with outdoor activities in a natural setting to help treat individuals with a range of needs including behavioral, emotional, psychological, and substance use issues" (p.1). While each wilderness program is unique and in how they function, all WT programs traditionally contain three common elements: (1) take place in wilderness, remote or natural setting, (2) the use of cognitive behavioral therapy (CBT) and other therapeutic elements, and (3) the use of outdoor activities such as camping and backpacking to build personal and interpersonal skills (Cramer & Wanner, 2022).

The exact number of Wilderness Therapy Programs operating in the U.S. is often up for debate. The Outdoor Behavioral Healthcare Council, one of the leading organizations attempting to monitor and uphold the standards of WT programs and the ethical treatment of the participants, has fifteen accredited programs (https://obhcouncil.org/). NATSAP (The National Association of Therapeutic Schools and Programs) provides accreditation and resources for WT programs, therapeutic boarding schools, residential treatment programs, therapeutic day schools, specialty psychiatric and behavioral hospitals, transitional independent living programs, and young-adult programs. One hundred thirty-eight programs and organizations are accredited through NATSAP, with twenty identified as WT programs (NATSAP).

An area of literature that is lacking is an examination of the long-term consequences this type of work has on the instructors who work for OBH programs. Due to the volatile and unpredictable nature of WT programs, these instructors are uniquely positioned to encounter various traumatic experiences and other challenging situations (Bunce, 1998; Marchand, 2010; Marchand & Russell, 2013). Factors affecting the well-being of FI include a strain on intimate relationships, difficulty creating and maintaining new relationships, and feelings of disconnect from friends and family (Bunce, 1998; Marchand et al., 2010). Research by Marchand (2010) found that FI remain employed full-time, on average, for less than a year (11.85 months). High rates of turnover can disproportionately affect morale and culture and disrupt the quality of care provided to clients (Kirby, 2006). Research has found that the turnover rate for WT programs is typically high due to the demands placed on the instructors (Kirk & O'Connell, 2012), and because of this, it is difficult to find a concrete number of wilderness instructors employed at WT programs.

In a study by Thomas (2001), 61% of outdoor educators surveyed identified long work hours and time away from home as the largest contributors to work related stress. Marchand et al, (2009) found that one third of those surveyed reported that their roles as FI affect their spouse or partner and negatively impact their intimate relationship with 22% reporting that their work at contributed to a split with an intimate partner.

There is little research on the lasting mental and physical effects on these instructors post-WT. Wilderness Therapy instructors have been shown to encounter and develop various mental health issues, including post-traumatic stress disorder (PTSD), secondary traumatic stress (STS), countertransference, and shared and vicarious trauma (Marchand & Russell, 2013; Wilson, 2009). Instructors become very adept at caring for their clients and recognizing their needs often before the adolescents do. However, the same field instructors often forego their own emotional, mental, and physical needs for the health and safety of the children and young adults they look after.

As I transitioned out of the wilderness therapy field, just as thousands of others have done before me, I was blissfully ignorant of how working in this environment would affect my mental state going forward. Field instructors are trained always to put the health and safety of the client first. This can often lead to intense emotional and physical interactions between field instructors and participants. However, these abusive and traumatic experiences can leave wounds we are unprepared to deal with. The only support I had during this transition time (from the WT field back to 'regular life') was the support I sought. I needed assistance or a program specifically designed to aid in this transition that provided community and other resources I could utilize if necessary. What I needed was someone who understood the pain I had gone through and some tools to aid me in living with these traumatic experiences.

While there is not much that can be done about the physical and emotional abuse instructors face while working in these programs (as this is often the nature of working with youth in these settings), there is an aspect of OBH programs that I can help change. I did not receive the support I needed; therefore, my goal is to provide that support to others. I believe the weeks and months immediately after an instructor leaves the field are a delicate period where the proper support can help provide the instructor with community and resources to help create an easier transition.

Purpose Statement and Research Questions

With this goal in mind, I designed and implemented a multi-day backpacking course for former WT field instructors as they transition out of the field of WT into their next professions. This initial course acted as a "pilot course" for future trips with the goal of studying experiences on this course to improve future iterations. The goal of this pilot course (and future courses) was to build a sense of community for former WT field instructors, create a space to share resources that will aid in this transition time, and provide time and space to reflect on and heal from past traumatic events. The analysis of this pilot course made up my thesis research study, outlined next.

Due to the sensitive nature of the discussion that will be present on a course such as the one I am designing; I have decided to begin by studying my own experiences on the course and allowing my co-participants on the course to experience the course without the added layer of "being watched" through a researcher's eye. Therefore, I used an autoethnographic approach grounded in Contemporary Trauma Theory (Goodman, 2017), which emphasizes a holistic approach and stresses the importance of proper trauma-informed practices (TIP), trauma-

informed care (TIC), and a great deal of patience and respect when addressing past traumatic events.

The purpose of this study was to explore my experiences and self-perceptions of a backpacking course specifically designed to aid former wilderness therapy field instructors as they transition out of the field of wilderness therapy. The research questions guiding my study were:

1. What are my experiences on a self-designed, 3-day backpacking course for former wilderness therapy instructors?
2. How did the course impact my physical, emotional, and psychological transition from out of the wilderness therapy field into everyday life?

I used the insights gained by answering my research questions to inform course modifications for future iterations. I will begin with a review of the literature and Contemporary Trauma Theory, then a discussion of my autoethnographic methodology and the methods I used: personal narratives, autophotography, and journaling. Finally, I share my results in the form of a manuscript, formatted in consideration for publication in the Leisure Sciences Journal special issue on The Interconnections of Trauma, Healing, Health, and Leisure.

CHAPTER 2: LITERATURE REVIEW

I will begin with a review of the literature, specifically a brief overview of Contemporary Trauma Theory which will ground my research. Followed by an examination of OBH and WT programs, a dive into the demographics and characteristics of wilderness instructors and their roles, and specific mental and physical issues affecting current and former wilderness instructors. Literature on individuals and other groups affected by similar issues, such as combat veterans,

will also be explored followed by review of current programs that provide transitional support. I conclude with a review of the literature on the benefits of nature interactions and the effects of walking/hiking and backpacking as mental health interventions.

Contemporary Trauma Theory

The true definition of trauma is often subjective to the author and the organization from where the research originated from. The American Psychological Association (APA) defines trauma as an "emotional response to a terrible event like an accident, rape, or natural disaster" (American Psychological Association). In recent years, the definition of trauma has traditionally included three characteristics: (1) an identifiable event or series of events, (2) the individual experiences these events as physically or emotionally harmful, and (3) has lasting effects on the individuals basic functioning (Goodman, 2017; Herman, 1992; Van der Kolk, 2014). The development and creation of Contemporary Trauma Theory (CTT) brings forth a paradigm shift in how those who work in the mental health field interact with and treat survivors of trauma. This new trauma-based approach views the individuals and their level of functioning as someone in need of healing and help, instead of viewing them as psychologically injured or weak (Bloom & Farragher, 2011; Van der Kolk, 2014).

CTT provides the theoretical framework to understand how trauma has impacted an individual's well-being and their cognitive functioning (Goodman, 2017). CTT is often based on the following characteristics: dissociation, attachment, reenactment, long-term effects on later adulthood, and impairment in emotional capacities (Goodman, 2017). One of the pioneering clinicians in the field of trauma work is Judith Herman (1992) whose research helped lay the groundwork for CTT.

At the heart of CTT is the belief that proper trauma-informed care (TIC) and trauma-focused strategies are beneficial and necessary treatment methods when working with an individual who has suffered severe trauma (Back et al., 2014).The National Center for Trauma Informed Care (SAMHSA, 2014) published six guiding principles necessary when working in the field of trauma; (1) safety; (2) trustworthiness and transparency; (3) Peer support; (4) collaboration and mutuality; (5) empowerment, voice and choice; and (6) cultural, historical, and gender issues. A proper trauma-informed approach strives to avoid the re-traumatization of clients as well as staff, therefore avoiding stressful environments is critical for all individuals included in the healing process (SAMHSA, 2014).

Characteristics of Outdoor Behavioral Healthcare Programs

Currently, one in five Americans suffer from a form of mental illness (NAMI). While traditional therapeutic approaches can appear daunting and ineffective to some individuals, particularly to adolescents, new techniques and methods continue to grow in popularity. As the amount of literature discussing the exploration of wilderness spaces and its proposed benefits on physical and mental health continues to increase (Tillmann et al., 2018), so too grows the number of programs seeking to capitalize on this interconnectivity. It is important to acknowledge that each OBH program has its own internal goals, desired outcomes, therapeutic practices, client demographics, and instructors' expectations. Therefore, research should be done into each program individually if one is seeking further information on a specific program's mission and values.

Wilderness therapy programs use traditional therapeutic techniques and adventure-based activities in an outdoor setting (Kolaski & Taylor, 2019). Programs use a group treatment modality that pursues nature's restorative and healing qualities, combined with structured

therapeutic work (Davis-Berman & Berman, 2008). Most adventure-based therapeutic programs involve the client spending a significant portion of their time in an extended wilderness setting, typically weeks or months, with the amount of time variying for each program. Wilderness therapy differentiates itself from adventure therapy by operating primarily in remote wilderness settings where the day-to-day outdoor routine is integral to the treatment process (Fernee et al., 2017).

A high cost comes with sending someone to an OBH or comparable program. All Kinds of Therapy (2017) surveyed multiple wilderness therapy programs across the U.S. and found the average cost to be $558/per day (AllKindsofTherapy). This cost includes boarding, food, and the cost of therapeutic treatment. The camping equipment and clothing are typically an additional cost. Depending on the type of program, participants can be enrolled from thirty days to over three months. In total, wilderness therapy can cost anywhere between $16,000 and $67,000 or potentially higher depending on how long the participant is enrolled. Behar et al. (2007) conducted a survey of families of wilderness camp participants in which it was discovered that half of the families had an income of $100,000 or more. Due to the high cost of attendance, only a specific population can afford these types of programs, typically families of higher socioeconomic status (Behar et al., 2007). Families are willing to spend a significant amount of money due to the severity of their child's issues, and typically, all other forms of therapy and intervention have already been exhausted (Behar et al., 2007).

Benefits and Disadvantages of OBH Programs for Participants

There is currently a vast amount of research on the positive and negative implications of participating in a WT or OBH program. A synthesis of research on WT programs conducted by Fernee et al, (2017) found that these programs increase self-confidence in the participants, with

the same individuals finding the wilderness environment as a place to heal. Russell (2000) found that time alone in nature provided the participants time to reflect and process past experiences as well as increased awareness and personal insight. Participants in a study conducted by Russell & Phillips-Miller (2002) discussed how the wilderness therapy model helped dissolve the stigma around mental health treatment and the process felt less intimidating.

A recent study by Cramer & Wanner (2022) reviewed and synthesized past research on the outcomes of wilderness therapy programs and uncovered a wide range of commonalities between the studies. Several hundred studies between 1969 and 2022 were collected and reviewed in this process. Research found that WT programs aided in an increase of self-esteem, academic performance, family development, physical health, and increase positive behaviors (Cramer & Wanner, 2022). WT programs have also been shown to decrease suicidal ideation in clients as well as aid in the addiction recovery process (Fernee et al., 2017).

While research has shown the vast number of positive effects therapeutic wilderness programs have for their participants, these programs are not without risk and controversy. Look no further than the report conducted by Kutz & O'Connell (2007) through the Government Accountability Office (GAO) which examined and reviewed ten civil and criminal cases from 1990 through 2004 where a youth participant died while enrolled in a private WT or OBH program. Most of these programs were unregulated by the state they were located in. Kutz and O'Connell (2007) uncovered an alarming number of issues that lead to the deaths of the participants including ineffective management, negligence, and lack of credentials and training for management and the field instructors, leading to untrained staff.

A theme consistent throughout most of the cases examined was the lack of trained staff who downplayed severe medical emergencies and instead believed the client was lying to get out

of the program (Bunce, 1998). This led to deaths from common treatable illnesses including dehydration and heat stroke. The lack of adequate nourishment was also a contributing factor in several of the deaths examined. Some programs required the participants to fast, provided a minimal amount of food for meals, and provided the equal amount of food per participants regardless of height, weight, or dietary needs (Kutz & O'Connell, 2007). Reckless and negligent operating practices were also found to be a cause of several of the deaths examined. Field instructors were sent to lead hikes in unfamiliar areas, important gear such as radios and first aid kits were left behind, and a general lack of background knowledge regarding the students coming into the programs.

Behar et al. (2007) examined the experiences of previous WT participants and found improper use of "seclusion", reports of abuse and neglect, and numerous violations of the participant's rights. Behar et al. found that a lack of direct regulation by the states aids in the neglect and abuse reported by the clients, as well as the deaths examined by Kutz & O'Connell (2007).

Characteristics of Field Instructors within OBH Programs

Field instructors working in wilderness therapy and other OBH programs have countless expectations, requirements, and roles placed on them before and during employment such as wilderness first aid/responder certification, knowledge of behavioral management techniques, outdoor recreation experience, training and use of certain physical restraints, and prior knowledge or experience working with youth with various emotional and psychological issues (Bunce 1998; Kirby 2006). For the sake of this study, the term "field instructor" refers to an individual employed full-time, either seasonally or year-round, to lead expedition-based outdoor programming for youth facing a variety of mental and behavioral issues. Field instructors

working in OBH programs fit a specific demographic: "young, educated, single, and Caucasian" (Kirby, 2006, p.79). Kirby (2006) observed that a particular group of individuals would consider work in an OBH program enjoyable and worthwhile, specifically those with a love of the outdoors and a desire to help others. Marchand (2010) found that those individuals with a strong desire to share their love of the outdoors with others often lead them to work for OBH programs for personal and altruistic reasons. It is worth noting that the demographics of field instructors have shifted over recent decades. The field was historically male dominated, with the average age in the late 20s to early 30s (Kirby, 2006; Kirk & O'Connell, 2012). Past research has shown the average age of field instructors to be 22 to 26, and men and women are now equally represented in field instructor roles (Kirby, 2006; Marchand et al., 2010). Current demographics post-2020 remain unknown.

The average age of field instructors has shifted within the past few years. The intensity of the job and the extreme physical and emotional demands appeal to a much younger generation with fewer fiscal and personal responsibilities (Marchand et al., 2010). These individuals can often successfully balance the time needed and the job requirements. Marchand et al. (2010) surveyed wilderness field instructors and uncovered that 74% of participants had completed at least a bachelor's degree. Further research into the backgrounds of field instructors and whether prior knowledge and skills in particular fields create more successful employees are needed.

Role of Field Instructors within OBH Programs

To understand why a transitional program is needed for field instructors, it is crucial to explore the daily roles, requirements, and expectations that field instructors encounter. FI are responsible for the safety and overall care of the clients, as well as the typical day-to-day living arrangements, such as cooking, laundry, and hygiene (Russell & Hendee, 1999). Programs that

work primarily in remote wilderness settings require the instructor to spend multiple days or weeks, on shift (Marchand et al., 2009). While working, FI will eat similar foods as the students, hike the exact same distances, often with multiple packs, wear gear and clothing comparable to the students, and sleep in the same environments and weather. Additionally, instructors can also be responsible for facilitating group and individual therapy sessions (Kolaski & Taylor, 2019).

Field instructors are responsible for the administration of any medications that clients are required to take. These medications are typically kept in a locked backpack that remains on the staff at all times. Field Instructors are trained in using physical restraints in case a client is a threat to themselves or others (Kutz & O'Connell, 2007). These physical restraints can be very demanding depending on the weight and size of the child, and the strength and size of the FI. Instructors are trained to use physical restraints as a last resort, but research has found that these restraints can be used as a form of coercion or discipline (Davis-Berman & Berman, 2007). A Wilderness First Responder (WFR) or Wilderness First Aid (WFA) course is required before employment can start (Russell et al., 2008).

The training and hiring of field instructors have previously been explored by Davis-Berman & Berman (1984), as well as the ethical considerations of hiring untrained instructors to work with youth. A more recent study by Marchand & Russell (2011) found that the most common elements of the initial training of field instructors were therapeutic and behavioral management tools, observing groups of students before employment, and being in the role of the clients. In the same study, field instructors found this training helpful but expressed the desire for more training on technical skills (2011).

Marchand and Russell (2013) discovered FI often have an unclear view or different expectations about their assigned roles. The initial bulk of the training of field instructors focuses

on wilderness and technical skills; however, very little time is spent on handling psychiatric emergencies (Russell et al., 2008). Field Instructors working in OBH programs need a wide range of skill sets to be successful and effective. This skill set includes wilderness competency, group and time management skills, counseling skills, physical endurance, knowledge of therapeutic interventions, and the ability to deal with and handle acts of violence and self-harm (Thompson, 1984).

Physical and Mental Issues Field Instructors Experience

Instructors working in WT programs and other nature-based therapeutic programs are uniquely positioned to experience numerous physical and mental disorders due in part to the nature of working with youth and adults in this unique setting. These issues include but are not limited to, post-traumatic stress disorder (PTSD), transference and countertransference, secondary traumatic stress (STS), vicarious trauma (VT), depression, and anxiety (Kirby, 2006; Kirk & O'Connell, 2012; Marchand, 2008).

Post-Traumatic Stress Disorder (PTSD)

Post-traumatic stress disorder (PTSD) is a devasting and historically disregarded medical issue that has been pushed to the frontlines of the mental health crisis within the past few decades. While PTSD is commonly associated with combat veterans and military service members, according to the National Center for PTSD (2018), thirteen million Americans were diagnosed with PTSD in 2020. The Covid-19 pandemic has only pushed the severity of PTSD further into the limelight (Blackman, 2020; Chamaa et al., 2021). The dawn of the written and oral history of PTSD in the U.S. began on the battlefields of the American Civil War. Da Costa (1871), a physician who treated wounded soldiers in military hospitals, noticed elevated heart rates, irritability, and increased arousal among those exposed to combat. This combination of

symptoms became known as "Soldiers Irritable Heart" and "Da Costas Syndrome" and was found to be related to the stress of combat (Trimble, 1981). During the First World War, Freud (1917) observed the effects of war-related stressors on soldiers who had experienced combat and theorized that war trauma presents a stimulus too powerful for the human mind to sustain.

Research has been conducted on combat-related trauma from past military conflicts, including World War II, the Vietnam War, and the wars in Iraq and Afghanistan (Hart et al., 2008; Jakupcak et al., 2007; Marmar et al., 2015; Orr et al.,1993). However, it is not only combat veterans who were studied regarding early forms of PTSD. Gaynor Lacy studied 400 British schoolchildren who had survived a mudslide that destroyed their school and killed over 100 of their classmates (Lacy, 1972). Nearly two years after the incident, students were reported having difficulty sleeping and a lack of desire to attend school or go out and play, with some children being terrified of bad weather, such as wind or rain, due to the inclement weather that preceded the incident (Lacy, 1972). Combat veterans are often the largest demographic associated with PTSD; however, this medical issue can affect anyone at any age (National Center for PTSD). Various factors affect whether or not a person will develop PTSD, including age, gender, past traumatic events, and stress levels (National Center for PTSD).

Defining and categorizing PTSD has been an ongoing issue over the past few decades, as various organizations have often defined and redefined it. The U.S. Department of Veterans Affairs (VA) defines PTSD as "a mental health problem that can only develop after someone goes through or sees a life-threatening event" (National Center for PTSD). The American Psychiatric Association defines PTSD as "a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances"

(American Psychiatric Association, 2013). PTSD symptoms typically present themselves in one of four "clusters":

- Avoidance – Avoiding reminders of traumatic events, including places, activities, objects, and scenarios that may cause distress. An individual may resist or avoid talking about specific events.
- Intrusion – Intrusive thoughts such as memories related to traumatic events, reoccurring dreams, intense vivid flashbacks, and other prolonged distress.
- Hyperarousal – Aggressiveness, irritability, recklessness, self-destructive behaviors, sleeplessness, hypervigilance, and easily startled.
- Changes in cognition and mood – Loss of memory surrounding certain events, consistent negative emotions, ongoing fear, anger, guilt, and shame, lack of interest in activities previously enjoyed, feelings of detachment from others, and the inability to experience positive emotions (American Psychiatric Association, 2013).

While field instructors working in the OBH field might not encounter the same experiences as combat veterans, the intensity of the environment, the demographics of the clients involved, and the constant stress of the day-to-day routine of group management of youth with mental and behavioral issues can create the potential for severe traumatic events for all of those involved.

Transference and Countertransference

Transference and countertransference are phenomena that occur in all types of relationships. Every human being has an impact on another. Scholars have discussed how these events are often convoluted and difficult to untangle and substantiate (Jones, 2004); nonetheless,

they are necessary for understanding a client/therapist relationship. Transference is defined as the "unconscious redirection of feelings from one person to another" (Prasko et al., p. 189, 2010) and, in the case of wilderness therapy, from therapist to patient or from patient to field instructor. Countertransference is the redirection of emotions from patient to therapist or from field instructor to patient.

Transference has been crucial in the field of psychoanalysis for over a century. First researched and discussed by Sigmund Freud (1888), his early concept of "displaced energies" laid the groundwork for later research into transference and countertransference. In his research, Freud witnessed the transfer of strong emotions from one individual to another when traumatic events were discussed. The early idea of transference was further researched in 1895 (Breuer & Freud, 1895), where Freud witnessed patients transfer ideas and emotions onto the physician present. When the professional boundaries between client and therapist become muddled, the door is open for harmful consequences for both parties. The therapist has opened themselves to potential emotional and psychological harm due to the distortion of communication.

Therapists undergo intense training on noticing signs of transference and changes in a client's nonverbal behavior, such as fidgeting behaviors or a subtle shift in gaze or expression (Prasko et al., 2010). This training assists clinicians in maintaining professional and emotional boundaries between themselves and their clients while cultivating an authentic relationship. Field instructors are not licensed clinicians but often direct group therapy sessions and in-the-moment crisis management and interventions. FI are not trained in how to avoid transference and, therefore, are more susceptible to the negative effects it may bring. Transference can lead to field instructors taking on roles and responsibilities they are not trained for and being asked to aid patients in processing feelings and events that can weigh heavily on the instructor. It is necessary

to acknowledge that most wilderness therapy field instructors are not licensed clinicians (however, there may be instructors with a therapeutic background and appropriate licensure). OBH and WT programs employ licensed clinicians to assist the clients on the therapeutic level, while the main duties of FI are the day-to-day management and safety of the clients.

There is a rich amount of literature regarding transference and countertransference in psychotherapy (Cartwright, 2011; Prasko et al., 2010) and nursing (Evans, 2007; Jones, 2004; Miles, 1993). However, there is no research on the effects of transference and countertransference in a wilderness therapy setting for field instructors. This could be due in part to the relatively small number of field instructors in the U.S. compared to psychologists, which a recent study by the U.S. Bureau of Labor and Statistics placed around 180,000 (Bureau of Labor Statistics) or registered nurses, around 3.1 million (Bureau of Labor Statistics). Another possibility is that the health and well-being of the clients, whether they are youths or adults, are placed before those of the field instructors. A study by Kirk & O'Connell (2012) found the average time employed for a FI was 11.85 months, with Kirby (2006) reporting that one WT program found it "common and expected" (p.3) to have a staff replacement rate of 100% every two years. With the employment rate of the FI constantly in flux, programs may choose to divert resources elsewhere.

Secondary Traumatic Stress and Vicarious Traumatization

It is well-known that forming an empathic relationship with another human being that involves sharing past and present emotional experiences can affect all those involved on both a conscious and subconscious level (Devilly et al., 2009). Figley (p.1, 2013) states it bluntly when he writes, "There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care." Individuals who work in

the mental health field or other care-giving professions in any capacity face a unique set of issues that come with prolonged exposure to the traumatic experiences of others. Two phenomena that can arise when working with traumatized individuals are secondary traumatic stress and vicarious traumatization. While these two challenges are often mentioned and researched as though they are one, the following paragraphs will explore the differences.

Secondary traumatic stress (STS), defined by Figley & Kleber (1995), is the natural consequences that arise between two individuals, one who shares past trauma they have experienced and the other who is affected by the first individual's past trauma. Compassion fatigue, now commonly referred to as STS, is the outcome of hearing emotionally shocking experiences from another individual (Canfield, 2005). Therapists and other mental health professionals who help process traumatic events may begin to experience similar physiological and psychological responses they see in their clients, including anger, fear, depression, and a sense of helplessness (Canfield, 2005). The symptoms of STS are nearly identical to those of PTSD and can include a sense of avoidance and intrusion (Figley & Kleber, 1995). Figley (1995) describes symptoms of extreme exhaustion, hypervigilance, avoidance, and numbing as a direct result of working with individuals with PTSD.

It is important to recognize that the experience, method, and exposure time varies drastically for each individual and each profession. An EMS worker responding to a vehicular accident will have a different experience than a psychotherapist hearing stories of attempted suicide or sexual abuse. The same can be said for a wilderness therapy field instructor who witnesses stories of self-harm and sexual assault. To try and compare each experience would invalidate the emotions and effort of those involved.

Whereas STS is identified by the psychological symptoms that mirror those of the traumatized client, vicarious traumatization (VT) is the direct shift in a professional's view of themselves and the world around them as a result of prolonged exposure to the traumatic events of their clients (Baird & Kracen, 2006). VT is the normal human response to the daily challenges of mental health professionals and can often result in decreased motivation and empathy (Baird & Kracen, 2006). One of the most alarming repercussions of VT for those exposed to the traumatic events of others is the drastic loss of hope and a sense of meaning spiraling downward into pessimism (Saakvitne, 2002).

The warning signs of STS and VT are both innumerable and alarming: helplessness, a loss of hope, loss of meaning, a sense that one can never be or do enough, a decline in creativity, chronic exhaustion and other physical afflictions, avoidance, dissociation, guilt, fear, shame, anger, depression, anxiety, loss of empathy, hypervigilance, loss of interest in activities that once brought joy, numbing, addiction, and an increase in cynicism (Figley, 1995; Pearlman & Saakvitne, 2013; Saakvitne, 2002; Selby, 2014). Individuals working in the mental health field or crisis work are likely to experience a drastic physical, emotional, spiritual, and professional shift, which can affect the organizations they work for and the clients they strive to help.

The Transition Process

It is important to note that research has been conducted on burnout and the challenges FI face while working within OBH programs (Kirk & O'Connell, 2012; Kolaski & Taylor, 2019; Marchand et al., 2009); however, there remains little research on the long-term effects this type of work has on the instructor. Field Instructors face numerous issues, including (1) constant awareness to keep clients safe, (2) lack of time for self-care, (3) lack of sleep, (4) consecutive days in wilderness settings in sometimes not-ideal weather conditions, (5) unpredictable nature

of clients, (6) threats or acts of violence from clientele, and (7) stress that arises from working with clients with psychological and behavioral issues such as self-harm, suicidal ideation, or running away (Kirby, 2006; Kirk & O'Connell, 2012; Marchand, 2008; Marchand & Russell, 2013). Moreover, most WT programs lack a transitional program designed for FI as they leave the field.

In addition to the potential exposure to numerous traumatic events, FI often spend several days, weeks, or potentially months away from family and loved ones (Kirk & O'Connell, 2012). This lack of familial connection and the stressors of working with youth in a wilderness setting can lead to a difficult transition process when leaving a shift or the profession. Bunce (1998) and Gass (1993) discussed the negative impacts that working in the field of WT could have on interpersonal relationships. A study by Lawrence-Wood and Raymond (2011) found that adult staff members describe "physically and emotionally intense experiences" (p.324) similar to that of the clients under their care. These staff members discussed a period of adjustment that involved positive and negative emotions, with periods of crying, difficulty sleeping, and intense self-reflection (Lawrence-Wood & Raymond, 2011). In the same study (2011), staff members were also reported to have difficulty discussing and normalizing the experience with family and friends. The results of this study show that a significant number of FI experience a psychological adjustment period that includes feelings of pride, feelings of loss, and recollection of moments on past trips (2011). Other responses included "becoming more upset easily," "having less energy than normal," "increased irritability," "withdrawing from others," and "difficulty relaxing" (Lawrence-Wood & Raymond, 2011, p. 331). This particular study involved instructors working with clients with "poor classroom behavior, high levels of truancy, and at-

risk of criminal behavior, and who had been referred to the program by several government and non-governmental agencies" (p.327).

Ulrich Dettweiler (2012) reflected on his time as the National Director of Program Safety at Outward Bound Germany and the post-course psychological adjustment symptoms he witnessed and their effects on his field staff. Dettweiler mentions, "the end of marriages, jobs quit, and living habits altered (p.24). Dettweiler (2012) does not mention the demographic his field instructors work with.

Studies show how important and difficult the transitional period can be for combat veterans returning from active duty (Dao, 2011; Rutherford & Allegria, 2010). Veterans face high levels of psychological abuse, substance abuse, and physical health problems (Ahern et al., 2015; Seal et al., 2007). Given the significant number of issues facing veterans leaving active duty, the importance of the transition process is critical to the health and well-being of the individual. Research conducted by Wands (2013) reveals that the long-term well-being of veterans is directly connected to a successful transitional period. Ahern et al. (2015) conducted a study involving twenty-four combat veterans and uncovered three challenges facing a successful transition:

- **Loss of a "family" and support system** – A sudden loss of a support system familiar with the uniqueness of military life and the structure provided in a military environment.
- **Normal is alien** – Aspects of civilian life no longer feel "normal." Strong disconnection from family and friends. Unsupportive institutions. Lack of structure in civilian life. A sudden loss of purpose.
- **Searching for a new normal** – Accepting support from individuals who lack shared experiences is difficult. Veterans who had support from a peer or support group had

practical, emotional, and psychological help. Embracing an ambassador role for themselves for other veterans. Transition gets easier with time. (Ahern et al., 2015).

The transition process is particularly important for veterans returning from Iraq and Afghanistan due to the skyrocketing suicide rate among those returning from active duty (RAND, 2011). Transitioning is made more difficult by the disparity between military and civilian life, moving from an intensely structured environment to one of more freedom and choice (Pease et al., 2015).

In this literature review, I do not seek to compare the experiences of combat veterans with those of field instructors working in wilderness therapy programs. The importance of an intentional and practical transition process or program has been shown to be beneficial to veterans returning to civilian life (Derefinko et al., 2019; Pease et al., 2015). FI and combat veterans face similar struggles during the transition process, such as a sudden loss of structure, purpose, and support system, and a struggle to connect with those unfamiliar with the experiences they faced (Ahern et al., 2015).

Current Transition Programs

Little information and research can be found on transition programs specifically designed for former wilderness therapy instructors, adventure therapy instructors, or outdoor educators. Some programs and organizations exist for students leaving wilderness programs, such as boarding schools or transitional living programs designed to provide structure and support while also encouraging freedom and choice. The websites of wilderness therapy programs provide occasional articles intended to provide advice and strategies to students on the verge of graduation, such as "Take time" and "Develop a plan" (Blankenship, 2020).

Numerous transitional programs designed for combat veterans have been found to aid in the transition to civilian life and improve overall mental health. A study by Scheinfeld et al. (2017) found that male veterans participating in an Outward Bound for Veterans (OB4V) therapeutic adventure helped improve overall mental health while providing an additional therapeutic option for veterans. Price et al. (2015) narrates his struggle with combat-related PTSD and how the activity of fly fishing provided the therapeutic outlet and access to resources he needed. Price et al. (2015) reflects on how "even the deepest emotional scars can be ameliorated through purposeful leisure rituals" (p.192). DeLucia (2016) discusses how an art therapy program at the Veterans Outreach Center in Rochester, New York, aids in the transition process for veterans returning home. This study (2016) further demonstrates how it is also the responsibility of non-veterans to understand the collective trauma that combat veterans have gone through and provide a space to aid in processing that trauma. The art therapy studio encourages a sense of connection among the participants, processing past trauma together and healing through community.

The U.S. Congress created a Transition Assistance Program (TAP) in the early 1990's to assist servicemen and servicewomen transitioning to civilian life (Faurer et al., 2014). The desired intent of these programs was to provide employment opportunities and job training services and to encourage higher education to returning military members (Faurer et al., 2014). A study conducted by Perkins et al. (2020) surveyed over nine thousand post-9/11 veterans seeking to discover what programs and services aided them in their transition back to civilian life and what specific components of those programs were the most effective. The study examined VA and non-VA programs. Of the veterans surveyed, 65% reported using at least one program, with over half of the population (53%) seeking only programs designed to aid employment

opportunities. Researchers (2020) found 1736 unique programs the respondents mentioned, including employment, education, legal, financial, housing, health, and social/personal relationship programs. Few veterans (less than 7%) reported using programs designed to encourage social relationships and connect them with other veterans (Perkins et al., 2020). A consistently reported issue among veterans is a feeling of disconnect from those without similar life experiences (Makin-Bryd et al., 2011).

Research has shown that more serious issues, such as mental health or relationship problems (Elnitsky et al., 2017), occur several months to one year after reintegration (Doyle & Peterson, 2005). It is imperative for mental health workers and others to provide services to those transitioning to take a more proactive stance rather than reactive.

Health Benefits of Nature Interactions

The restorative and health benefits of nature interactions and experiences have been widely discussed in current and past literature (Kaplan, 1995; Kaplan & Kaplan 1989; Tillmann et al., 2018). As the globalization and industrialization that began over 200 years ago continues into the 21st century, shifting away from urban environments into wilderness and nature settings can increase the quality of life and provide numerous health and psychological benefits (Aldous, 2006). Nature and wilderness environments provide a space for some to escape the stress and structure of everyday life, participate in leisure and recreation activities, or seek personal growth and leadership opportunities. The foundation of OBH and Wilderness Therapy programs stands on the belief that extended time in a wilderness context provides a unique therapeutic approach that addresses the client's emotional, behavioral, and psychological issues (Fernee et al., 2017). Keniger et al. (2013) reviewed research from fifty-seven articles and studies exploring the

benefits of nature interactions and found that of the articles reviewed, there was a greater focus on the psychological, cognitive, and physiological benefits that participants experience.

Several studies focus on the psychological effects of intentional interactions and activities in nature, such as engaging with wildlife and gardening (Curtin, 2009; Van den Berg & Custers, 2011). Other studies have found that interactions with nature increase self-esteem, improve overall mood, reduce anger and frustration, reduce anxiety, and improve behavior (Keniger et al., 2013; Kuo & Sullivan, 2001; Maller, 2009; Pretty et al., 2005). A study by Maller (2009) found that hands-on interactions with nature improved the self-esteem of school children while encouraging a sense of empowerment. Participants of Wilderness Education Programs (WEP) reported increased self-esteem, improved communication, and a sense of personal accomplishment (Moore & Russell, 2002).

A substantial amount of research further shows the cognitive benefits of interactions with nature including, but not limited to, a reduction in mental fatigue, improved academic performance, improved productivity, and attention restoration (Fjeld et al., 1998; Fuller et al., 2007; Herzog et al., 1997; Moore et al., 2007). Fuller et al. (2007) found that urban green spaces provided users the space and ability for self-reflection. Hartig et al. (2007) found that individuals preferred a "natural setting" for a restorative experience compared to urban settings. Taylor et al. (2001) researched the cognitive benefits of time spent in nature in children diagnosed with attention deficit disorder (ADD). Parents and guardians of the children reported a higher level of focus post-activity. Research surrounding WT and other OBH-related programs points to positive psychological and cognitive benefits for the participants (Berman & Davis-Berman, 2008; Davis-Berman & Berman, 1989 Fernee et al., 2017). Significant evidence shows that direct interaction with nature can provide positive cognitive benefits.

Past research on the physiological benefits of time spent in nature has shown to reduce stress and blood pressure, aid in addiction recovery, decrease deaths associated with cardiovascular diseases, and improve restoration (Hansmann et al., 2007; Mitchell & Popham, 2008; Van Den Berg & Custers, 2011) Bennett et al. (1998) performed a study where participants actively in substance abuse treatment participated in a program that combined principles from adventure camping, therapeutic camping, and relapse prevention. Results uncovered that the participants showed improvement in the frequency of negative thoughts and alcohol cravings, adding to the body of research that outdoor adventure activities and outdoor therapeutic experiences aid in substance abuse treatment (Bennett et al., 1998). Individuals who live in more scenic environments report a sense of better overall health than those in urban areas (Seresinhe, 2015).

Health Benefits of Hiking and Backpacking

The research and literature on the psychological, cognitive, and physiological benefits of time spent in nature has brought forth a new subset of research focusing on specific outdoor activities. Outdoor leisure and recreation activities such as hiking and backpacking have emerged as powerful tools that promote the physical and mental well-being of those involved (Bratman et al., 2015; Grassini, 2022; Kelly et al., 2018; Mitten et al., 2018).

Hiking is a low-cost activity that has proven effective in helping treat issues such as depression and anxiety (Elmahdy et al., 2017; Hendrick et al., 2010). Hiking is also considered a low-impact sport that places minimal stress and strain on the body yet provides numerous health and cardiovascular benefits, such as aiding in lowering blood pressure (Lloyd-Jones et al., 2010).

Research has found that outdoor recreation activities such as hiking and camping positively impact the participants' mental health as well. Every year, thousands of hikers set out

on long-distance hikes across the U.S., searching for one benefit or another. These "thru-hikers" typically hike thousands of miles over the course of a few months. Hill et al. (2009) surveyed thru-hikers on the AT, and research found that self-fulfillment, self-reliance, an increase in the enjoyment of life, relationships, and connection-building were all aspects of hiking that the participants valued. A study of thru-hikers and non-thru-hikers by Yun & Peden (2018) uncovered that both groups value the mental and health benefits of hiking.

Outdoor recreational activities have also effectively addressed serious mental and physical health issues such as addiction and suicidal ideation (Bennett et al., 1998). A study by Harmon (2019) found that a hiking group for cancer patients and survivors provided non-traditional resources that encouraged coping skills and a healthy and active lifestyle. Participants in the hiking group found that this exercise encouraged the "normalization process" and aided in the acceptance of their current or past situations. Price et al. (2015) explored how the sport of fly fishing provided a therapeutic activity for a combat veteran suffering from severe PTSD. Mutz & Müller (2016) examined the benefits of two multi-day backpacking trips for youth participants and found an increase in life satisfaction, mindfulness, happiness, and a decrease in stress. Studies show that hiking for high-risk suicide patients can provide an effective method of reducing hopelessness, depression, and suicidal ideation and can lead to an increase in physical activity (Neunhäuserer et al., 2013; Sturm et al., 2012).

In the next section, I detail a course design that seeks to aid former FI during the transitional period by establishing a sense of community and providing resources to these individuals.

CHAPTER 3: COURSE DESIGN

Why a backpacking trip?

Backpacking is a significant aspect of wilderness therapy for students and field instructors, with programs strategically designed around using backpacking as a therapeutic method. I sought to use the same model and designed a multi-day expedition incorporating various community building and trauma-informed practices to aid instructors during this transition period.

A backpacking trip was intentionally chosen and designed to help instructors create a new relationship with nature and provide a safe experience with no adolescents or the stressors that typically occur while backpacking in WT programs. Traumatic and stressful events often leave lasting psychological subconscious effects on the brain and create new, negative memory associations (Van der Kolk, 2014). Trauma often causes individuals to become stagnant in their growth due to the lack of desire for new experiences (Van der Kolk, 2014). This transition program aims to encourage new memory associations with nature and backpacking by providing a safe space similar to that of a WT expedition but without the stressors of group management that typically arise when working with youth.

Why a GROUP backpacking trip?

Group therapy has been found to be an effective treatment modality for individuals experiencing various issues (Harrison & Morris, 1996; Shaffer et al., 1998). Research by DiNunno (2000) found that the personal nature of group therapy provides safe environments where relationships can be examined while simultaneously decreasing feelings of isolation. Group acceptance can provide individuals with the space to share painful memories and feelings and aid in developing trust (DiNunno, 2000). FI working in WT have the potential to experience

a form of collective trauma, the psychological reactions to a traumatic event or events that affect a large group of people (Hirschberger, 2018). A group setting allows the sharing ofbpast events and emotions with those with similar experiences.

Mental health issues can often be a complex subject to discuss among friends and coworkers, and the cultural stigma around mental health is still present in some communities (Bharadwaj et al., 2017). The purpose of this backpacking course is not to seek out the processing of trauma, however that does not mean it cannot occur. The sharing of resources between instructors is encouraged. Resources have a broad definition, but examples include helpful local mental health organizations, such as clinicians or programs, employment opportunities, sharing methods that have been helpful during the transitional period, and group personal communications after the trip.

Why Peer-led and not Clinician-led?

This trip was intentionally designed to be peer-led without the aid of a licensed clinician. A significant amount of money and time will be required to hire a licensed clinician. There is also a specific power and understanding that comes from surrounding oneself with those who have been through the same or similar experiences, as with combat veterans returning to civilian life (Ahern et al., 2015). Some bonds form between individuals who have lived through specific experiences, and by surrounding oneself with those people, a safe environment is created where everyone is aware of the information shared and can relate accordingly. The self-determination theory holds that human beings need three basic aspects to be happy and content: a sense of competency, a feeling of authenticity and autonomy, and a connection to others (Ryan & Deci, 2017). Junger (2016) stresses the importance of connection to others and how a sense of belonging can be a powerful emotion.

Aspects and methods of other peer-led organizations, such as The Circle Way, and Alcoholics Anonymous (AA), will be incorporated into the backpacking trip. The Circle Way (Baldwin & Linnea, 2016) and Alcoholics Anonymous (Alcoholics Anonymous) emphasize peer support in the healing process and encourage sharing life experiences at the participant's own pace. Alcoholics Anonymous meetings consist of a member designated the "speaker" who will help lead the meeting that day, using literature provided by A.A. that explores the steps needed to combat addiction (Alcoholics Anonymous). The Circle Way is an organization that provides resources and support for various clients and focuses on using a circle format as a method of collaborative dialogue (Baldwin & Linnea, 2016). Some beneficial elements incorporated into the course from of the Circle Way method include the design of the group circle where all participants face each other, the agreements and contracts made by the participants amongst themselves, and discussion is an integral part with a beginning, middle, and end (Baldwin & Linnea, 2016).

It would be irresponsible to not acknowledge that research has shown that the therapist-client relationship plays an integral role in predicting positive outcomes of psychotherapy (Horvath & Symonds, 1991). Further research argues that the client-patient relationship is the single most important factor for integrating positive therapeutic change and without a strong relationship there is little chance for success and growth (Macneil et al., 2009; Swift & Callahan, 2010). The intent of choosing a peer-led approach instead of the use of a licensed clinician is built on the foundation that the traumatic events that these instructors faced can be hard for an "outsider" to fully understand and there is power and healing in sharing similar experiences. The peer-led aspect is not meant to replace the knowledge and expertise of a licensed clinician but instead to provide participants with a space to share openly amongst friends and colleagues.

Individuals participating in cognitive behavioral therapy (CBT), or other forms of psychotherapy, before and after the backpacking course can create a more well-rounded experience while offering different perspectives. Participation in psychotherapy beforehand can prepare participants to share difficult stories, as well as find their own personal threshold of what is important to share and what is not.

Group Discussions

The group discussion aspect of the course was specifically designed to be informal with little structure. Discussion prompts will be given to the participants throughout the day, but the intention is that authentic connection and conversations happen organically without the need for a prompt. This program is not designed to "compare stories," and the facilitator should be mindful of knowing when to navigate conversations in a new direction. "War storying," as it was often called in the field, can be defined as the constant back and forth of storytelling without genuine discussion or reflection. While telling humorous or traumatic past events in a safe setting can occasionally lead to a cathartic release for an individual, the goal of the group discussion is human connection and understanding.

With the course being peer-led and not clinician led there is the potential for sensitive topics or inappropriate behavior to be present. It will be up to the leader of the trip and all who are present to hold themselves accountable for the topics that are discussed. Below are two potential scenarios that could arise and how I as the leader and participant would address them.

Scenario 1:

While sitting around a campfire on the first evening it is apparent that Participant A has begun to dominate the group conversation and share multiple stories and experiences from their time in the field. Participant A responds to the comments and stories of the other participants

with stories of their own instead of genuine feedback and understanding. Other participants have become hesitant to share due to Participant A's behavior. We want to remind everyone of the expectations the group set at the beginning of the trip and stress how this is a "group" trip, and everyone has the right to participate and the right to their own emotional and physical safety. Warstorying is a slippery slope that can quickly lead to loss of control and often provides no therapeutic value if reflection is not present. Broad overviews of past experiences can provide a much safer environment while not diminishing what the participants have gone through.

Scenario 2:

In response to a prompt given by the leader of the trip, Participant B begins to describe an experience of dealing with a student struggling with self-harm. Participant B provides in-depth details about the experience to all present. This is where the group or the leader will remind everyone of the expectations we created at the beginning of the trip. We are here to acknowledge these traumatic events and learn and grow from them. There is always the possibility of re-traumatization when going into detail of these events and that is what we want to avoid. If necessary, we can encourage Participant B to speak with a licensed clinician to discuss in greater detail the traumatic events they experienced. We can address the experience of trauma and the fact that most, if not all present, encountered one or multiple traumatic experiences, but the goal is to "shift the narrative" and learn from these experiences instead of dwelling on them.

Discussion Prompts

Basic discussions prompts will be provided for various reasons. It is likely that the individuals participating in this course may not know each other beforehand, therefore some of these prompts are included as "conversation staters" or introductions. Some individuals might be hesitant to share or not know where to start in regard to sharing. These prompts are scaffolded in

a way that guides individuals to begin discussing lighter topics before encouraging them to share more intense moments if they desire. A selection of the discussion prompts is listed below:

- Basic Introductions – Name, name of wilderness program employed at and how long, position while at the program, and any other relevant information the participant would like to provide.
- Why did you want to participate in this transition program?
- What are you hoping to get out of this transition program?
- How can we, as a group, best support you?
- What attracted you to the field of Wilderness Therapy?
- What is the most prevalent emotion that comes to mind when you reflect on your time in the field?
- Describe the best day you had in the field.
- Describe the worst day you had in the field.
- What are ways you practiced self-care in and out of the field?
- What aspect of WT caused you the most distress?
- What aspect of WT brought you the most joy?
- What we were like, what happened, and what we are like now (Alcoholics Anonymous)
- Would you say your time working in WT was generally a positive or negative experience?
- What was lacking in your role as a FI that you needed?
- Did you feel cared for? Why or why not?
- Was working in the field of WT how you envisioned it?
- Was working in the field of WT worth it to you?

- If given the opportunity, would you work in the field of WT again?
- What emotions were the most present when you left the field of WT?
- What is your relationship like to the outdoors post-wilderness therapy?
- How might your unique personality affect, positively and negatively, your experience in with WT?

Participant Selection

The participants will be selected via the snowball method (Creswell & Creswell, 2017). All participants will include former wilderness therapy field instructors who worked in an AEE-OBH or NATSAP-accredited program for a minimum of six months. There will be a maximum of six participants. The number six was deliberately chosen as it remains a small and intimate number to encourage sharing. Any number larger than six would slow down the pace of the hike while also providing too many voices in intimate settings.

Backpacking Location and Setting

The backpacking course took place over two days with a maximum hiking distance of eight miles per day. The course took place in the Blue Ridge Mountains of Western North Carolina. Various potential routes were chosen such as the Art Loeb Trail in Pisgah National Forest, and a section of the Mountain-to-Seas Trail, a section of the Appalachian Trail. Multiple options will limit the amount of foot traffic on the trail, and the facilitator can add or increase the distance if needed. The first day consisted of more activities designed to get the participants comfortable with each other. The facilitator and the group established group expectations and agreements before the course begins.

Itinerary

The itinerary of a typical day is listed below:

- 6:30 am – Wake-up call
- 7:00 – Breakfast
- 7:30 – Tear down camp
- 8:00 – Intention circle – Each participant will set one or two intentions for the day (a goal they would like to accomplish or something they would like to try/learn)
- 8:15 – Personal reflection time
- 9:00 – Hike
- 12 pm – Lunch
- 12:30 – Group check-in. The facilitator will check in with the group and ask guiding questions.
    - How is the hike going so far?
    - Does anyone have anything to share?
    - Has anyone experienced any difficult situations?
- 1:00 – Hike
- 5:00 – Arrive and set up camp.
- 5:30 – Dinner
- 7:00 – Campfire
    - The facilitator will start the conversation with guiding or inquiring questions. However, the hope is for the facilitator to be hands-off for most of the evening and let the participants guide the conversation with what they want to share. The facilitator will step in if the conversation needs to be redirected in a different trajectory.
- Personal reflection time

- Lights Out

One of the most important aspects of the backpacking course will be the "Expectations Circle" that will take place at the trailhead after introductions with a significant amount of time being allotted for the circle. This is where the group will discuss detailed methods of how they will ensure the emotional, physical, and psychological safety of all participating. This includes certain topics that elicit strong emotions for some and acknowledging that each experience/event affects others differently and what might be minimal for someone can be traumatic for others. The topic of "war storying" will be discussed and how the group plans to share meaningful stories to learn from them instead of just sharing traumatic events with no reflection. The goal of this course is to help shift the narrative that these former wilderness therapy instructors have faced, and by sharing stories back-to-back with no time to discuss and reflect then the narrative stays the same. The group can also plan to allot more or less time that is strictly designated to leisure activities such as swimming or games to not emotionally overload the participants. Going into detail of traumatic events can lead to possible re-traumatization, therefore the group needs to set a boundary on how much detail one should go into when discussing a past event. The group should also discuss what should be done when one or more participants dominate the conversation or starts treating the other participants as if they are a licensed clinician.

Risk Management Plan

No outdoor activity is completely void of risk regardless of the skill level of the participants, the difficulty of the terrain, or the time spent outside. A risk management plan was created and shared with the participants to be examined and reviewed. All wilderness therapy field instructors are required to obtain either a Wilderness First Aid (WFA) or Wilderness First Responder (WFR) certification before their employment at a WT program. While it can be

assumed that the certifications of the participants will be valid at the time of the course, the leader of the course will maintain an active certification and carry a properly packed First Aid Kit.

Due to the nature of the course, there is a possibility that participants could be re-traumatized by the discussions taking place. The leader of the course will closely monitor the group conversations being held and redirect the discussion if necessary. Participants will have the option to leave the course early for any reason and an exit plan was created unique to the trail and course location.

CHAPTER 4: METHODOLOGY AND METHODS

The purpose of this study was to explore my experiences and self-perceptions of a backpacking course specifically designed to aid former wilderness therapy field instructors as they transition out of the field of wilderness therapy. In the following section, I expand upon the methodology and methods used throughout the study. I will begin by explaining the methodology of autoethnography, as well as my role as both researcher and participant, and explore my personal biography and how my identities will shape this study. I will then detail my data collection methods, including journaling and autophotography, followed by the procedures I will use to analyze my data. I will end by exploring the issue of trustworthiness and credibility and address ethical considerations for this study.

METHODOLOGY

Autoethnography

Intended Audience

At the inception of this study, one question continued to sit at the forefront of my mind: *Who am I doing this for?* Is this study for OBH programs? Is it for current field instructors? Is it for former field instructors? Both? Or is it for me?

As a field instructor, my time did not belong to me when I was on shift. It belonged to the students and other staff under my care. For almost three years, I put everyone else above me. I understood my job, and I understood the sacrifices that I would have to make. I missed meals. I lost out on sleep. My body was abused, inside and out. I was on shift for the death of my grandfather. I missed birthdays, weddings, and holidays. Thus, I have a strong desire to aid current and former field instructors in any way I can. I have designed and created this study for them. However, I find my life continually affected by my time working in WT, and this study is an opportunity to look back on past events with new eyes in an attempt at clarity and peace.

I have guided adolescents and adults on numerous hikes, climbs, and mountaineering experiences. One common aspect of these adventures was that I always led from the front. I was always the first on the trail, the first one to climb the route or test the snowpack. Since this is a pilot program involving personal reflection on past traumatic experiences, it would be irresponsible of me to ask something so personal of someone without asking it of myself first. That is why I have chosen the route of autoethnography. Marshall et al. (2022) defines autoethnography as a reflexive approach that, through personal narratives and stories, seeks to understand the human condition through one's analysis of personal experiences.

The 'what' of autoethnography

After I found the answer to the question "*Who am I doing this for?",* the route of autoethnography will only further support and strengthen my research questions. The researcher uses aspects of both autobiography and ethnography to do and write an autoethnography (Ellis et al., 2011). Autoethnographic research was born out of the desire to step away from the idea that "Truths" and "facts" were universally connected to certain paradigms, and instead, the use of narrative and stories introduced new ways of thinking (Denshire, 2014; Ellis et al., 2011). Specific concerns regarding qualitative research aided in the emergence of autoethnographic research: a concern about the ethics of research practices and representation and the increased importance of participants' social identities (Adams et al., 2015; Sparkes & Smith, 2014). The world is not black and white, and researchers need to consider the complexities of human emotion and actions and whether the researcher can properly speak the "truth" for those involved (Humberstone & Prince, 2019). Autoethnographies are often conducted retrospectively, whereby the researcher actively reflects on past events.

Storytelling, personal experiences, and emotions were often (and for some researchers, still are) considered a roadblock to objective research (Adams et al., 2015; Edwards, 2021). On the contrary, all research methods, whether qualitative or quantitative, are entwined with human emotions (Edwards, 2021). Storytelling and emotions are vital parts of the human experience. They help give experiences and life meaning. To do this study in any other way besides autoethnography would be doing a disservice to myself and the stories I tell. Autoethnography is the perfect methodology for this study because it centers on stories, human emotions, and individual reflexivity.

Autoethnographic studies and leisure activities, when combined, create a strong and unique fusion. Anderson & Austin (2012) explored how autoethnography can capture unique insights into leisure activities. An autoethnographic study by Beedie (2003) examined the first-hand experiences of mountain guides, while Jonas et al. (2003) explored the interactions of individuals while whitewater rafting. Buckley (2012) conducted a study of her guiding experiences in a foreign country through an autoethnographic approach. Price et al. (2015) used autoethnography to narrate how the sport of fly fishing aided a combat veteran in coping with PTSD.

Placing oneself at the forefront of research, as autoethnography does, is not a new concept. Researchers, scientists, and countless others have utilized forms of self-analysis that have led to universally accepted treatment methods, with several researchers using themselves as subjects in their experiments. After creating the first Polio vaccines, Jonas Salk tested the vaccine on himself first to test its safety and efficacy (Jacobs, 2015). The Salk vaccine soon became one of the world's first successful polio vaccines. German Physician Werner Forssmann performed the first human cardiac catheterization on himself, laying the groundwork for modern cardiac catheterization, a common tool in cardiology (Forssmann-Falck, 1997). Swiss chemist Albert Hoffmann synthesized Lysergic Acid Diethylamide, commonly called LSD, and through self-experimentation, studied its psychedelic effects leading to future use in the therapeutic treatment of addiction, anxiety, depression, PTSD, and end-of-life care (Fuentes et al., 2020).

This study will use the Layered Accounts of autoethnography as described by Ellis et al (2011). This method focuses on the authors own experiences, alongside data, abstract analysis, and relevant literature (Ellis et al., 2011). Data collection and analysis often proceed simultaneously using reflexivity, multiple voices, and introspection in invite readers into the

experience. This method perceives identity as an "emergent process", meaning I am learning just as much about my new self as the readers are (Ellis et al., 2011).

The 'how' of autoethnography

At the heart of autoethnographic research are stories. These stories are about the self told through our own personal, cultural lens (Adams et al., 2015; Hopkins, 2022; Price et al., 2015). In autoethnography, the author's "actions, feelings, and emotions are part of the research process" (Humberstone & Prince, 2019, p. 112). When the researcher draws upon these personal stories and experiences, it provides the stage for critical reflection on social and cultural norms and issues (Humberstone & Prince, 2019). In autoethnographic research, current circumstances are informed by past and present experiences, and uncovering how those experiences shape our future and current selves is critical to the research.

As I began my autoethnographic process I followed the format outline by Chang (2016) in her book and divided the process into seven unique steps. The first two steps took place before the backpacking course. The third step took place non-linearly throughout the entire research process. The fourth step was the backpacking course where the data was generated. The last three steps occurred after the backpacking course.

Chang's Suggested Steps (2016)	**Data Generation Methods**	**Implementation of Steps**
Conceptual Preparation	Step 1: Examine Past Journals	I reviewed the journals I kept as a FI to identify significant or memorable moments.
Personal Memory Generation	Step 2: Write Personal Narratives	Memories were chosen that significantly impacted the trajectory of my life, or "epiphanies" as Bochner & Ellis (1992) call them. Five Personal narratives will be handwritten and

		generated three weeks before the backpacking course.
Self-Observation and Reflection	Step 3: Attend CBT Sessions	I regularly attended CBT sessions throughout the entire research process. CBT has been found to be an effective method when examining and processing past traumas. This will also aid in combatting the "navel-gazing" that is often associated with autoethnographic research.
Generate External Data	Step 4: Attend the backpacking course and generate journal/photograph data.	Journal entries and photographs were generated throughout the course.
Manage/Organize the Data	Step 5: Organize the Data	Personal narratives and journals were transcribed into a digital format and then paired with conversations, as well as journal entries and photos from the backpacking trip.
Analyze the Data	Step 6: Analyze the Data	See Data Analysis section.
Write the Autoethnography	Step 7: Write Autoethnographic Narratives	The four data generation method were combined to create chapters of my autoethnographic story.

Critiques of Autoethnography & How I Will Address Them

The methodology of autoethnography does not come without its critics. The researcher places themselves at the heart of the research process with an entire focus on themselves instead of other participants. This methodology can often come off as "selfish" and "narcissistic" and, as Anderson (2006) calls it, "self-absorption". Atkinson (2006) argues that autoethnography values personal commitment rather than scholarly purpose and disciplinary contributions. Without the proper guidance, researchers can entangle themselves in the ethics of autoethnography, and researchers often find themselves "fixed" on certain perspectives (Lee, 2018). As the researcher,

the generated data and narratives will be entirely from my perspective and memory. These stories often involve other individuals with no say in their representation (Tolich, 2010).

As I navigate my storytelling, I am constantly aware of the implications of using autoethnography as research. All the names of individuals in my narratives will be omitted or changed to protect their identity and representation. I will use the pronouns "they/them" to protect the self-identified gender of these individuals, whether they identify as female, male, non-binary, transgender, or other genders not listed. In response to autoethnography described as "selfish," I do not fully agree with that belief. We, as researchers, require the insight of others to help us understand ourselves, and that is especially prevalent in autoethnography. Through the sharing and processing of stories, I open myself up to the feedback and advice of the audience, and I welcome it. Cairo (2021) explores how storytelling is "a means to learn your place in the family and affirm your existence in the world as a whole" (p.21). The purpose of this study is the examination of my own past experiences. These experiences are deeply personal and are often traumatic for me to discuss openly. There are countless other former field instructors who are uncomfortable sharing or do not have the platform to share their stories. I want to counter that it would be selfish not to share my stories. I seek to engage in an open conversation in my analysis process to intentionally disrupt the navel-gazing that researchers believe coincides with autoethnography.

Personal Biography and Reflexivity

As a cis-gendered white male who worked in the wilderness therapy field, I must be aware of how my background uniquely affects my research. All the pieces that make the puzzle that is me affect how I view the world and how I interpret the data collected. Having worked in wilderness therapy for as long as I did, I have found it hard to describe my experiences to those

who have never worked in these programs. Some slight nuances make sense to some and are confusing to others.

Even though I worked in the mental health field, I consistently fell into the hegemonic norms of male suppression of mental health issues (Lynch et al., 2018). I encouraged the children I worked with to open up and confront the issues they face while simultaneously avoiding my own issues. I hid behind the belief that I was older and had it under control and that I should focus on helping these young people in front of me instead.

Although these experiences have shaped me into who I am today, I must know how they could shape and influence this study as both participant and researcher. To properly examine my reflexivity, I turn to the reflexive strategies introduced by Pillow (2003). These strategies include reflexivity as recognition of self, recognition of others, truth, and transcendence. Reflexivity typically involves introspection and requires the researcher to fully understand the participants' experiences (Eaker et al., 2018). Autoethnography requires much more introspection than other methodologies, as I am the only participant. This study will require me to dive deep into personal issues and embrace a form of radical vulnerability; therefore, my justification for this research must be strong. Reflexivity as transcendence allows for authentic self-appraisal and accurate portrayal (Eaker et al., 2018). As both the researcher and participant, I am uniquely positioned not to have to worry about the misrepresentation of the participants or misidentifying their thoughts because they are my own.

The most direct method I will be using to combat the critique of "navel-gazing" that is often present in autoethnographic research will be my participation in Cognitive Behavioral Therapy (CBT) throughout the research process. The use of CBT allows me space for reflection and processing as well as practical advice and support to aid me in this process. While

autoethnographic research is deliberately focused on the individual researcher and no one else, my participation in CBT allows for critical self-reflection to combat the navel-gazing present.

METHODS

Autoethnographic research excels at using personal narratives and stories to convey participants' analysis of past or current experiences. Through autoethnography, I am not restricted to using any one particular method. I will be using three data generation techniques for this study:

1. Personal Narratives detailing an experience or moment from my time working in WT will be collected before the start of the backpacking course.
2. Photographs collected using autophotography while on the backpacking course.
3. Daily journal entries gathered that align with the photographs taken.

Personal Narratives

Chase (2011) tells us that a narrative approach is often selected to retell stories to a much broader audience in an attempt to bring about social change. The writing down of memories instead of just events aids in the elicitation of stories (Cairo, 2021; Crawford et al., 1992; Lea Gaydos, 2005). We often associate memories with a specific conflict or injustice we faced. An internal or external disagreement arises between our interpretation of the event and the views of the social world (Crawford et al., 1992). Personal narrative, at its essence, is a form of storytelling that helps us shape how we have experienced the world and, in turn, helps others see the world through a different lens. Cairo (2021) explains that in order to honor the stories of others, we must first be comfortable and confident in our own stories.

The first step in this process was writing down personal narratives from my past experiences in the field with the intention of the trip providing me with new insight into these

specific moments. I wrote these narratives three weeks before the backpacking course. One narrative was written each day, and I allowed myself a maximum of two hours to write the narrative to support myself emotionally while re-examining these moments. As these narratives are the most personal and time-consuming, writing them while backpacking would take away from the experience of being in the moment.

I wrote about moments and memories that significantly impacted my time as a FI and beyond or moments post-wilderness therapy where I noticed signs of mental struggles. Using personal narrative allows me time to write my stories without the pressure typically present in interviews or other methods within a set amount of time. This method allows me to tell the stories I choose instead of conforming to requirements set by other researchers.

Autophotography

Visual methodologies such as photography, video, art, and other forms bring new insights into the participants' lives (Barbour, 2014). Autophotography, and other photography methods, allow participants to take photos and choose images that directly represent themselves (Noland, 2006). This method allows the researcher to see the world through the eyes of the participant. A critique of photo collection as a method is the possibility that the researcher misinterprets the meaning behind the photograph. The photographer might have taken a picture of a tree to remember when they climbed trees as a child, but a researcher might see the same photo and interpret it as a universal love of the outdoors. There can often be a disconnect between the researcher and the participant. However, there was no disconnect in this study because I am both the researcher and participant. I know the meaning behind my photos and interpreted them correctly.

Since the participants themselves take the photographs, this is a particularly effective method when researching traditionally marginalized groups, as it does not rely on culturally biased instruments such as specific survey questions (Noland, 2006). This method is also beneficial when there is a language barrier between the researcher and the participant. There is no reliance on written language; however, as mentioned above, there is the possibility of misinterpretation. Visual media captures details and meaning often overlooked in verbal and written methods (Glaw et al., 2017). Noland (2006) shares how autophotography allows participants to think critically about who they are, where they come from, and the experiences that shaped them and express these thoughts through images.

While on the backpacking course, I photographed moments, locations, or items that elicited a strong emotion from me. I took a photograph of anything that caused me discomfort, fear, sadness, anger, anxiety, or happiness or reminded me of moments from my time working in wilderness therapy. There was no set limit of pictures I took throughout the day.

The goal of autophotography is to provide examples of random moments or items that invoke an emotional response within me. On a personal level, it will help me document the parts of everyday life that bring up negative or positive memory associations with my time working in WT.

Journals

Journaling and mental health are often intertwined with each other. Proper journaling can be a powerful method of healing and reflection. Through journals, one can reflect on past and present experiences and understand how they have helped shape their perspectives. Dimtroff et al. (2016) describes how journaling develops insight, compassion for oneself and promotes body awareness. Research has shown that journaling has a wide variety of benefits, including the

expression of emotions, increased self-awareness, can aid in the analysis of past life experiences, and keeping relevant the joy of discovery (Dimitroff et al., 2017; Kuo et al., 2011; Michael Brady & Sky, 2003). Hayman et al. (2012) describe journaling as a tool to record experiences and the emotions present. Journaling allows the writer to express thoughts, feelings, and beliefs without judgment or criticism, and is one of the purest forms of self-expression.

The final step in the data generation process was the use of daily journals throughout the backpacking course. While on the course, I brought a journal and voice recorder to write or record my thoughts and feelings at the beginning and end of the day. There were several themes, moments, and prompts provided by myself through my CBT sessions that I chose to journal about. However, most of the journaling was random and concerned whatever I was feeling in that moment. I limited myself to ninety minutes of journaling in the mornings and evenings.

As mentioned above, my time in wilderness therapy consisted of suppressing many emotions to be an effective instructor. The goal of journaling and photographing these high-emotional moments is the desire to embrace instead of avoiding these feelings. Through the journal entries, I reflected on my past experiences and the pieces that still affect me today to assist me in accepting these new parts of me.

Data Analysis

All three data generation techniques were combined to create chapters of my story. Each chapter is unique with some consisting of a narrative paired with a journal entry and photographs, while some consist of a narrative and a conversation between my professor or my therapist. In autoethnographic research, the author first "gazes through the ethnographic lens, focusing outward on social and cultural aspects of their experience, then they turn inward,

exposing a vulnerable self that is moved by, though, refract, and resist cultural interpretations (Ellis & Bochner, 2000, p. 739).

I asked myself, "How can I possibly analyze and categorize these intensely personal stories?." Jackson and Mazzei (2017) describe qualitative research as "rhizomatic," with all the pieces crashing into each other and becoming entangled, like the roots of a tree. We as researchers must humanize the act of gathering data and interpreting and writing research (Gallant & Yuen, 2021; Glover, 2013). The writing process and products are often intertwined and cannot be separated from the producer (Richardson, 2003). I cannot divide this data, these parts of me, into sections for they are all intertwined parts, building and supporting each other. What I can do is embrace the chaos and messiness that is Layered Accounts autoethnography and let my stories speak for themselves (Richardson & St. Pierre, 2008).

The data analysis process was informed by a combination of the research questions guiding this study:

1. What are my experiences on a self-designed, 3-day backpacking course for former wilderness therapy instructors?
2. How did the course impact my physical, emotional, and psychological transition from out of the wilderness therapy field into everyday life?

Along with the six guiding principles of trauma-informed care (SAMSHA, 2014):

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration and Mutuality
5. Empowerment, Voice and Choice

6. Cultural, Historical, and Gender Issues

Using the research questions and the six guiding principles stated above, I was directed and informed by the following questions while analyzing the personal narratives, journal entries, and photographs:

1. Why did this narrative/journal/photograph elicit such a strong emotion from me?
2. What emotions did this narrative/journal/photograph elicit from me while on the backpacking course?
3. Did the backpacking course provide the appropriate time, place, and space to reflect on past experiences?

Personal narratives were written before the backpacking trip as they are the most personal and time-consuming. Photographs were saved in a folder, and physical copies will be printed for redundancy. Any photos of individuals on the trip who did not sign a photo consent form were immediately deleted to protect the privacy of those involved. All individuals on the trip will reconfirm they signed the consent forms and will be given one final opportunity to reconsider if they desire. The journal entries were transferred to a digital copy for redundancy, and the physical copies placed in a secure location.

Population

Autoethnographic research requires the participation of a single individual, the researcher. While other individuals will participate in the back-packing course I designed, no data will be collected from those individuals. My role will be one of both researcher and participant. For other methodologies, the role of the researcher and participant are purposely

divided to protect the credibility of the data. However, for this study, I cannot divide these roles, for they are the same.

Trustworthiness and Credibility

Lived experiences are multi-faceted, complex and often difficult to understand to an outside reader (Schwandt, 2014). Therefore, multiple steps will be taken to establish the credibility and trustworthiness of the research study. As an autoethnography, no data will be generated from participants other than myself. Ragan (2000) argues that since autoethnography is a non-traditional form of research and has no set system, it can be difficult to assess credibility. Instead, the author lists three forms of evaluation that can be utilized: is the narrative accurately written, is the issues addressed important, and will the audience learn anything? Parry and Johnson (2007) provide a list of criteria for the researcher to follow when engaging in creative analytical practice (CAP) including: (1) the important contribution the text will provide, (2) the aesthetic merit of the text, (3) reflexivity and the role of the researcher, (4) the emotional and intellectual impact of the text, (5) the text needs to embody the idea of lived experiences and be believable. As both the author and the participant, I regularly reflected on my own biases, reflexivity, and the desired goal of the study to ensure my methodology and data generation techniques continually aligned with the goal I established. I cannot separate the "self" from the research because they are the same. However, I can continuously examine the goals of my study, the desired impact I wish to have, and will this study contribute to previously published literature on the subject (Le Roux, 2017).

Patti Lather (1993) emphasizes critical self-reflection and how one should continuously look inward to see the whole truth. I am wholly aware of the complexities of this study as both the participant and the researcher. Instead of trying to separate the two parts, I embrace them.

Ethical Considerations

Autoethnography requires no IRB approval because the researcher is gathering and analyzing data on themselves. However, autoethnography still has ethical issues that must be examined and addressed. Tolich (2010) outlines three issues for the researcher to examine: consent, consultation, and vulnerability. While the data collected will only be from me, other participants will still be on the backpacking trip. The appropriate information and consent forms will be sent to participants to review and sign, at minimum, one month before the start of the trip. Participants will visually inspect physical copies a second time on the day of the trip. Photo consent will also be confirmed when applicable.

As a storytelling method, the authors of autoethnographic research must be aware of their study's potential impact on those involved. Due in part to the fact that most of my past experiences involve children under eighteen, all names, genders, and ages have been omitted to protect those mentioned. Medford (2006) suggests that the author would not publish any literature they would not show to those involved.

The most significant ethical consideration in autoethnography is one of vulnerability. The author willingly exposes themselves and past traumatic experiences to the judgment and critique of the public (Lapadat, 2017). Authoethnographers embrace vulnerability while remaining ignorant of how their literature could be received. Tolich (2010) treats autoethnography as a tattoo forever inked on the author's skin. This is where I, as the researcher, must continually reflect on the purpose of my study and be confident in the path I have set upon.

Past research reveals how autoethnographic research often focuses on the self and can come off as selfish and narcissistic (Anderson, 2006; Atkinson, 2006; Delmont, 2007). I seek to

share my stories not out of a sense of self-indulgence but in an attempt to assist the former field instructors who were left to fend for themselves as I was.

Manuscript Thesis Option

Per the Western Carolina University Experiential and Outdoor Education Handbook, I have chosen to complete the manuscript thesis format option. This option requires Chapters One, Two, Three, and Four plus a full-length journal manuscript formatted to the requirements of a specific journal. The following chapter contains my complete manuscript, which I have chosen to submit for consideration for publication in the Leisure Sciences Journal special issue on The Interconnections of Trauma, Healing, Health, and Leisure. This journal requires authors to submit a manuscript of approximately 9000 words, including references, tables, and figures, written in APA format.

CHAPTER 5: FULL-LENGTH JOURNAL MANUSCRIPT

The parts I've lost: An autoethnographic study of a transition program designed to aid former wilderness therapy field instructors

Connor Mathias[1], Dr. Callie Schultz[1], David Wynn[1], Dr. Russ Curtis[1], Dr. Jeremy Schultz[1]
Western Carolina University[1]

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Word count with references: 9863

Abstract
Wilderness therapy (WT) programs remain a popular treatment modality for youth facing various emotional and behavioral issues (Berman & Davis-Berman, 2008). Little research exists on the long-term effects this work imparts on the field instructors (FI) working in these programs. As instructors transition out of WT, they can potentially face various emotional and physical challenges (Marchand et al., 2009). I designed and implemented a backpacking course for current and former FI. Using autoethnography coupled with journaling, photography, and cognitive behavior therapy (CBT), I examined my own experiences of the course. Narrative results explore the power of the group setting with those who have shared experiences and the difficulty of finding enjoyment in outdoor settings after leaving the WT field. The use of CBT allowed for reflexivity and clarity throughout the research process. An industry-wide landscape analysis of the well-being of former FI is recommended to better illuminate these issues.

Keywords: Wilderness therapy, field instructor, autoethnography, transition program

The parts I've lost: An autoethnographic study of a transition program designed to aid former wilderness therapy field instructors

I'm sitting on the ground, preparing to dispense a nighttime medication to a student in front of me. I'm hunched over a large Tupperware container, trying to cut a tiny, white pill in half. I'm leaning over, and out of my peripheral, I see a hand and the bottle move. I look up to see the student swallowing every pill in a desperate attempt to commit suicide.

I shove my fingers down the student's throat to expel the pills, being covered with water and vomit in the process. I radio a nearby group to send a staff to assist. I create a grid system on the ground and I walk back and forth, looking for any pills. I take off my outer layers and check every crevice and comb my hair in case one somehow landed there. There were none because the student swallowed every single pill. We sit together as we wait for help to arrive. Through tears, they ask me, "Am I going to be ok?". "I don't know…" is all I manage to say—a brutally honest answer to a scared child who needs reassurance when I had none. We sit in silence. One of us scared, and the other trying not to be. Help arrives, and the student is taken to the hospital, where they receive medical help.

It is not until a year later; the day finally catches up to me. It is early in the morning. I go to dump a Claritin into my hand, and a pill slips through my fingers and falls onto the floor. I bend down to pick up this tiny white pill and suddenly feel a massive surge of anger - how easy it is for me to find this pill, but not the others. In that moment, the full realization finally hits me - how close I was to causing the death of a child. I think about that child and those pills every day and how one decision entangled our lives in ways both of us will never fully understand.

I share my stories to illuminate a critically overlooked component of Outdoor Behavioral Healthcare (OBH) and Wilderness Therapy (WT) programs: the lack of support for field instructors (FI) transitioning out of the field. This study will utilize Cramer and Wanner's definition of wilderness therapy as the combination of "therapeutic elements with outdoor activities in a natural setting to help treat individuals with a range of needs, including behavioral, emotional, psychological, and substance use issues" (Cramer & Wanner, 2022, p.1). A substantial amount of literature has explored WT programs and the positive and negative impacts they generate for the *participants* (Berman & Davis-Berman. 2008; Marchand, 2008). However. a current gap exists in the examination of the long-term effects this type of work has on the instructors who work for these programs. Due to the volatile and unpredictable nature of WT programs, these instructors are uniquely positioned to encounter various traumatic experiences and other challenging situations (Bunce, 1998; Marchand, 2010; Marchand & Russell, 2013). FI are susceptible to developing various mental health issues, including post-traumatic stress disorder (PTSD), depression, anxiety, and substance abuse disorders (Marchand & Russell, 2013; Wilson, 2009). I was employed as a FI for almost three years. The months following my departure were a critical period in which I would have benefited from a transitional support program.

Purpose Statement and Research Questions

With this need and gap in mind, I designed and implemented a backpacking course for former WT field instructors as they transition out of the field into their next professions. The aim of this course was to build a sense of community for former WT field instructors and create a space to share resources to aid in this transition time. I studied my own experiences on the course, allowing my co-participants to experience the course without the added layer of "being watched" through a researcher's eye. I employed an autoethnographic approach grounded in

Contemporary Trauma Theory (CTT) which emphasizes a holistic approach and stresses the importance of proper trauma-informed practices (TIP), patience, and respect when addressing past traumatic events.

Specifically, the purpose of this study was to explore my experiences on a backpacking course specifically designed to aid former wilderness therapy field instructors as they transition out of the field of wilderness therapy. The research questions guiding my study were:

1. What are my experiences on a self-designed, multi-day backpacking course for former wilderness therapy instructors?
2. How did the course impact my physical, emotional, and psychological transition out of the wilderness therapy field into everyday life?

Literature Review

I begin this literature review by defining the foundational theory for this study: contemporary trauma theory. I provide a brief overview of WT programs, the roles and characteristics of the FI and potential psychological issues FI can experience. The review will conclude with an examination of transition programs and the benefits of nature interactions and outdoor leisure activities in the transition process.

Contemporary Trauma Theory

The American Psychological Association (APA) defines trauma as an "emotional response to a terrible event like an accident, rape, or natural disaster" and centers the term around three characteristics: (1) an identifiable event or series of events, (2) the individual experiences these events as physically or emotionally harmful, and (3) has lasting effects on the individuals basic functioning (American Psychological Association; Goodman, 2017; Herman, 1992; Van der Kolk, 2014). There are numerous ways a therapist or counselor may work with individuals who have experienced or witnessed traumatic events.

The development and creation of Contemporary Trauma Theory (CTT) brings forth a paradigm shift in how we interact and treat survivors of trauma (Goodman, 2017). In CTT, the individual is seen as someone needing healing and help instead of someone who is psychologically injured or weak (Bloom & Farragher, 2011; Van der Kolk, 2014). Herman (1992) conducted research that laid the groundwork for this new approach. CTT provides the theoretical framework for examining and understanding the influence trauma has on an individual's ability to function and is centered around five basic tenets: dissociation, attachment, reenactment, long-term effects on later adulthood, and impairment in emotional capacities (Goodman, 2017; Herman 1992). At the heart of CTT is the belief that proper trauma-informed care (TIC) and trauma-focused strategies are beneficial and necessary treatment methods when working with an individual who has suffered severe trauma (Bloom & Farragher, 2011).

When traditional therapeutic approaches fail to assist youth suffering from various behavioral and psychological issues, including those who have experienced traumatic events, parents or guardians may choose to send their child to a WT program. What are the impacts, positive and negative, on the individuals who participate, often unwillingly, in these types of programs?

Benefits and Disadvantages of OBH Programs for Participants

A synthesis of research on WT programs conducted by Fernee et al. (2017) found that these programs increase self-confidence in the participants while providing time alone and a place to heal and reflect (Russell, 2000). A recent study by Cramer and Wanner (2022) synthesized past research on program outcomes for participants and discovered common themes of an increase in self-esteem, academic performance, family development, physical health, and an increase in positive behavior.

While research has shown the vast number of positive effects WT programs provide, these institutions are not immune to controversy. The report by Kutz & O'Connell (2007) through the Government Accountability Office (GAO) examined and reviewed ten civil cases where a youth participant died while enrolled in a private WT or OBH program. The authors uncovered several issues that led to participant deaths, including ineffective management, negligence, and a lack of credentials and training for management and FI regarding medical training (Kutz & O'Connell, 2007). A lack of official state regulation aided in reports of neglect and abuse (Behar et al., 2007). Within recent years a movement has emerged that seeks to expose the "institutional child abuse" prevalent in the troubled-teen industry (TTI) called Breaking Code Silence (Breaking Code Silence, n.d.).

The connection between FI and the participants in WT programs has been shown to play a major role in the success of these programs (Bunce, 1998). Therefore, it is critical to examine the numerous roles placed on FI.

Role of Field Instructors within OBH Programs

To understand why a transitional program is needed for FI leaving the field (or at the conclusion of a program), it is crucial to explore the daily roles, requirements, and expectations of FI. For the sake of this study, the term "field instructor" refers to an individual employed full-time, either seasonally or year-round, to lead expedition-based outdoor programming for youth or adults facing various mental and behavioral issues. In recent years, FI working in WT programs fit a specific demographic: "young, educated, single, and Caucasian" (Kirby, 2006, p.79). These individuals are responsible for the safety and overall care of the clients, as well as the typical day-to-day living arrangements, such as cooking, laundry, and hygiene (Russell et al., 1999).

FI can be responsible for the administration of medications that clients are required to take while also being trained in the use of physical restraints if the safety of the clients or themselves is at risk (Kutz & O'Connell, 2007). FI live with the participants for weeks or months while constantly maintaining and monitoring the safety of everyone involved. There is very little "downtime" during expeditions for instructors.

Physical and Mental Issues Field Instructors Experience

Instructors working in WT programs are uniquely positioned to encounter physical and psychological disorders due in part to the nature of the profession. These issues include, but are not limited to, post-traumatic stress disorder, transference and countertransference, secondary traumatic stress (STS), and vicarious traumatization (VT). (Kirby, 2006; Kirk & O'Connell, 2012; Marchand, 2008). I discuss each one of these in detail below.

Post-Traumatic Stress Disorder (PTSD)

According to the National Center for PTSD (2018), thirteen million Americans were diagnosed with PTSD in 2020. Combat veterans are often the largest demographic associated with PTSD; however, this medical issue can affect anyone at any age (National Center for PTSD). The American Psychiatric Association defines PTSD as "a psychiatric disorder that may occur in people who have experienced or witnessed a traumatic event, series of events or set of circumstances" (American Psychiatric Association, 2013). PTSD symptoms present themselves in one of four "clusters": avoidance, intrusion, hyperarousal, and changes in cognition and mood (American Psychiatric Association, 2013).

Transference

Transference is a phenomenon that occurs in all types of relationships and is necessary for understanding the client/therapist relationship (Jones, 2004). Transference is the "unconscious redirection of feelings from one person to another" (Prasko et al., p. 189, 2010). In

the case of WT, transference is from therapist to patient, or from patient to field instructor. Therapists undergo in-depth training on how to notice the signs of transference. This allows the therapist to maintain the professional and emotional boundaries between themselves and their clients, while continuing to cultivate an authentic relationship. FI often help direct group therapy sessions and in-the-moment crisis management but are not trained on how to avoid transference.

Secondary Traumatic Stress

Compassion fatigue, now commonly called secondary traumatic stress (STS), is the natural consequences that arise between two individuals when one shares past trauma they have experienced, and the other is affected by what is shared (Canfield, 2005; Figley & Kleber, 1995). As Figley (2013) states, "There is a cost to caring. Professionals who listen to clients' stories of fear, pain, and suffering may feel similar fear, pain, and suffering because they care" (p.1). Individuals working in the mental health field who help process traumatic events may experience similar physiological and psychological responses they see in their client, such as anger, fear, depression, and a sense of helplessness (Canfield, 2005).

The Transition Process

Most WT programs lack a transition program designed specifically for FI. In addition to the potential exposure to numerous traumatic events, FI spend extended time away from loved ones, often negatively effecting the transition process (Kirk & O'Connell, 2012). FI have discussed a period of adjustment that was marked by difficulty sleeping, intense self-reflection, feelings of loss, the recollection of past events, and difficulty discussing and normalizing the experience (Lawrence-Wood & Raymond, 2011). Additionally, Ulrich Dettweiler (2012) reflected on his time at Outward Bound Germany and the adjustment symptoms affecting staff, such as "the end of marriages, jobs quit, and living habits altered" (p.24).

Studies show how difficult the transition period can be for combat veterans returning from active duty (Dao, 2011; Rutherford & Allegria, 2010). The long-term well-being of veterans is directly connected to a successful transitional period (Wands, 2013). A study involving combat veterans revealed three challenges facing a successful transition: the sudden loss of a support system, lack of shared experiences, and aspects of civilian lack of normalcy (Ahern et al., 2015). I do not seek to compare the experiences of combat veterans with those of FI working in WT programs. However, with FI and combat veterans facing similar struggles post-transition, it is helpful to explore transition programs for combat veterans as these programs can be beneficial in combatting the issues present.

Little information and research can be found on transition programs specifically designed for former WT instructors. However, transition programs designed for combat veterans have been found to aid in the transition to civilian life (Ahern et al., 2015). Scheinfeld et al. (2017) found that male veterans participating in an Outward Bound for Veterans (OB4V) therapeutic adventure helped improve overall mental health while providing an additional therapeutic option for veterans. DeLucia (2016) utilized an art therapy program to aid in veterans' transition through connection and community healing.

Additionally, the Transition Assistance Program (TAP) is a cross-agency government program designed to assist veterans transitioning to civilian life by providing employment opportunities, job training services, and access to higher education. (Faurer et al., 2014). A survey of post-9/11 veterans sought to discover what programs or services were beneficial in their transition to civilian life, with less than 7% reporting using programs designed to encourage social relationships and connect them with other veterans (Perkins et al., 2020). Veteran transition programs where connection and social relationship building are emphasized provide

one piece of a format for future transition program designs. Nature connection is a foundational aspect of WT as well as multiple transition programs (Price et al, 2015; Scheinfeld et al, 2017), therefore it is crucial to explore the benefits time in nature can provide.

Health Benefits of Nature Interactions

Outdoor spaces provide an escape from stress, encourage participation in leisure activities, and allow opportunities for personal growth (Kaplan, 1995; Tillmann et al., 2018). The foundation of OBH and WT programs is built on the evidence that time in the outdoors provides a unique therapeutic approach to address a client's needs. (Fernee et al., 2017). Interactions with nature increase self-esteem, improve overall mood, and reduce anger and anxiety (Keniger et al., 2013; Maller, 2009). Time spent in nature can reduce mental fatigue and improve academic performance, productivity, and attention restoration (Fjeld et al., 1998; Fuller et al., 2007; Herzog et al., 1997; Moore et al., 2006). Stress and blood pressure reduction, addiction recovery, and cardiovascular benefits were also reported (Hansmann et al., 2007; Mitchell & Popham, 2008; Van Den Berg & Custers, 2011). Many transition programs utilize outdoor spaces in the healing process due to the physical and psychological benefits they provide.

Outdoor leisure and recreation activities such as hiking and backpacking have emerged as powerful tools to promote physical and mental well-being (Bratman et al., 2015; Grassini, 2022; Kelly et al., 2018; Mitten et al., 2018). A study by Harmon (2019) found that a hiking group for cancer patients and survivors provided non-traditional resources that helped the "normalization process" and aided in the acceptance of their current or past situations. Studies show that hiking for high-risk suicide patients can provide an effective method of reducing hopelessness, depression, and suicidal ideation. (Neunhäuserer et al., 2013; Sturm et al., 2012). Youth participating in a multi-day backpacking trip reported increased life satisfaction, mindfulness, happiness, and a decrease in stress (Mutz & Miller, 2016). It was critical for this backpacking

course to take place in an outdoor setting in order to gain the physical, emotional, and psychological benefits of extended time in outdoor spaces.

Course Design

Important aspects of the backpacking course are listed below:

- A backpacking-style expedition helps participants create new relationships with nature while crafting new memory associations with outdoor activities.
- A group design decreases feelings of isolation and provides individuals with the space to examine collective trauma (DiNunno, 2000; Hirschberger, 2018).
- The trip is peer-led with no licensed clinician, for an understanding comes from being surrounded by those with similar experiences (Ahern et al., 2015).
- Influence is taken from peer-led organizations, The Circle Way and Alcoholics Anonymous, as both encourage peer support (AA Anonymous; Baldwin & Linnea, 2016).

Methodology and Methods

In the following section, I introduce the methodology of autoethnography, how it will be utilized for this research topic, and how, through layered accounts and reflexivity, I add methodological rigor. This is followed by an examination of the methods I used to generate the data and how I systematically analyzed the data and represented the results.

Autoethnography

Autoethnographic research is a reflexive approach that uses the researchers' personal experiences to examine and critique social and cultural norms and experiences (Ellis, 2004). Born out of the desire to step away from the idea that "truths" and "facts" were universally connected to certain paradigms, autoethnography centers narratives and stories, introducing new ways of creating knowledge (Denshire, 2014; Ellis et al., 2011).

Autoethnographic stories are about the self, told through our own personal and cultural lens (Adams et al., 2015; Hopkins, 2022). In autoethnography, the author's “actions, feelings, and emotions are part of the research process” (Humberstone & Prince, 2019, p. 112). When the researcher draws upon these personal stories and experiences, it provides the stage for critical reflection on social and cultural norms and issues (Humberstone & Prince, 2019).

Placing oneself at the forefront of research, as autoethnography does, is not a new concept. Researchers, scientists, and countless others have utilized forms of self-analysis that have led to universally accepted treatment methods, with several researchers using themselves as subjects in their experiments. Jonas Salk tested the first polio vaccine on himself to confirm its safety and efficacy, Werner Forssmann performed the first human cardiac catheterization on himself, laying the groundwork for a modern cardiology procedure, and chemist Albert Hoffmann utilized self-experimentation to study the psychedelic effects of LSD, leading to its future use in therapeutic treatment (Forssmann-Falck, 1997; Fuentes et al., 2020; Jacobs, 2015).

Indeed, autoethnography is not new to the leisure field. Anderson and Austin (2012) explored how autoethnography can capture unique insights into leisure activities. An autoethnographic study by Beedie (2003) examined the first-hand experiences of mountain guides, while Jonas et al. (2003) explored the interactions of individuals while whitewater rafting. Through autoethnography, Price et al. (2015) examined how the sport of fly fishing aided a combat veteran upon return from active duty.

While autoethnography is not new to the leisure field, it is not without its critics. Autoethnography has often been critiqued as “navel-gazing” or “narcissistic”, leading to self-absorption (Anderson, 2006). Ragan (2000) argues that since autoethnography is a non-traditional research form with prescribed “system”, it can be difficult to assess credibility.

To address these criticisms, I have chosen the Layered Accounts of autoethnography described by Ellis et al. (2011) alongside Chang's (2016) suggested steps to structure the study. This aligns with Patti Lather's (1993) emphasis on the importance of reflexive methodologies and engaging critical self-reflection to look inward to see the whole truth. The Layered Accounts method of autoethnography focuses on the author's own experiences alongside data, abstract analysis, and relevant literature (Ellis et al., 2011). Data collection and analysis often proceed simultaneously using reflexivity, multiple voices, and introspection to invite readers into the experience. I utilized AI programs to analyze several personality variables including the MBTI, Enneagram, and Attachment style to gain a better understanding of my own character and disposition, how it compared to traits found in successful FI, and how with this knowledge I can tailor my own outdoor healing experience. This method perceives identity as an emergent process, meaning that throughout the research process, I continue to learn new aspects of self-identity (Ellis et al., 2011). This is only possible through critical reflexivity. To properly examine my reflexivity, I turn to the reflexive strategies introduced by Pillow (2003): reflexivity as recognition of self, recognition of others, truth, and transcendence.

Methods

Autoethnographic research excels at using personal narratives and stories to convey participants' analysis of past or current experiences. As I began my autoethnographic process, I followed the format outline by Chang (2016) and divided the autoethnographic process into seven unique steps:

Chang's Suggested Steps (2016)	Data Generation Methods	Implementation of Steps
Conceptual Preparation	Step 1: Examine Past Journals	I reviewed the journals I kept as a FI to identify significant or memorable moments.

Personal Memory Generation	Step 2: Write Personal Narratives	Memories were chosen that significantly impacted the trajectory of my life, or "epiphanies" as Bochner & Ellis (1992) call them. Five Personal narratives will be handwritten and generated three weeks before the backpacking course.
Self-Observation and Reflection	Step 3: Attend CBT Sessions	I regularly attended CBT sessions throughout the entire research process. CBT has been found to be an effective method when examining and processing past traumas. This will also aid in combatting the "navel-gazing" that is often associated with autoethnographic research.
Generate External Data	Step 4: Attend the backpacking course and generate journal/photographs	Journal entries and photographs were generated throughout the course.
Manage/Organize the Data	Step 5: Organize the Data	Personal narratives and journals were transcribed into a digital format and then paired with conversations, as well as journal entries and photos from the backpacking trip.
Analyze the Data	Step 6: Analyze the Data	See Data Analysis section.
Write the Autoethnography	Step 7: Write Autoethnographic Narratives	The four data generation method were combined to create chapters of my autoethnographic story.

Step 1: Examine Past Journals

The first step in the data generation process was re-reading the journal entries I wrote while working as a FI. For a significant portion of my time working in the field, I journaled every night about the events of the day, where I was located, and my thoughts and feelings about the day. I read through the journals and chose moments that I perceived to have significantly impacted the trajectory of my life, or "epiphanies," as Bochner and Ellis (1992) call them. These

epiphanies reveal ways I can examine past experiences and the effects they caused long after the event has happened.

Step 2: Write Personal Narratives

The second step in this process was writing down five personal narratives from my journals written during my time as a WT FI. I identified five past experiences and, through rich narrative, flushed out the details through storytelling, intending to examine them with new insight during the trip. Chase (2011) tells us that a narrative approach is often selected to retell stories to a broader audience to bring about social change. The writing down of memories instead of just events aids in the elicitation of stories (Cairo, 2021; Crawford et al., 1992; Lea Gaydos, 2005). Personal narrative, at its essence, is a form of storytelling that helps us shape how we have experienced the world and helps others see the world through a different lens. To honor the stories of others, we must first be comfortable and confident in our own stories (Cairo, 2021).

Step 3: Attend CBT Sessions

Often, autoethnographies include conversation only with the self. However, it was important to me to add the viewpoint of an "other" to the research process in philosophical alignment with the therapeutic process. I chose to make my bi-weekly cognitive behavioral therapy (CBT) sessions an integral part of the process (Beck & Weishaar, 1989; Meichenbaum, 1977). After I reviewed my journals and wrote the personal narratives, I spent one to two sessions examining each incident and processing them with a licensed clinician. This step was non-linear and took place several times throughout the data generation process.

Step 4: Collect Journal and Photograph Data/Attend Backpacking Course

I attended the backpacking course from October 14-16, 2023, where I spent an hour each morning and evening reflecting on the day's events. Additionally, I used photography to document meaningful events during the course and to spark my memory as I journaled.

Autophotography

Visual methodologies such as photography bring new insights into the participants' lives while allowing individuals to choose images that directly represent themselves (Barbour, 2014; Noland, 2006). Visual media capture details and meaning overlooked in verbal and written methods by allowing critical reflection about who we are and the experiences that shape us (Glaw et al., 2017; Noland, 2006). I photographed moments, locations, and items during the course that caused me discomfort, fear, sadness, anger, anxiety, or happiness or reminded me of moments from my time working in WT.

Reflexive Journals

Journaling and mental health are entwined with each other, as journaling can be a powerful method of healing and reflection. Journaling develops insight and self-awareness, compassion for oneself, and promotes body awareness while providing space to express emotions (Dimitroff et al., 2017; Kuo et al., 2011; Michael Brady & Sky, 2003). I recorded my thoughts and feelings at the beginning and end of each day, with each journal entry circling back to the research question: *How did the course impact my physical, emotional, and psychological transition from out of the wilderness therapy field into everyday life?*

Step 5: Organize the Data

The personal narratives and journals were transcribed into a digital format and paired with conversations and photographs from the backpacking course, forming a chapter of my story. The format and layout of each chapter are unique, with some containing photographs while others contain conversations and dialogue. A common theme flows throughout each chapter with the components connected through said theme.

Data Analysis

My data analysis process was systematic but not linear. Jackson and Mazzei (2017) describe qualitative research as “rhizomatic,” with all the pieces crashing into each other and becoming entangled, like the roots of a tree. My data analysis consisted of rereading journals and narratives, discussions, introspection, reviewing and discerning the motivation and meaning of the photos I took, and revisiting conversations in my CBT sessions. The Layered Accounts of autoethnography, as described by Ellis et al. (2011), was the foundation upon which the analysis was conducted. This format placed a primary focus on my own experiences alongside data, abstract analysis, and relevant literature (Ellis et al., 2011).

In between re-reading my journals and writing personal narratives, I intertwined my CBT sessions as a form of reflexivity. I cannot divide this data, these parts of me, into sections, for they are all connected, building and supporting each other. What I can do is embrace the chaos and messiness that is narrative inquiry and let my stories speak for themselves (Richardson & St. Pierre, 2008).

Throughout the backpacking course, I recorded my thoughts, feelings, emotions, and actions throughout the day in conjunction with photographs of places and objects during the course. My journals were guided by my research questions as well as the personal narratives written before the course. These stories often involve individuals who have no say in their representation. Therefore, names will be omitted, and the pronouns “they/them” will be used to protect the identity of those involved.

Layered on top of and throughout the data analysis process was my re-visiting the photographs and journals generated on the course and pairing them with a personal narrative and conversations I had with my therapist, professors, and others.

The results I am presenting below will be layered in a way akin to what Parry and Johnson (2007) call Creative Analytic Practice (CAP). As you (reader) examine the results in the following section, I encourage you to use these principles to judge the merit of the work: (1) "the important contribution the text will provide, (2) the aesthetic merit of the text, (3) reflexivity and the role of the researcher, (4) the emotional and intellectual impact of the text, (5) and the text needs to embody the idea of lived experiences and be believable" (Parry & Johnson, 2007).

Results

The first narrative dives into the constant state of hypervigilance required by FI to operate and the hidden consequences of maintaining that state for an extended period of time. Responsibilities placed on FI include 24-hour observation of the clients, day-to-day group management, long work hours in wilderness settings, potential violent encounters, maintaining the health and safety of students with a history of self-harm and suicidal ideation, and maintaining the health and well-being of the instructor themselves (Kirk & O'Connell, 2012; Marchand, 2008). Eventually, there came a point where I could no longer turn off the constant state of alertness. Today, three years after I left the field of WT, the anxiety and fear are still present. This first chapter unpacked a scenario when I did not remain alert and how, through this transition backpacking course, I learned how to turn off the constant state of hypervigilance. I begin with a personal narrative with pictures from the course laced throughout, a conversation between my therapist and myself, and I end with a journal entry from the backpacking course.

In the second narrative, I explore the idea of "fun." Most of the children who attend WT programs do not attend willingly, with recent studies revealing that 50-65% of participants enter OBH programs through coercion or transporting (Tucker et al., 2018), with one of the few alternatives being involuntary commitment to a hospital. These kids are here to address and confront behavioral or substance abuse issues, not have fun. My time working in WT took many

things from me, the most significant being my love of the outdoors. In recent years, I have struggled to have fun and feel at home again in outdoor spaces. The second chapter explores one of my positive memories of my time as an FI and how the course encouraged me to rediscover my love of the outdoors.

Chapter 1: I Let My Guard Down

Personal Narrative

The radio call was short but urgent. The lead staff pulls me aside and tells me how two students barricaded themselves in a yurt. I watch as an instructor tries peak through a hole in the side of the yurt when, suddenly a fire poker emerged from the hole and narrowly missed their eye. Inside the yurt, I hear laughter, and someone say, "Are you really going to set it on fire?!" Without even telling the staff I shove the barricaded door open, holding my backpack in front of me as a makeshift shield. A burning log is hurled towards me, and I watch it miss its mark and sail to my left. I don't wait to see if the log hits anyone behind me. I sprint over to the first child I see and put them in a restraint. The staff behind me grab the other child and put them in a restraint. I smell burning plastic and see a tent smoldering, the item they were attempting to burn.

We guide the students outside the yurt. The child in my arms is calm and we sit down in the snow. My arms loosely cradled around their torso as a precaution. I feel the situation dying down, and I let down my guard. That was my mistake. I shouldn't have thought it was safe.
I hear shouting from behind and turn to see the other student sprinting toward us having slipped out of their restraint. I have nowhere to go and no way to protect myself. I wrap my arms around the student I am sitting next to and bend over on top of them. I expect be kicked but instead feel my shoulder-length hair jerk to the left and right repeatedly. I sat there. Powerless. My scalp

being torn in every direction. I hear my co-staff around me but can't understand what is being said. I feel multiple hands wrestling on my scalp. I tell myself repeatedly, "The staff will get them off me. The staff will get them off me. The staff will get them off me." And they did. I'm not sure how and I don't care. I feel the hands on my head recede. I shouldn't have let my guard down.

August 2nd, 2023 – A conversation between my therapist and myself

Therapist: "What is it about this day in particular that still bothers you?"

Connor: "I think…I just remember how angry I got. I was angry at everyone. The students. The staff. The situation. Myself. I had been there two years now at that point. This type of shit shouldn't be happening. I shouldn't have burning logs thrown at my head. I shouldn't be having my hair pulled like that. I think I was just tired. Physically, emotionally, mentally. I just wanted to relax but every time I tried to relax someone got hurt."

Journal Entry – October 14th, 2023 (during the transition backpacking course)

Me and my crocs are not friends. We have been in each other's lives for six years now and we know little about each other. I start unpacking and setting up my tent and I see something that stops me dead in my tracks: the other participant taking off their hiking boots and putting on their camp shoes. Confusion. Anger. Annoyance. They're puttingtheir camp shoes on now? It's still daylight out.

My camp shoes are a pair of knock off, tan-colored crocs that were once too large for a student and had conveniently found their way in my pack. Crocs are comfy and practical, but you can't chase a student through the woods in them. I was trained (and told) to keep my boots on until all students are in bed for the night. I've made the mistake of letting my guard down and

slipping into my crocs early, only to find myself stumbling through the woods trying to catch a kid who is running to nowhere. Over time my crocs saw less and less use, but they would always be strapped to the outside of my pack.

I watch the other participant finish putting on their camp shoes. What's stopping me from doing the same? There are no kids here. No one to chase. No one to pull my hair. But remember what happens when you let your guard down? "But I'm safe here" I tell myself. But putting on my crocs feels wrong. It goes against everything I learned. Everything I experienced. The woods don't feel safe, but can I change that? Can that start with my crocs? I think of the day the students tried to burn down the yurt. I didn't put my crocs on that night. Or for many nights after that.

I put on one croc. The world doesn't end. So, I put on the other. They're stiff, not as comfy as I remember. I set up my tent in my crocs. I gather wood and start a fire in my crocs. I cook in my crocs. It starts raining but my crocs stay on. The anxiety is still here. Reminding me of what happened and how it could happen again. I don't ignore it. But it feels good to be walking through the woods in crocs again.

Chapter 2: I Learn How to Have Fun

Excerpt from Personal Narrative

"Can we roll down the hill?!" The cabin we are at has a large open field directly out the front door with a giant fire pit right in the middle. Past the fire pit is a large, decently sloped hill. I was taken aback by the request. "Roll down the hill?". I think it was the simplicity of the request that took me so off guard. "Yeah, go for it." I say. I find a spot on the top of the hill off to the side where I can see everyone. For the next hour, I sit there and watch these children roll down

the hill while laughing, stumble around, then run up the hill to do it again It was beautiful and innocent. I spent the last week surrounded by violence and the universe blessed me with a moment of pure joy and pure fun.

September 19th, 2023 – A conversation between Dr. Callie Schultz, David Wynn and myself

David: "Do you have downtime slotted in your itinerary? For fun stuff?"

Connor: "Oh….uhhh yea I can schedule some fun time. Maybe sometime in the afternoon after lunch but before we arrive at camp?"

Callie: "Well don't say it like that! But David's right. Bring a frisbee, maybe hop in a river, ohhh bring a bottle of wine!"

Connor: "I'm not gonna hike out a bottle of wine…"

David: "Instructors partake in enough vices during their off time. No need to encourage it here."

Callie: "Ok that makes total sense. It doesn't have to be alcohol, but I think you should be adamant about including time just for fun. Just fun time. Play, swim, be merry, all that jazz. That's so important."

David: "That's one of your goals, right? To do this differently? If you wanted this to be like wilderness therapy, then you would go back to wilderness therapy. You want to break the cycle. So do it differently."

Journal Entry – October 14th, 2023. (During the transition backpacking course)

I'm struggling to have fun. I am not sure I know how I should be having fun. A river runs next to our campsite but it's too cold to get in. Too many trees for a frisbee. The deck of cards and other games lay abandoned in my car. I didn't think I'd need them. Why am I obsessed with

making sure I have fun? If people don't have fun is the course a failure? I was told to allot time for fun. I feel anxious out here, waiting to hear screaming from across the campsite. But I can discover new ways to have fun. "Hey, you want a beer?" Now I'm the one screaming across the campsite. Two cans were easier to pack out a bottle of wine. I toss a can to my buddy. The company. The weather. The leaves. The warm beer. I was spending too much time looking for fun instead of enjoying the present. It's no hill but I would say I'm having fun.

Discussion

I found myself utilizing a form of "narrative therapy" by condensing my experiences into a narrative format to make them easier to understand and provide a frame of reference (Etchison & Kleist, 2000). Through this method I examined how I grew from this experience by moving from a PTSD mindset to a post-traumatic growth mindset. The backpacking trip helped me craft a new narrative; one where I was no longer a victim of the traumas I endured, and instead had a corrective emotional experience (CEE) in a place that once brought me anxiety.

Within the first narrative, we explore a key aspect of WT programs: the constant alertness required by FI to maintain the clients' safety. Exhaustion caused by long work schedules is a norm for FI (Marchand et al., 2009). Every student must remain within the eyesight of FI. Weapons are everywhere as a rock on the ground can be thrown or used to self-harm. These feelings of constant alertness can quickly lead to burnout and chronic exhaustion, affecting the success of the client/instructor relationship (Bunce, 1998).

I underestimated the feelings of hyperarousal that emerge when the fight-or-flight response is triggered, especially when I spent time outdoors post-WT (Jansen et al., 1995). Using my CBT sessions throughout the process, I was able to reflect on these feelings of alertness and prepare beforehand. I chose a location that had no prior association with the program I worked for. Therefore, there were no negative memory associations. I used contemporary trauma theory

as a form of reflection and understanding during the analysis process by constantly assessing my own mental state and not pushing too hard or too far and thus, I gained a better understanding of how trauma has impacted my well-being (Goodman, 2017). The use of journals and introspection provided greater insight into certain characteristics of CTT present in my daily life such as: dissociation, the long-term effects, and impairment in emotional capacities (Goodman, 2017). Writing down my thoughts and experiences using journals allowed me to examine my daily life, post-WT and how I tend to distance myself emotionally when overwhelmed instead of confronting those feelings. Journals also provide the space for me to explore my feelings of anxiety and fear in outdoor spaces when once there was peace and curiosity.

I stated my feelings openly about how it feels odd not to have to count kids or worry about rocks everywhere. The other participant validated my feelings by sharing that they also experience feelings of high alertness sometimes. I often suppress my thoughts and feelings concerning my time as a FI with friends and family because it is difficult to describe the subtle nuances. There is comfort in surrounding myself with those with similar experiences (Ahern et al., 2015), and I relied on that comfort during the course.

In the second narrative, we examine the losses due in part to my time as an FI and my attempts to discover new types of joy. This narrative aligns with previous research surrounding the individuals who work in the field of behavioral health, as they often choose to do so for altruistic reasons and a strong love of the outdoors (Kirby, 2006; Marchand, 2009). My love of the outdoors has been replaced with a fear I cannot fully understand. However, this backpacking course brought some excitement back. The combination of the group setting, the unknown terrain, the structure of the course and the discussion prompts, and the time allotted for downtime and fun activities added to the success of the course. The group setting was instrumental in

combatting stress, and this course was a gentle reminder that my relationship with the outdoors is constantly evolving. A surprising yet powerful revelation was understanding just how much the research process aided in my healing process. Every part offered a new insight, from reading my journals, the CBT sessions, journaling and photography, and the writing down of my narratives were all pivotal pieces in understanding my story. If I were to list three important takeaways from this backpacking course they were:

1. The group aspect played the most vital role in the healing process.
2. The use of CBT, and other forms of therapy, throughout the process provided greater insight into the past trauma I have faced.
3. Participation in an outdoor leisure activity was a gentle first step into erasing my fear or outdoor spaces.

Conclusion

Researchers have explored WT's benefits for youth and adults with behavioral and psychological issues (Cramer & Wanner, 2022; Fernee et al., 2017), while also exploring how easily improper management and training can lead to the loss of life (Kutz & O'Connell, 2007).

An industry-wide landscape analysis of the well-being of former FI can be crucial in illuminating the issues these individuals have or are experiencing because of employment in WT. Further research into the aid offered to current and former FI will reveal how much time and resources are put towards the well-being of current FI, and whether any at all is put towards departing FI. The power of transition programs have been found to be beneficial for combat veterans, with FI experiencing similar transitional issues such as the loss of a support system, a struggle to find a "new normal," and a lack of shared experiences (Ahern et al., 2015; Derefinko et al., 2019). A transition program of this nature provides tools, connections, and closure designed to set departing and returning FI up for success. The positive well-being of FI will

increase the success of WT programs while ensuring the safety and well-being of the clients. There is further potential for WT programs to utilize a program of this design for seasonal employees to increase staff retention and morale.

By sharing my stories through an autoethnographic lens, I have gained a greater insight into the parts of me I feel I have lost. Storytelling is a vital part of being human and a powerful catalyst for change (Cairo, 2021; Ellis et al., 2011). To change my story, I must first begin to understand it (Cairo, 2021). Everyone has a story to share, and I encourage you to share yours, for through our interwoven stories, we can disrupt the narrative.

Those who wish to read my full autoethnography or listen to me describe my experience with committee member Dr. Russ Curtis can follow the links below:

https://docs.google.com/document/d/1mat18R2nkz9qBoTRGGw72VVjl4jrxS8d/edit?usp=sharing&ouid=113003231754776978836&rtpof=true&sd=true

https://www.youtube.com/watch?v=KFb6IHqxHgc

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CHAPTER 6: COMPLETE AUTOETHNOGRAPHY

THE PARTS I'VE LOST

Chapter 1: The Pill Bottle

It was cold. A few days before Christmas. I'm sitting on the ground, preparing to dispense a nighttime medication to a student sitting in front of me. Our breaths were visible as we sat there, both unaware of the events about to unfold. I was hunched over a large Tupperware container, attempting to cut a pill in half that was the size of a small insect. I'm leaning over, cutting this pill, and out of my peripheral, I see a hand, and I see the bottle move. Three seconds. The student had taken the bottle and swallowed every single pill in a desperate attempt to commit suicide and escape the program we were both trapped in.

This was where my choice was immediately taken from me. I wasn't allowed to feel. I wasn't allowed to be angry. Wasn't allowed to be scared. I wasn't even allowed to worry. I had this student in front of me; I had seven other students in a yurt and staff who were all looking at me. If I show fear, then I lose all control. So I did what I was trained to do, and I pushed my fear, my anger, and my worry aside.

I shove my fingers down the student's throat to expel the pill, being covered with water and vomit in the process. I radioed a nearby group to send one of their staff to help watch my group. I had my personal phone in one hand and my work phone in the other, contacting the appropriate medical and management personnel. I created a grid system, and with my headlamp and the light from my phone, I walked back and forth, back and forth, to find any loose pills on the ground. My fear increased as I continued to find no pills lying in the dirt, but I had to push that down. I took off my outer layers and checked every single nook in a desperate attempt to find any pill. I even combed my hair in case one somehow landed there. It became evident that the student swallowed every single pill in the bottle.

The student and I sat together as we waited for help to arrive. Through tears, they asked me, "Am I going to be ok?". I looked up at their face and saw something I did not see before. I saw a scared, confused young child. The anger and fear I felt were suddenly replaced by shame and guilt. I had lost my empathy. I had been trained so well to keep these children safe that I had realized my mistake too late. I no longer saw them as children. "I don't know." Was all I managed to say—a brutally honest answer to a scared child who needed reassurance when I couldn't provide any. We sat there in silence. One of us scared, and the other trying not to admit it. Help arrived soon after, and the student was taken to the hospital, where they were given the proper treatment and rejoined the group later the next day. I think about those three seconds every day. I think about that student every day. I think about how those three seconds entangled our lives in ways both of us are still attempting to comprehend.

While I had a few sleepless nights immediately following this incident, it was not until a year later, after I had left the field of wilderness therapy, that I finally allowed the anger and fear that I had so recklessly suppressed to take over. It was early morning, my nose stuffy, and my head

hurting from allergies. As I grabbed a bottle of Claritin, a pill slipped through my fingers and fell onto my bathroom floor. I bent down to pick up this tiny white pill and suddenly felt a massive surge of anger. How easy it was for me to find this pill, but not the others. In the confines of my windowless bathroom, the full realization of the experience finally hit me. How close I was to causing the death of a child. How close I was to ruining so many lives. And three seconds was all it took.

Journal Entry – October 12th, 2023

I remember almost every aspect of the pill incident but there is one part that still bothers me; I cannot remember the type of medication the student swallowed. It doesn't really matter, but to me it does. It's the last piece of the puzzle. As a form of reflection and in an attempt to remember and make sense of the role medications played during my time as a Field Instructor, I attempted to list the medications I remember dispensing to students.*

*This is not a complete list, but instead just a list of the medications I can specifically remember. Some medications listed below are generic brands for a similar medication. I chose to list both.

SSRI/SNRI – Antidepressants/Anxiety
Citalopram
Escitalopram
Fluoxetine
Sertraline
Venlafaxine
Bupropion
Duloxetine
Trazodone

Sleep Aid
Melatonin
Zolpidem

Stimulants
Adderall
Vyvanse
Dextroamphetamine
Dexmethylphenidate
Methylphenidate

Mood Stabilizers
Lithium
Lamotrigine
Quetiapine
Divalproex
Lorazepam
Klonopin
Risperidone
CBD Gummies
Alprazolam
Diazepam
Ketamine Gummies
Aripiprazole
Guanfacine
Gabapentin

Asthma
Albuterol
Levalbuterol
Qvar Redihaler
Fluticasone

Allergies
Diphenhydramine
Cetirizine - Zyrtec
Fexofenadine
Loratadine
Azelastine
Flonase
Prednisone
Epinephrine

Diabetes Management
Insulin
Metformin

Journal Entry October 15th, 2023

I thought about not bringing my watch on the trip. See what it feels like to not know what time it is. Wake up with the sun instead of beeping.

I couldn't do it. I brought my watch. I tell myself it was for practical reasons, but I felt uncomfortable without it. I still wear it with the face on the inside of my wrist as I did on shift. I've tried to wear it with the face out, but it instantly made me uncomfortable. I can't explain why. I was gifted a beautiful wooden watch a few years back and I love it. I've put it on a few times, and it felt strange on my wrist. Like it kept slipping everywhere. I told myself it didn't fit right, and I just needed to adjust it but I couldn't separate myself from my current watch. I bought this Timex Ironman digital watch about two weeks before I started as a field instructor. It lasted me though my entire time in the field.

I lived and died by my watch. Time was so important out in the field. Alarm goes off at 6am. Morning medications at 8am. Breakfast around 9. Afternoon medications at 12. Dinner around 5/6. Nighttime medications at 8. Hopefully in bed by 9. You can't miss dispensing medications. You miss one med bubble and you're screwed. You just made the ladies in the med department very mad. This is what happens if you missed a medication:

- Call PR (Primary Responder) or leave your group and walk over to the med office if you are on base or radio them.
- PR or the med department then must call the pharmacy. Every time. For every medication. Adderall to Lithium to Flonase.
- The pharmacist will give the ok to dispense the medication after the designated window. You typically have a few extra hours to dispense it.
- You must then monitor the student for any possible side effects from missing the medication.
- You fill out an Incident Report for missing the medication dispensation window. If you missed multiple medications (which is typical because the students often took multiple meds) then you had to write a report for each medication missed.
- Turn those into the Med Staff at the end of the shift. First missed med is a polite reminder. After that you will go through medication training again. After so many missed medications you were written up and it went in your employee file. Continue to do it and you are no longer allowed to dispense medication. Make a big enough mistake and they fire you.

I believe I messed up a med bubble four, maybe five times in my career. I relied a lot on my watch for the reminders. Even asking my co-staff to set alarms as well. But that doesn't matter because a child almost committed suicide in one of my med bubbles.

I haven't thought much about med bubbles on this trip so far. I think that was one aspect that I was desperate to forget. I had so many alarms set on my watch to remind me. It's wonderful to wake up to the sun. I remember my routine in the field. Take off my watch, double and triple check that my multiples alarms are set, then set it next to my head so I'll hear it go off

After the student swallowed all the pills, I sat with them while we waited for help to arrive. Neither of us really talked. I remember I kept looking at my watch…

10 minutes since they swallowed the pills…

"They're gonna die. They're gonna die and it's entirely my fault."

14 minutes since they swallowed the pills…

"Will I go to prison if they die? Is my partner going to break up with me? Did I just murder a child?"

27 minutes since they swallowed the pills…

"How long until they kick in? Will they kick in slowly or all at once? Should I try and make them throw up again?"

(Help did eventually arrive. I don't remember how long it took)

Last night after I slid into my sleeping bag, I took off my watch, double and triple checked that I had NO alarms set, then set it down next to my head where it always went.

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Chapter 2: The Gear List

Below is a list of the gear I packed the night before the backpacking course. After I finished packing, I laid out my gear and recounted the supplies I ***realistically*** would need. I found that I drastically overpacked. Recently I found myself overpacking when heading outside even if it's for a simple day hike. I attribute it to my time as a lead staff and the attempt to prepare myself for any situation, behavioral, emotional, or physical that might pop up.

The left column displays the type of gear, the middle column shows the amount of gear I brought on the backpacking course, and the column on the right shows the amount of gear that was *realistically* needed.

Gear Packed	Amount Packed	Actual Amount Needed
Backpacking Pack	1	1
Tent	1	1
Sleeping Bag	1	1
Sleeping Bag Liner	1	**NOT NEEDED**
Headlamp	2	1
AAA batteries	9	3
Camp Lantern	2	1
Boots	1	1
Crocs	1	1
Socks	10	4
Hiking Pants	2	1
Thermal Leggings	1	1
Thermal Shirt	1	1
Sweatshirt	1	**NOT NEEDED**
Puffy	1	1
Fleece sweater	2	1
Hiking shirt	1	1
Rain jacket	2	1
Rain pants	2	1
Beanie	2	1
Fleece Gloves	2	**NOT NEEDED**
Liner Gloves	2	**NOT NEEDED**
Buff	1	**NOT NEEDED**
Reading book	3	**NOT NEEDED**
Journal	2	1
Pens/pencils	6	2
Voice recorder	1	1
Phone	1	1
Portable battery	2	1
Snacks (days)	5	2.5

Breakfast Meals	1	2.5
Lunch Meals	1.5	2.5
Dinner Meals	5	2.5
Hot Sauce	1 full bottle	**FULL BOTTLE NOT NECESSARY**
Chipotle Sauce	1 full bottle	**FULL BOTTLE NOT NECESSARY**
1 jar of Peanut Butter	1	**NOT NEEDED**
Tea Bags w/ Caffeine	8	3
Mio Energy	2	**NOT NEEDED**
Ibuprofen	10	4
Advil x	10	4
Bottle of Pepto-Bismol	1	**NOT NEEDED**
Pepcid	4	**NOT NEEDED**
Beer	2	**SUBJECTIVE**
Map	2	2
Paperwork	4	2
Large trash bag	3	1
Ziploc bags	10	3
Stuff sacks	3	1
Deck of Card	1 (left in car)	1
Travel Games	4 (left in car)	1
KIDS reading books	2 (left in car)	**NOT NEEDED**
First Aid Kit - Personal	1	**NOT NEEDED**
First Aid Kit (Professionally Assembled)	1	1
Water Bottle	2	2
Water Filter	1	1
Pocketknife	2	1
Spoon	2	1
Fork	2	1
Bowl	2	1
Teacup	2	1

Below is an examination of certain items and why I believe I consciously or subconsciously brought that specific amount or that gear at all. Most reasons related directly to one specific instance or learned techniques that made a shift easier or more bearable.

Headlamp and batteries – There were many nights when I was up dealing with a behavioral issue, or we just had a slow day and were setting up camp in the dark. Students were not allowed headlamps therefore staff provided light for the entire group. Have you ever had eleven kids asking you for light all at the same time? One headlamp on my head and the second around my neck worked the best. A few times an upset student would grab my headlamp and

break it. Always bring a backup. I went through so many batteries because I kept the brightness at maximum.

Socks – Wet socks are typical when out on an expedition. Especially if it rains for multiple days. There were a lot of shifts where all my socks would be wet. I kept a pair of socks at the bottom of my sleeping bag; my "vampire socks". That way I at least had a dry pair for bed. Also, the most lost item by students were their socks. Lost in the laundry or literally left in camp when it was time to leave with no one claiming them. Multiple times, I had to give my own socks to students who had none. For reference, kids were supposed to have at least 6-7 pairs.

Rain jacket and pants – You were going to get wet no matter what. All the jackets seeped through eventually. And I came to love rain pants. But just like with the socks, students would also misplace their rain jackets which was a huge safety concern, especially during the wet summer. Many times, we would be hiking in the rain, a single file line of 8 kids and 2 staff, all wearing bright, neon orange rain jackets. Always keep two that way when a kid needs one you still have one.

Gloves and liners – Same as socks and rain gear. Kids lose them so you must give up yours. I went through 6 pairs of REI fleece gloves during my time in the field. I lost them all. They were never damaged. I would just lose them in the chaos of the day. One time a student stole a pair of my fleece gloves and then tried to pass them off as their own.

Pens/Pencils – Each student was given one pencil. Kind of ridiculous now that I think about it. They would also lose them on the regular. So always bring a lot for the kids who lose theirs. It got really tiring, constantly being asked to borrow a pencil. I kept my pens in my locked pack. Students were not allowed pens because staff signed all their work in pens. So, if there was a staff signature in pencil you know a student forged it. That also happened to me and that was a blunt firsthand lesson about not trusting the students.

Reading books – My very first shift I remember I brough Jack Kerouac and Jack London to read in the evenings on shift. I did not open those books once. It's funny looking back on it. How naïve and stupid that was. I did not have the emotional or physical energy to read "adult" books in the evening. Most nights I didn't have any time at all. Harry Potter, Hunger Games, Star Wars. A lot of Star Wars. Those were the books I could read at night. Easy, light and they didn't deal with nature. I don't want to read a book about backpacking while I'm out backpacking. Space and fantasy gave me the hour of escape I needed.

Snacks – I did not eat healthy while on shift. Ironic as the diet and food prep for the students was very in-depth and precise. My first shift I severely under packed and lost 8lbs in two weeks. A student threw out a bag of uneaten prunes and I remember literally digging through the trash at night so no one would see me and eating them with no hesitation. A bag of skittles, a bag of peanut M&Ms (because the peanut ones don't melt in the summer), goldfish, trail mix, cliff bars, and dried fruit. That was my regular snack game. Sometimes I would mix it up and bring

something different. Gummies or mini pies. Sneaking off and eating a handful of skittles many times brought me down after an intense altercation with a student.

Breakfast/Lunch/ Dinner – Meals were always provided for staff. We ate the same food the students did. The problem was sometimes the students couldn't cook worth shit. Or they measured the food incorrectly. I ate so much burnt R&B (rice and beans) that I could tell just by looking at the amount of water whether they would end up burnt or not. And when I told that to the student who oversaw cooking, there was a 50/50 shot they would take my advice. Most times they didn't, and we ended up with burnt food. The worst was when they didn't measure correctly and there was only enough food for the students and not the staff. Now we are all upset, hungry, and are forced to eat Clif bars for dinner. Always bring more food than you think. One time I watched a student, (who didn't have cooking gloves on) stick his hand in his pants, scratch his bare ass, then grab the spoon and stir the food in the pot. That is who was cooking our food. I struggled to eat the food in that group for a long time.

Hot Sauce – The food was bland. We couldn't change the food but what we could do was bring hot sauce or something to make it more edible. Sometimes hot sauce could save the day when I'm eating burnt food for the third night in a row. Eventually the hot sauce became bland, and I had to switch it up to another sauce.

Peanut Butter – The most recurring lunch meal we had was PB tort. Peanut butter on a tortilla. In my almost three years in the field, I would say I ate close to 300+ PB torts. Multiple a day. The last three months I did not eat them anymore. I physically couldn't. I would rather skip lunch than eat a PB tort. So, I did. I still haven't eaten peanut butter. I wanted to challenge myself on this course to see if I could try and eat a PB tort again. I did not even open the jar.

Caffeine – I'm not sure of the amount of caffeine I consumed while on the shift, but I know it was one of the direct factors that lead to my persistent gastrointestinal issues. Caffeine was a necessity. I could not physically or mentally stay with the group without caffeine. Some nights I wouldn't go to bed until 2am and would have to wake up 4 hours later. If I was on sleep duty, then I would have to wake up every 3 hours to count the students and make sure everyone is present and alive. Whenever I had a new student, I couldn't sleep because I didn't know how they would react. Are they going to run? Are they going to try and hurt themselves? So, I just stayed awake. Coffee in the morning. Mio energy throughout the day. Sometimes management or logistics staff would bring a Redbull which I would drink quickly. Mio energy was a life saver. It was supposed to be diluted with water, but I would squirt it directly into my mouth then chase it with water. It hit hard and fast but caused me to crash equally hard and fast. So, when I would feel that crash coming I would take another squirt.

Over the counter medicine – Eventually my day pack contained two bottles of Pepto-Bismol, Prilosec, Pepcid, and tums tablets. Later I would find out that the combination of the constant stress I was under, consuming only caffeine and skittles, and my lack of adequate daily nutrition would lead to severe GI issues. I remember many nights of sneaking off to the bathroom while the students were asleep and laying on the floor in agony, chugging Pepto until

the pain went away. The first few days of my off shift consisted of me lying in bed not eating anything, waiting for my stomach to settle. Ever since I stopped drinking coffee, and no longer living with the constant stress of violence or kids running my GI issues have disappeared.

Trash bags and Ziploc Bags – On shift, everything I had was in a waterproof bag of some kind. My gear got wet too many times and I got frustrated too often. My clothes went into a Ziploc bag then went into a waterproof stuff sack. Books were double bagged. My sleeping bag was double bagged. Paperwork double sealed. My bivy used to stay on the outside of my pack but kept getting wet and one day I noticed mold growing on the inside, about 3 inches from where I laid my face at night. I couldn't afford to buy a new one, so I made sure it did not get wet anymore.

Cards/Games – The games were brought specifically to keep the students entertained. Bored students lead to violent students. They also helped the day pass by faster. The younger kids needed fun. They needed game time and I made sure they had multiple hours of it every day. I firmly believe that most days they needed games more than therapy. Especially here. On Christmas eve my first year working I let the kids stay up late to play monopoly and I was reprimanded by management the next day for "keeping the kids up to late.". Uno, Exploding Kittens, Unstable Unicorns, Monopoly Go, several decks of cards. Small, lite, cheap card games that I could afford and was ok with eventually being destroyed by weather or in a student's fit of rage.

Reading Books – Reading to the kids at night was one of the most pleasant experiences I remember from my time in the field. The kids used to have to earn reading time in the evening. But the nights when we didn't read were often filled with fighting that lasted late into the night. It also gave the kids a little bit of quiet time for their nighttime meds to kick in. For my group, they always had an automatic chapter of reading in the evening, and throughout the day they could earn more chapters depending on how quickly they completed the day's tasks. Harry Potter, Hunger Games, Maze Runner, Percy Jackson, and the Hobbit. Sometimes I would add some excitement and throw in some unique voices. On Christmas I would read *How the Grinch Stole Christmas* and *The Polar Express*. On Halloween I read *Scary Stories to tell in The Dark*. I think the reading was necessary for both me and the students. It gave me the opportunity to calm myself. And I think it reminded the students of home. Everyone loves having someone read to them.

Utensils – The kids were only allowed to have spoons. Forks could be used as a weapon. Spoons were also another item that was habitually lost by students. If students were only allowed to have spoons, then that meant that staff were only allowed to have spoons. I used to make a giant serving of spaghetti in the kitchen before we went out on expo and would put in in several Ziploc baggies. I called it my "expo spaghetti". You ever tried to eat spaghetti with a spoon while out in the woods? Impossible. I have a strange memory of me, and my co-staff huddled in a circle at midnight grabbing handfuls of spaghetti without dirty ass hands and shoveling it into our mouths and we were all so happy.

Chapter 3: I Let My Guard Down

The radio call was short but urgent. The lead staff pulls me aside and tells me how two students barricaded themselves in the yurt. I watch as an instructor tries peak through a hole in the side of the yurt when, suddenly a fire poker emerged from the hole and narrowly missed their eye. Inside the yurt, I hear laughter, and someone say, "Are you really going to set it on fire?!"

It was time to act. Without even telling the staff I shove the barricaded door open, holding my backpack in front of me as a makeshift shield. A burning log is hurled towards me, and I watch it miss its mark and sail to my left. I don't wait to see if the log hits anyone behind me. I sprint over to the first child I see and put them in a restraint. The staff behind me grab the other child and put them in a restraint. I smell burning plastic and see a tent smoldering. A free staff places the tent out in the snow, extinguishing the flame.

We guide the students outside of the yurt. The child in my arms is calm. We sit down in the snow. My arms loosely cradled around his torso as a precaution. I feel the situation dying down, and I let down my guard. That was my mistake. I shouldn't have thought it was safe.

I hear shouting from behind and turn to see the other student sprinting toward us having slipped out of the restraint. I have nowhere to go and no way to protect myself. I wrap my arms around the student I am sitting next to and bend over on top of them. I expect kicks but instead feel my shoulder-length hair jerk to the left, the right, then straight back. I sat there. Powerless. My scalp being torn in every direction. I hear my co-staff around me but can't understand anything. I feel multiple hands wrestling on my scalp. I tell myself repeatedly, "The staff will get them off me. The staff will get them off me. The staff will get them off me." And they did. I'm not sure how and I don't care. I feel the hands on my head recede. I shouldn't have let my guard down.

August 2nd, 2023 – A conversation between my therapist and myself

Therapist: "What is it about this day in particular that still bothers you?"

Connor: "I just remember how angry I got. I was angry at everyone. The students. The staff. The situation. Myself. I had been there two years now at that point. This type of shit shouldn't be happening. I shouldn't have burning logs thrown at my head. I shouldn't be having my hair pulled like that. I think I was just tired. Physically, emotionally, mentally. I just wanted to relax but every time I tried to relax someone got hurt."

Journal Entry – October 14th, 2023.

My crocs and I are not friends. We have been in each other's lives for six years now and we know little about each other. I start unpacking and setting up my tent and I see something that stops me dead in my tracks: the other participant taking off their hiking boots and putting on

their camp shoes. Confusion. Anger. Annoyance. You're putting your camp shoes on now? It's still daylight out. There is still work to do.

My camp shoes are a pair of knock off, tan-colored crocs that were once too large for a student and had conveniently found their way in my pack. Crocs are comfy and practical, durable, and dry quickly, easy to slip on and off, cheap and replaceable. But you can't chase a student through the woods in them. I was trained (and told) to keep my boots on until all students are in bed for the night. I've made the mistake of letting my guard down and slipping into my crocs early, only to find myself stumbling through the woods trying to catch a kid who is running to nowhere. In my crocs. Over time my crocs saw less and less use. They would be strapped to the outside of my back, a yellowish dangling eyesore. They looked good for their age.

I watch the other participant finish putting on their camp shoes. What's stopping me from doing the same? Theres no kids here. No one to chase. No one to pull my hair. But remember what happens when you let your guard down? "But I'm safe here" I tell myself. But putting on my crocs feels wrong. It goes against everything I learned. Everything I experienced. The woods don't feel safe, but can I change that? Can that start with my crocs? What harm can come from putting them on? I told myself that, but this time I might believe it. I think of the day the students tried to burn down the yurt. I didn't put my crocs on that night. Or for many nights after that.

I put on one croc. The world doesn't end. So, I put on the other. They're stiff, not as comfy as I recall. I set up my tent in my crocs. I gather wood and start a fire in my crocs. I cook in my crocs. It starts raining but my crocs stay on. The anxiety is still here. Reminding me of what happened and how it could happen again. I don't ignore it. But man it feels to be walking through the woods in crocs.

Chapter 4: I Break My Water Bottle

We were located at Cabin 7 on our main base camp. We are all sitting outside, building a fire, reading, bow drilling, and preparing dinner. Out of the corner of my eye, I saw a student get up and start to walk out of camp. I follow them and get in front to try to stop them. Step 1 of the physical intervention training is to "create a physical barrier." I try to talk with them and find out what is going on. It doesn't work. They keep trying to walk past me. I really did not want to use a physical restraint. I had performed maybe two restraints so far during my time as a field instructor. I was not very confident, and, being a brand-new student, I did not know how they would react to being put in a restraint. The student and I "monkey danced" for a while. They would try to get around me, and I would walk in front of them to stop them. Eventually, he turned to trying to shove me out of the way. Small shoves at first. Then bigger. And bigger. Suddenly, without even realizing it, I had become on the defensive. I was being shoved up against the side of the cabin over and over. I was still hesitant to perform a restraint, but at this point, I should have. But I didn't. As bad as the shoving was, it was the yelling that got to me. "You don't fucking care about me! Get out of my fucking way! You don't know anything about me! I'm going to fucking kill you! You're making me more upset!".

I don't know why the words had gotten to me. I had insults thrown my way before by upset children, but this felt different. Was I being unreasonable? I had done nothing but try and talk with this student, to try and understand them. The shoving grew more aggressive. I found myself backed up against the side of the cabin, being shoved repeatedly. I should have put the child in a restraint, but still, I hesitated.

Eventually, I had no other choice. I could no longer put it off. I gave the child one last chance to come back to camp otherwise I would have to put them in a restraint. We always had to let the student know that we were about to use a restraint. Legal reasons, I think? It never failed to make the student more upset. So, I put them in a restraint. Every time it appeared the child had calmed down, I would let them go, and they would immediately turn around and swing at my head, and I would have to put them in a restraint again. I'm not sure how many times this happened, but it was enough to cause the muscles in my forearms to twitch. Out of the corner of my eye, I see a staff member walking up the hill to check on the situation. I'm not sure if my co-staff radioed for help or if they heard the screams from their own cabin but help had finally arrived.

My face expressed the helplessness I felt. I locked eyes with this staff and no words escaped my mouth. A silent exchange. My eyes began to swell, and I felt the tears coming. I needed help and more importantly, I needed to get away from this child. I waited until the staff was within arm's reach of the child, and I let go, turned around, and started walking away. I braced myself for the inevitable swing at my head that would follow, but the staff intercepted it before it could land and, judging by the screams and curses, had put the child back into another restraint.

I grabbed my water bottle as I walked towards an empty cabin to find somewhere to be alone, now incredibly aware of how dehydrated I was. At this point I was crying. From exhaustion. From anger. It was the anger that emerged first. I threw my water bottle as hard as I could

against the backside of the cabin. The lid shattered and broke into two pieces. I owned that water bottle for years. It had been decorated with stickers from parks I visited, and Pokémon stickers gifted by former students. My anger was replaced by sadness. Then shame.

I sat on the porch of this cabin for five minutes. I felt guilty for being gone for that long when my group needed me. This was the first time I was pushed to the brink emotionally by students, but it won't be the last.

Journal Entry – October 15th, 2023

I brought two water bottles with me today as I do every trip outdoor expedition. These have a fun collection of stickers that I'm very proud of. A couple Sierra Nevada Brewery stickers, some REI stickers. A turtle wearing a backpack.

I'm trying to remember the stickers that were on the water bottle I broke four years ago. I can't, but I remember the water bottle was lime green. And I remember feeling an overwhelming amount of sadness when I broke it. Followed instantly by shame.

Shame that I let my anger get the best of me. Shame that I preached openly to the students about controlling their emotions and then turned around and broke something like a child throwing a tantrum. It feels odd sitting here with my two new water bottles thinking about that day. That incident. It's not shame or anger I feel anymore, but empathy. I let a student physically and verbally assault me for close to an hour before I chose to act. And all I took was five minutes to think about it.

I was told and trained to suppress my emotions to be successful. "You can't let the kids get to you. You can't get angry back. You must be at a higher level emotionally." We are simultaneously taught to suppress our emotions while teaching the students to embrace theirs. I understand that I am an adult and should be more in control. I get that part. But why did I feel shame for being angry? Why did I feel guilty for taking five minutes to myself.

It is empathy that I reach for now. Empathy for that student because this was the first of dozens of violent encounters between us.

Empathy for myself because I needed more than five minutes but did not have the confidence or understanding to know better. Because it is ridiculous to ask someone to be attacked for that long and not feel anything.

I took a little time for myself and walked and sat beside the river running through camp right now. As an outdoor leader my time belongs to the people under my care. That will never change. But I notice I've been sitting by myself and writing for going on 20 minutes now…

Chapter 5: I Learn How to Have Fun

"Can we roll down the hill?!" The cabin we are at has a large open field directly out the front door with a giant fire pit right in the middle. Past the fire pit is a large, decently sloped hill. I was taken aback by the question. "Roll down the hill?". I think it was the simplicity of the request that took me so off guard. It was the genuine look of happiness on this kids face that forced my hand. "Yeah, go for it." The child turns around and yells "HE SAID YES" and joins in the stampede to the top of the hill.

I find a quiet spot off to the side where I can see everyone. For the next hour, I sit there and watch these children roll down the hill while laughing, stumble around all wobbly, then run up the hill and do it again. Over an hour. I spent the last six days dealing with the most violent student I would ever work with, being spat on and attacked for hours on end. And then the universe blessed me with a moment of pure joy and pure fun. It was one of the most beautiful moments I have experienced in my life.

September 19th, 2023 – A conversation between Dr. Callie Schultz, David Wynn and Connor Mathias.

David: "Do you have downtime slotted in your itinerary? For fun stuff?"

Connor: "Oh….uhhh yea I can schedule some fun time. Maybe sometime in the afternoon after lunch but before we arrive at camp?"

Callie: "Well don't say it like that! But David's right. Bring a frisbee, maybe hop in a river, ohhh bring a bottle of wine!"

Connor: "I'm not gonna hike out a bottle of wine…"

David: "Instructors partake in enough vices during their off time. No need to encourage it here."

Callie: "Ok that makes total sense. It doesn't have to be alcohol, but I think you should be adamant about including time just for fun. Just fun time. Play, swim, be merry, all that jazz. That's so important."

David: "That's one of your goals, right? To do this differently? If you wanted this to be like wilderness therapy, then you would go back to wilderness therapy. You want to break the cycle. So do it differently."

Journal Entry – October 14th, 2023

I'm struggling to have fun. I am not sure I know how I should be having fun. My tent is yards away from a river but it's too cold to get in. Too many trees for a frisbee. The deck of cards and other games lay abandoned in my car. I didn't think I'd need them. Why am I obsessed with making sure I have fun? If people don't have fun is the course a failure? Making me a failure? I was told to allot time for fun. I've seen kids have hours of fun with just a hill. Maybe that's not the point. The woods once brought me joy but now only bring discomfort. But it doesn't have to end there. I can discover new ways to have fun. "Hey, you want a beer?" Two cans were easier than wine. I toss a can to my buddy. The company. The weather. The leaves. The beer. It's no hill but I would say I'm having fun.

Chapter 6: Hugs

When I checked my watch, the time read 12:12am. Me and another staff member have been sitting on the porch of a cabin with this student for about an hour now after they woke up and started crying. We brought them out on the porch to talk and to not disturb the other students who were sleeping. This kid arrived just this morning, and they were not settling in ok. They were very homesick. They were crying, trying to make sense of why they were here. The student was small. Tiny. And sitting there listening to him cry, his body heaving just broke my heart. Multiple times I reached out to pat him on the back to provide some form of comfort and I had to stop myself. The only time we are allowed to touch the children is in a medical or safety situation. No hugs. No pats on the back. Can you imagine being a child and not receiving any physical contact for over three months? The student looked up and me and asked,

"Can I have a hug?"

A terrified, confused, lonely child who just wanted a hug.

And I said "no."

Journal Entry – October 14th, 2023

In regard to love languages, I've never been much of a Physical Touch kind of person. I've always been rather distant and "cold" as someone once described me. I'm not sure when that started, but I know that wilderness therapy magnified that feeling to a level that was worrying. I've been thinking a lot about physical touch lately. The other day someone asked if I wanted a hug and I almost too quickly said "no". The look on their face was one of confusion and (in my mind) a little bit of disgust. I know that wilderness therapy changed the way I connect with people. You would think connection would be easier. Being surrounded by violence and wanting to come home to peace.

My therapist told me to think about physical touch and physical connection while on this course. To reflect on why it's been bothering me so much recently. I asked the other participant about restraints, but they did not have to use them as much as I did. I find myself wishing there was a participant here who used restraints as much as I did to see if they have the same problem. I hate writing this because it sounds corny, but I feel like a part of me is broken because of my anxiety around physical touch. It's a main element of being human, feeling connection and touch, and I don't have it. I think I underestimated that aspect of wilderness therapy. Going so long without physical connection. I've done it before, so I wonder why wilderness therapy intensified it. It also makes me think about the kids and how they went without physical touch for over 3 months. As a child. It's cruel. And I was complicit in that.

January 8th, 2024 – a conversation between my therapist and myself

Therapist: "This isn't the first time you mentioned your concern over your struggle with physical connection…."

Connor: "It's been on my mind a lot recently. I was surrounded by people who enjoy physical touch. Who desire it. I don't understand why I'm not one of those people. It's gotten worse over the past few years. It makes me uncomfortable, and I don't know why. It ruined my relationship. Holding hands felt weird. Hugging and kissing felt weird. Being close to someone was…..difficult."

Therapist: "Can I share my observations?"

Connor: "You're about to school me aren't you?"

Therapist: "In a compassionate way, yes. Connor…you faced several traumatic experiences. You were physically assaulted. You had a child violently grab your groin multiple times. You put kids in holds constantly. Daily. Sometimes for hours. Then you went home, where it was safe. You would hug and kiss your partner. But your brain wouldn't let you be safe. It remained in that ON position that we've talked about. You've internalized that physical touch and created a subconscious connection between touch and pain. Between physical touch and discomfort. For two weeks you would have no intentional physical contact unless it was related to violence. Either against yourself or someone else. Of course your body and brain feel that physical intimacy is uncomfortable. These violent encounters and even putting children in a hold left scars. Doesn't it make sense that you spent all this time around physical violence that when you get home your brain naturally wanted to distance yourself, physically, from someone, even if you wanted to be close to them?

Connor: "(stunned silence)….huh…..damn."

Therapist: "You don't dislike physical touch and connection because you hate being touched, you dislike it because your brain learned to associate physical touch with violence. It's helping you to feel safe, even two years later."

Connor: "But how do I explain that to people?"

Therapist: "You're not obligated to explain that to anyone…"

Connor: "(more quiet contemplation)…I've tried to fix it though. To just push through until I don't feel that discomfort anymore."

Therapist: "This isn't something you can bulldoze your way through. That rarely works for anything."

Connor: "Hmmm fair….but how DO I fix it? I'd prefer not to go the rest of my life with people thinking I hate being touched."

Therapist: "Time. And a lot of compassion for yourself."

Chapter 7: The People

It's raining outside. I watch the lightening light up the sky every few seconds. I am in the middle of reading Harry Potter and the Chamber of Secrets to my group when I hear a radio call. "Is anyone available to come to Debris Shelter? We might have a medical emergency." I've made enough emergency radio calls of my own to know when a staff is in trouble. The individual making the radio call was a first-time lead staff…and she was gorgeous. I had quickly developed a soft spot for her. I pass the book off to a co-staff to finish reading. Most of my kids were still awake and had heard the radio call. "Hey everyone, I need to go help another group. I'm not sure what is going on, but I better not get a radio call forcing me back here. Everyone got that?" My group, this group of kids in particular, could be a wild card on the behavioral scale, but I was pleasantly surprised when all the kids replied with serious nods and oks. One kid even said, "Will you let us know that everyone is ok when you get back?"

I throw on my bright orange rain jacket and rain pants and head out into the storm. I walk the quarter mile to the camp site to a rather unusual scene. All the students and staff are sitting in a circle under a tarp strung up between various trees. Some students are half in their tents while others are already laying down ready for bed. The lead staff pulls me aside and tells me that while the group was attempting to hang their food bags in a tree for the night, a branch had snapped and fallen on a student's head. The student was now complaining of severe head pain. With every clap of thunder, they would clutch their head, as if to further exaggerate what had happened to them.

I didn't really know how I could be of much use with a head injury, especially one that may or may not be real. I asked the lead staff what she needed from me. "Can you help watch my group while I go call PR?" I sat with the group while she walked off to find cell service. I checked some feet for blisters and helped pass out some hygiene products for the campers to use. I went to look at the branch that fell on the kid's head to see how big it was. It was small. The lead staff returns with little help from PR. "Just monitor them throughout the night". An easy request to ask but that means that a staff will be waking up every hour to check on the student. The student still flinched with every thunderclap.

The kids all zip up their tents and the four staff convene away from the tents. I felt useless. I felt like I did nothing to help. I watch as one of the staff opens their arms for a hug and the lead staff falls into them. I feel weird. Out of place. I'm not much of a physical touch person. Especially on shift. I'm suddenly aware how soaking wet I am and how badly I probably smell. But I want to hug her. To provide some form of comfort. She comes out of the hug with nervous laughter. We all have nervous laughter. "I'm sorry I didn't do more." That's all I managed to get out. "No no no. Just having you here was helpful. Thank you for coming". I walk back to my group, excited about that little encounter but frustrated that I felt so useless during the incident. I arrive back at my cabin and slip out of my soaking wet rain gear still thinking about the incident. I leave my radio on and place it right next to my head, hesitant yet eager for another radio call. As I settle down for bed, there is one student who is still awake, and they silently ask me "Hey Connor. Was everyone ok?".

"Yea buddy. Everyone was ok."

I think fondly about this day a lot for different reasons. A strong sense of melancholy that I can never quite grasp. I fell in love that night.

My mind always wanders to what I believe was the most powerful aspect of working in Wilderness Therapy: the people.

Spring 2024 – A Conversation between my therapist and myself

Connor: "I don't like calling it this because I don't like comparing myself to people who have experienced actual combat and watched people die…but it feels like survivors' guilt sometimes."

Therapist: "You don't have to call it that if you don't want. But why do you say that?"

Connor: "I don't feel guilty about not getting hurt as much as some of my co-staff were. I was faster. I didn't trust the kids. I always gave them an extra foot or two when they were upset. I was lucky. I think….I didn't like seeing my staff get hurt. You know? The staff only had to look after the kids. But as the lead staff, I had to look after the kids AND my co-staff. And I watched some good friends get hurt. That's why I hated working with a new staff. It was like adding another kid to the group. I didn't even really care to try and make friends toward the end."

Journal Entry – October 13th, 2023.

If there is one aspect about this trip that I am disappointed about, it is that not everyone could make it. I was excited to spend time with these people. I was excited to see what conversations happened between new friends.

I always called the field instructors I worked with a "collection of lost souls". People from all walks of life who stumbled into this field, much like myself. People looking for direction or just looking for a summer job. I met many wonderful people who were amazing field staff who had better, authentic connections with students than I ever could dream of.

I think about the friendships that ended early because of this job….

I worked with a staff who was a wonderful, jolly human being and I watched as a child jumped on his back and choked him until we pulled the child off him. He quit soon after that. I have a friend who had their collarbone broken by a student. Another, their nose. I watched a staff be escorted to their car, blood dripping down their face after a student hit them in the head with a large rock. Staples were required for that one. Another friend of mine, bleeding from their head after having a rock thrown at them while trying to de-escalate a student. A staff member who almost lost an eye trying to deal with an incident. Scars from bite marks on the forearms of another. And that's just the physical wounds.

But I also think of the moments with field staff that bring me extreme joy…

That night out in the rain with the broken branch. Making pancakes at 5am Christmas morning with other staff. Playing Dungeons & Dragons late into the evening. Having a staff vs. students snowball fight and getting a little carried away. The late nights dealing with an escalated student together. The starry nights on the Parkways. And countless others.

I miss the team aspect I had while in the field. We were all in it together. No one was out for themselves. We worked together and my co-staff's success was my success. We had each other's back. I remember a day when we were dealing with a pretty violent student. It was late into the night and another staff member and myself were out on a porch trying to de-escalate this child. The student took a big swing at me that I was not expecting or prepared to block, and the other staff stepped in and caught it and said, "We don't hit Connor." That was the first time in my adult life that someone stood up for me.

I designed this trip with the intention to connect field instructors with other field instructors. The community aspect is what gave me strength in the field and I'm hoping it does that for others as well.

So far, my favorite part of this trip has been the conversations. Talking while hiking keeps my mind occupied and in a positive direction. There have been moments where I am discussing an aspect of wilderness therapy or telling a story and instead of someone laughing about it, I receive validation. Something I'm not entirely used to when telling my stories. The mood has also been very light and upbeat. I was worried about the weight of the conversations and how exhausting it could be constantly discussing traumatic events.

My time in wilderness therapy is done. I have no desire to go back into the field in any role. But I miss the people. I felt aspects of that today. Hiking and setting up camp together. Sharing food. Discussing our past experiences openly with someone who understands. Working together to build a fire. Sharing the best spots to go poop.

For so long I felt isolated and alone in my feelings. Believing that no one understood my experiences. It was the community aspect that kept me sane while in the field and I think it might be the community aspect that helps me better understand my stories and gives me the confidence to share them.

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