

Tell cancer to take a hike: post traumatic growth on the trail to recovery

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Abstract:

This study focuses on posttraumatic growth (PTG) in patients and survivors of cancer through their participation in a hiking program. Major life crises like cancer can significantly challenge or destroy one's sense of self, thus necessitating the need to find PTG during the treatment and recovery process. Building on the fundamentals of nature therapy and support groups, the hiking program created a non-traditional resource for people with cancer and survivors outside of medicalized venues to attend to their needs of meaning-making and PTG on their trail to recovery. As many participants did not find the structure and/or 'problem-focused' feel of traditional support groups to their liking, the hiking group served as a welcomed resource for coping and living a healthy life. Hikers found that their participation in the hiking group led to a normalization process that helped them acclimate to their 'new normal' as either a patient of cancer or survivor.

Keywords: Cancer | leisure | nature | posttraumatic growth | support groups

Article:

"My diagnosis came from a doctor I had never seen before because no one I knew was there that day to tell me. And as I was leaving the hospital, walking down the hallway with the gray carpet, looking into the offices as I passed by them, no one would look at me; it was as if they knew. I got to the lobby, ready to leave and start my life as an old lady with cancer, and the woman at the desk said to me: 'We have a survey we'd like you to complete.' I thought to myself, 'Are you kidding me?' But being the proper southern lady that I am, I did it. I couldn't help but laugh; gallows humor for sure. It was right then and there that I knew if I was going to get through this, I was going to have to make the best of it." – Paula (70, breast cancer)

Introduction

Cancer is an international health concern that occurs at an alarmingly high rate. In the United States, females have a 38% chance of developing cancer in their lifetime, and males have a 42% chance (American Cancer Society, 2018). According to the American Cancer Society, it is estimated that nearly 1.8 million new cases of cancer will be diagnosed in the year 2018 alone. And while the 5-year survival rate is 69% for the period ending in 2013, up from 49% in the period ending in 1977, it is estimated that nearly 600,000 people will die of cancer in 2018 in the United States. In Canada, there were more than 200,000 new diagnoses of cancer in 2017, with a 60% 5-year survival rate. Roughly one in every two Canadians will be diagnosed with cancer in their lifetime, with one in four succumbing to the disease (Canadian Cancer Society, 2018).

In spite of these ominous numbers, it should be emphasized that there were 15.5 million Americans with a history of cancer alive as of 1 January 2016. In Canada, in 2013, there were roughly 800,000 people with a history of cancer still living, and this number is expected to grow. While survival rates and medicalized treatments have greatly improved, the disease continues to be an omnipresent force in our society that often controls the life narratives of those who are diagnosed with the disease (Karnilowicz, 2011). Because of this, there exists a great need to understand how to help those in recovery through complementary programs that occur *outside* of medicalized facilities, suggesting that new social support programs are necessary to help survivors adjust to new identity roles that are brought on by their battle with cancer (Glover & Parry, 2009).

People with chronic illness often experience a dissolution of their sense of self upon the diagnosis of a serious disease like cancer (Charmaz, 1983). Unfortunately, for many, once a diagnosis of cancer has been determined, individuals often begin to see themselves first as a 'patient,' and no longer the person they were before becoming sick (Alonzo, 1979; Benzein, Norber, & Saveman, 2001). It is essential that those who are diagnosed with cancer be given numerous modes of support within their community to help reestablish their original sense of self in order to maintain a positive outlook which has been shown to be beneficial to the recovery process (Bixler, 2014). Coleman and Iso-Ahola (1993) defined social support as a sense of feeling cared for by others, and the perception that when the support is needed, it will be available (Glajchen & Magen, 1995; Glover & Parry, 2010; Parry, 2007). Equally so, the link between leisure participation and its implications on health more broadly has also been well-established (Henderson & Ainsworth, 2002), suggesting that making more leisure-oriented support systems available will lead to better health outcomes for those with cancer.

This study focuses on posttraumatic growth (PTG) in patients (those still in treatment) and survivors of cancer (those in remission or no evidence of disease). PTG has been defined as a 'positive psychological change experienced as a result of a struggle with highly challenging life circumstances' (Tedeschi & Calhoun, 2004, p. 1). The process of PTG is initiated by a major life crisis like cancer that significantly challenges or even destroys one's sense of self (Tedeschi & Calhoun, 2004). It is through community support groups that operate in 'therapeutic landscapes,' natural views and landscapes that positively affect one's mood like public parks (Williams, 2002, p. 148), where we may be able to aid in the process of 'cognitive rebuilding,' the changed reality of life after trauma, (Tedeschi & Calhoun, 2004, p. 5) for those affected by cancer, thus stimulating the process of PTG. What this study sought to surmise was, how can a hiking support group affect posttraumatic growth after diagnosis of cancer?

Literature review

Hiking and leisure

Hiking has been called an ‘appreciative’ activity due to its non-consumptive nature where the focus is primarily on the enjoyment of time spent in natural environments (Svarstad, 2010, p. 92). Early research on the importance of hiking to recreationists established that the accessibility and lack of skill required makes the activity a popular one with few barriers (Fesenmaier, Goodchild, & Lieber, 1981), especially to those who reside or have access to semi-rural or wildland-urban interfaces (Kil, Stein, & Holland, 2014). Regardless of proximity, hikers have been shown to establish feelings of attachment to the trails they traverse (Kyle, Graefe, Manning, & Bacon, 2003). Hull and Stewart (1995) demonstrated that the ‘experience’ of the landscape while hiking was of paramount importance to the mood and satisfaction of the hiker, and these sensations can be carried into life off the trail (Svarstad, 2010).

As is the case, frequent immersion in nature has been linked to higher reports of perceived wellbeing (Capaldi, Passmore, Nisbet, Zelenski, & Dopko, 2015; Harmon, 2018). The positive effects of exposure to natural environments has been found to help people work through problems in their lives (Mayer, Frantz, Bruehlman-Senecal, & Dolliver, 2009), thus making participation in regularly scheduled hikes a significant opportunity to find healing and catharsis over time. In Goodwill, Peco, and Ginther (2009) study on hiking for people with spinal cord injuries, the authors suggested that ‘recreational activities [like hiking] may hold unique value to those with disabilities and that these unique values may not be reflected in the cultural norms’ of traditional support systems (p. 53).

Nature-based therapy

Nature therapy is a health promotion method that renders a state of relaxation and seeks to promote and maintain health through exposure to natural environments (Song, Ikei, & Miyazaki, 2016). Morita et al. (2007) stated that forest environments are therapeutic landscapes, echoing earlier work by Kaplan (1995). Natural environments are therapeutic through their potential to create opportunities for people to find meaning and support, as well as ‘recollective’ by reestablishing the human-nature connection (Wolsko & Hoyt, 2012, p. 11). Lee et al. (2014) posited that since humans have evolved in, and alongside, natural environments, it makes it easier for people to draw on their exposure to wilderness to facilitate states of physiological relaxation and stress reduction.

When individuals are diagnosed with cancer, their lives are greatly disrupted and require support mechanisms to help find, facilitate, and conserve their attention, allowing them to take the necessary steps to overcome their illness (Cimprich & Ronis, 2003). Numerous studies have documented the potential of immersion in natural environments to attend to needs of those diagnosed with cancer (Chalquist, 2009; Park, Furuya, Kasetani, Takayama, & Kagawa, 2011; Shin, Yeoun, Yoo, & Shin, 2010; Tsunetsugu, Park, & Miyazaki, 2010), which can lead to people with serious illnesses like cancer being able to find growth post-diagnosis (Glover & Parry, 2009).

Cancer support groups

Support group participation for those diagnosed with cancer has shown numerous benefits, including improved communication skills and coping mechanisms, as well as an improvement in the patient's overall psychological wellbeing (Docherty, 2004). Peer support also helps to buffer against the impact of stress associated with diagnosis (Hoey, Ieropoli, White, & Jefford, 2008). Support groups allow those afflicted with cancer to compare their diagnoses, treatments, and associated hardships with others who have been, or are currently going through, similar situations, thus allowing a 'normalization' process to take place (Campbell, Phaneuf, & Deane, 2004, p. 3). Additionally, those with adequate social support have longer survival rates and lower levels of reported loneliness (Yildirim & Kocabiyik, 2010). Ussher, Kirsten, Butow, and Sandoval (2006) suggested that empowerment is closely associated with participation in support groups, and is derivative of three processes: motivation, which is associated with finding meaning in life; mastering one's illness through the development of skills and knowledge; and the transformation of thought through acceptance of the illness as a mechanism to overcome it.

And while the majority of evidence points to support groups being significant to the outlook and wellbeing of *most* people diagnosed with cancer, others are wary of participation in groups focusing on cancer diagnosis and recovery (Winefield, Coventry, Lewis, & Harvey, 2003). Some people find support groups to be stressful in their own right, further compounding the hardships associated with diagnosis. Patients can be turned off to participation because other participants, or their medical situations, are depressing, thus affecting the willingness and desire to participate (Winefield, et al.). This aversion to traditional cancer support groups is important to note, as Winefield et al. point out, because society needs to develop a better understanding of how to get the most beneficial support resources to people based on their need and preference. There exists a need to find and develop multiple options and opportunities for peer support for those battling cancer, because just as the disease affects everyone differently, so too does the treatment and the support mechanisms needed.

Posttraumatic growth

Posttraumatic growth (PTG) has been characterized as a strong sense of self associated with a psychological maturation process after trauma that leads to greater personal meanings and hope for the future (Arpawong, Oland, Milam, Ruccione, & Meeske, 2013). It is believed that survivors of cancer should be encouraged to discuss and make sense of their illness experiences in accordance with their goals and values, helping to normalize the experience of life with cancer and life after cancer (Connerty & Knott, 2013), thus aiding in the maintenance or reconstruction of one's identity. Researchers have found that people diagnosed with cancer need to engage in 'cognitive processing,' or a personal 'detoxification' of the impact of the trauma, (Park, Chmielewski, & Blank, 2010, p. 1139) which can then lead to 'cognitive rebuilding' (Tedeschi & Calhoun, 2004, p. 5), an essential component of PTG. Without engaging in these processes, patient's identity may further solidify with their illness, leading to loss of agency and a lack of a sense of control in their lives (Karnilowicz, 2011).

It is not that growth automatically occurs as a result of a trauma or diagnosis like cancer, but through the individual's 'struggle with a new reality' that leads to a determination to overcome their illness (Scrignaro, Barni, & Magrin, 2011, p. 829). Morris, Campbell, Dwyer, Dunn, and Chambers (2011) found that to initiate PTG there must be a diverse array of options available to patients, and that their illness, cancer, should not always be the focus. In tandem with this, by embracing a 'salutogenic' approach that focuses on the factors that support and encourage human health, instead of those that caused the disease, patients may be able to offset the negative effects that coincide with diagnosis (Gianinazzi et al., 2016). This can lead to some diagnosed with cancer to find the illness experience to have benefit in their life because it leads to the exercise of control and intentional actions of embracing a positive outlook found through existential growth (Antoni et al., 2001). To understand the role of immersion in natural environments as a resource for social support, meaning-making, and PTG, Kleiber, Hutchinson, and Williams' (2002) four properties of leisure as a coping mechanism are applied: leisure to buffer the impact of negative life events by distraction; to generate optimism; to facilitate reconstruction of one's life story; and to serve as a vehicle for personal transformation. As research on the potential for leisure to facilitate PTG has been conducted in numerous areas (Chun & Lee, 2010; Morris, Chambers, Campbell, Dwyer, & Dunn, 2012; Shannon & Shaw, 2005), this suggests the importance of expanding opportunities for non-traditional forms of support for those battling cancer or coming to terms with their 'new normal.'

Methods

Background of study

A twice weekly hiking program for people with cancer, survivors, and their caregivers was started in the late fall of 2016 and takes place year round on Wednesday and Saturday mornings. Wednesday hikes are geared towards individuals who may not be working, as well as individuals with balance, stamina, and/or physical strength limitations. The midweek hikes are typically one mile, but can be as long as two miles depending on the participants and their health. Saturday hikes are roughly four miles and geared towards individuals who may still be working and individuals with higher levels of physical ability. There have been thirty-seven participants to date, with twenty-one having participated in at least ten hikes (most have participated in 25 or more, however).

The program was instituted by the author, and he is the primary facilitator of hikes. Participants are referred to the program from the nearby cancer center, [insert name here], by oncologists and clinical social workers. The program is promoted through the first author's appearances at support groups at the cancer center as well as through informal partnerships with other local organizations, including the Livestrong Foundation and a non-profit arts-based cancer support group, [insert name here].

The hiking program does not focus on the cancer experience or treatment in that participants are not expected to talk about their illness or treatment regimen. It is implicit why people are there as most are referred through the local cancer center. Participants do, however, often candidly talk about their illness experiences matter-of-factly while hiking. Oftentimes the hikers will confide

in the author about the benefits they derive from participation, directly and indirectly referring to their involvement as therapeutic due to the catharsis they find in nature.

Participants

Interviews were conducted with twelve participants, two males and ten females, with an average age of 67 years old. All participants either had cancer or were in remission. Nine of the participants were white, two were black and one of Hispanic ethnicity. Pseudonyms were assigned to protect identity. The hikers found out about the program through either the nearby cancer center, or a local nonprofit arts-based cancer support group. All hikers were told about the research agenda behind the hiking program on their first hike, though they were not asked to participate in an interview until they had been out on a minimum of ten hikes. Because of the hike quota before asking for an interview, participants were chosen using purposive sampling (Patton, 1990) based on informal discussions while hiking about their experiences with cancer and the importance of the hiking program to their lives.

This manuscript focuses on four of the participants' 'stories' so as to emphasize their agency as people who have overcome, or are currently fighting, cancer. This helps to limit the reduction of the individuals to 'sound bites' and 'points of emphasis' by giving more depth on the experiences of the selected hikers.

Bill, Glenda, and Paula had been hiking since their childhood, but Glenda was the only one who hiked consistently without a hiatus; these three were Saturday hikers. Bill and Paula stopped hiking when life got in the way, family and career, but always longed for it. Glenda found her physical ability lessened in the face of declining health yet still wanted to hike, even if for shorter distances and a slower pace. Joy, a Wednesday hiker, had always loved nature but did not have as many opportunities to hike in her early life, largely because her family was never interested. Each one's story was compelling and articulated various aspects of growth and transformation in the face of their diagnoses. These four were often very vocal about their appreciation of nature, typically leading discussions with others about the wonder of their hiking experiences, thus helping others to take notice of the beauty of their surroundings. These data provided the foundation for understanding how cancer diagnosis, treatment, and their subsequent participation in the hiking program affected PTG in their lives.

Interviews

Semi-structured interviews were conducted with each participant following a pre-established set of questions to understand their historical relationship to nature and leisure, their diagnosis of cancer and accompanying treatment program, participation in the hiking program, and their outlook for the future. Some of the questions asked include: How important is being in nature to your quality of life (QOL)? How would you have described yourself pre-diagnosis of cancer? How would you describe the feeling of being diagnosed with cancer? What have been the best support mechanisms in your recovery process? And, how has participation in the hiking program affected your life? Interviews were conducted in public spaces of the participants' choosing, typically coffee shops or bars, and two were conducted during one-on-one hikes. Interviews typically lasted about an hour, though several lasted up to two hours. The informed consent and

interview guides were approved by the university's institutional review board. All interviews were recorded and transcribed by the author.

Participant observation and informal discussions

The author undertook this investigation as both a participant and an observer. The author participated in the majority of hikes (and was assisted by graduate students who served as 'guides' in his absence), floating between hikers throughout the duration of the outings to establish and build meaningful relationships rich in context. As an observer, the author made mental notes during participation in order to write up more expansive field notes after each hike (Tracy, 2013). The informal discussions that took place on hikes often led to topics to be followed up on, as well as specific issues to address with participants at interviews. All notes and jottings then became a part of a larger field journal for the project. The field journal contained notes from more than sixty hikes with the hiking program.

Data analysis, interpretation, and representation

Data analysis occurred through a back-and-forth examination of data using both an inductive and deductive process (Crotty, 2010). The analysis process used a primary and secondary coding technique which was derived from thorough re-readings of the interview transcripts and field notes, making notes and categories of patterns and comments of interest. Primary codes were assigned, when possible, using *in vivo* terminology (the language of the participant). Primary codes were then grouped into specific categories using focused coding (Tracy, 2013).

Deductive analysis occurred through further categorization of data within the structure of Kleiber et al.'s (2002) framework and comparison of participant comments with the PTG concept. Inductive analysis occurred through viewing each individual's illness experience as unique in its own right. This involved developing an understanding of the personal story of cancer from diagnosis through treatment, and as applicable, remission or health maintenance.

The data were managed by establishing which content spoke to the research question, and then grouping the data into themes (Saldaña, 2012). Four participants' narratives were employed to illustrate how PTG was found through participation in this meaningful and ongoing leisure activity. The rationale for attributing participants to 'themes' was to avoid the reduction of the individual to aspects of an illness. In qualitative research focused coding often generates the 'themes'; in this instance, 'participant as theme' demonstrated the subjectivity of the illness and recovery experience by paying respect to the complete person and not elements of the illness or the treatment process.

Trustworthiness

Validity and reliability was established for this study through member checks and external expert review (Crotty, 2010). The author informally spoke with each of the participants on several subsequent hikes once the analysis and writing process commenced. The purpose of this was to confirm the accuracy of how the data were interpreted. Additionally, an impartial qualitative observer (i.e. one who was not affiliated with either the hiking program or with the writing of the

current paper) reviewed the coding categories, asking for clarification about rationale and application when warranted.

Results and discussion

“I remember one time when I was at my oncologist’s office for tests. I was completely naked in front of her with a tube up my frontside and one up my backside; it was humiliating. I thought I had been reduced to a lab experiment and this is what I had to look forward to for the rest of my life. I left that office feeling emasculated and defeated; it really was one of the lowest points in my life. Now here I am today, getting the opportunity to hike every week on different trails, meeting nice new people and making friends. This really has been the best thing to happen to me this year.” – Bill (71, prostate cancer)

Bill

On the very first hike for the hiking program, I¹ met Bill (71, prostate cancer), an Ivy League graduate with a master’s degree in theology who was an avid reader of nature and backpacking novels. The program had been available for several weeks, but it was not until Bill contacted me in December of 2016 that I had my first hiker. He filled out the online registration and provided me with a brief history of his experience with hiking and comfort level in the wilderness. I met Bill the following Saturday in the parking lot at the trailhead, and within two minutes he told me that he was both impotent and incontinent. These were the sort of conversations I had expected to have, and had in the past with a similar style program I volunteered for in Colorado, but nonetheless it was an abrupt way to start a friendship. Bill told me he was diagnosed with prostate cancer twelve years earlier and had to take three hormone therapy shots a year to control its growth. He did not consider himself a ‘survivor’ if for no other reason than he still had cancer and would always have it, but he also feared what would happen when the shots were no longer effective. He was still working fulltime, and this was solely to keep his insurance; he knew he could not afford the treatment otherwise.

When I asked him what prompted him to reach out and come hiking, he said that he did not want to be complicit in leading a sedentary lifestyle any longer. Hiking was something he had done for much of his life only to have abandoned it years ago, and he was well-aware that if he was ever going to do it again, the time was now. Bill reflected on his past excursions, stating, ‘There was a time when I would go out for 8–10 mile hikes, several days a week. Then as time went on, it became less and less, until eventually, I had just stopped going.’ As an avid reader of hiking and backpacking memoirs and novels, Bill had come to live somewhat vicariously through the stories on their pages; however, he no longer found them to be as fulfilling and was grateful to find the hiking program.

In one of our first discussions, Bill referred to an encounter with his oncologist about treatment options, with Bill responding, ‘I am willing to do whatever it takes to save my life.’ His physician countered that he had to complement the medical treatment with activities that were healthy and personally fulfilling. And while it was several years before Bill went hiking again, he responded to the availability of the hiking program that, ‘I knew this was what I needed in my

life; a chance to get out in nature and do what I used to love to do so long ago. Only now it's more important because I need it to help keep me healthy, maybe even alive.' Bill fully embraced two of Kleiber et al.'s (2002) properties, both in his attempt to divert his attention from negative feelings associated with his illness and treatment regimen, as well as by his intentional action to generate hope for the future by becoming re-immersed in an activity he once found significant to his sense of self (Castonguay, Crocker, Hadd, McDonough, & Sabiston, 2015).

Song et al. (2016) remind us that having accessible green space for walking is a cost-effective method for improving QOL and health, and because of the abundance of trails and their ease of accessibility, the residents of [this city] are fortunate to have multiple opportunities for healthy exercise in restorative natural environments. Related, immersion in nature has also been demonstrated to increase the longevity of senior citizens, with one of the health aspects being closely tied to the reduction of stress that may be associated with illness or treatment (Lee et al., 2014). Bill was still working fulltime, past when he had hoped to retire due to the expenses associated with his cancer-related medical care, and he was also responsible for taking care of a family member who had medical issues of her own. For Bill, he needed a healthy, positive outlet to develop his life coping skills and help him navigate the hardships in his life (Campbell et al., 2004), and this came in the form of frequent escapades onto the local trail system.

While Bill described himself as somewhat of a loner, he was quick to admit that he did need and want social support in his life in some areas (Chun & Lee, 2010). While he had accepted his illness and the associated treatments that had become ritual for over a decade, he was still troubled by what might lay ahead. A deeply religious man, he confided in me that he wanted to live a long time and was not yet ready to 'admit his mortality.' This admission was interesting for two reasons: one, it has been reported that females cope with serious illnesses better than males (Gianinazzi et al., 2016), which Bill confirmed in some regards (not to mention being one of the few regular male participants), and two, that his identity was in some ways still connected to the cancer diagnosis that he had not yet transcended (Karnilowicz, 2011). However, Bill did know that he wanted to enact his agency and take control of his life narrative, and he hoped to find that potential through the hiking program (Tedeschi & Calhoun, 2004).

Paula

"There's too much focus on the illness experience these days. It's bad enough that you get the dang disease, now we have to wallow in it? Uh-uh, no, sir, not me. I never would have anticipated getting that kind of cancer, but when I did, and I had to go through chemo – which was antithetical to how I live my life, but I had no choice – I wasn't looking for a pity party, I was looking for creating more opportunities for self-care, some TLC. Anything you can do to be connected to yourself during treatment is a good thing, but what you don't need is to give yourself over to the cancer."

Paula (70, breast cancer, double mastectomy) was an early member of the group as well. She first came out in January of 2017, and she too was hopeful to rekindle a love for past time spent in the wild. She had 'grown up in the woods' and had always tried to stay immersed in them, but there were simply times in her life when she did not have access to the resources that she did now. The environment was very important to her, and the conservation of it was something that

she spoke about frequently. For Paula, she fully embraced Kleiber et al.'s (2002) third property of using leisure to connect to her past, as well as to reconstruct her life story. Paula was looking for continuity in her life, but she had always been hesitant to go hiking on her own; she did not always feel safe doing so. She was hoping to find the inner-strength and courage to be able to venture out into the woods on her own, but first she would need to become more comfortable in the environment with others. In short, Paula was looking to empower herself, and to do so she needed a stable peer support group to help her embrace her potential (Ussher et al., 2006).

I asked Paula how active she had been in the existing cancer support groups in town; she said she had gone once and that they were not for her. Docherty (2004) and Winefield et al. (2003) found this assertion to be true for many: some existing support groups' focus too much on the illness, and as described by Paula and several other participants (Clara, 59, breast cancer; Glenda, 68, breast/cervical cancer; Annie, 67, breast cancer), are both depressing and antithetical to living a healthy life. Docherty (2004) emphasized that sometimes an 'impartial mediator,' such as someone not directly connected to the medicalized aspects of the cancer diagnosis and treatment process, can be beneficial to those afflicted by cancer; a role I seemed to fill for many. Equally so, not making the illness the primary focus helped patients in their normalization process (Campbell et al., 2004; Morris et al., 2011; Winefield et al., 2003).

Ultimately Paula was looking for a stronger sense of self and to build on her already positive disposition and mindset (Arpawong et al., 2013). She had already come to terms with her mortality and had assessed her life in an overall positive manner. Paula was an active 'detoxifier' of the cancer experience (in that she wanted to eradicate its negative impacts and presence in her life), and she was continually processing her experiences and what they meant to her life now (Park et al., 2010). For Paula, she openly embraced, if not directly acknowledged, the act of 'cognitive rebuilding,' and finding a new narrative for herself to follow into the future (Kleiber et al., 2002; Tedeschi & Calhoun, 2004). Paula closed our interview with this comment: 'It's (cancer) a chunk of experience like any other trauma. It's always in there and you go back to it for whatever reason, but it's a jumping off point too. Who knows, I may get it again, but if I do, it will not be my narrative. Only I will write that.'

Glenda

"When I got the diagnosis, it was mentally disturbing. I just assumed that because of the diagnosis there were whole aspects of my life that would no longer be accessible to me. And now that I'm Stage IV I'll be in treatment for the rest of my life. I remember talking to my doctor about what I thought I could no longer do physically, like bicycling, swimming, and hiking; it was defeating. But he simply asked me, 'Why can't you do those things?' I paused for a second and said to myself, 'Yea, why can't I do those things?' And here I am every week, hiking, biking and swimming. I want to take advantage of the rest of my life – not wallow in it." – Glenda (68, breast/cervical cancer, metastasized)

Glenda would not strike anyone as a 'free spirit' upon first – or fifth – meeting, but after you get to know her, you find that she has a deeply embedded 'hippie' ethos. While she is open to chatting with people on the trails, just as often she will amble along somewhere in the middle by herself, occasionally stopping to touch the trees and 'feel their energy' as she puts it. I asked her

what it was she thinks about during those times when she journeys solo within the group, and she said, ‘It’s a feeling of freedom. Freedom from society. I really do love nature. It’s fresh, it’s pure. Hiking is more mental for me; it is calming and regenerating. Mostly I just think about how lucky I am to be able to experience the wilderness – and to be alive.’

As illustrated in Glenda’s vignette to start this results and discussion section, she had a tough time coping with the diagnosis and what it meant for her QOL and lifestyle. While she certainly considered the things she might no longer be able to do, she soon came to reframe that focus to what she *could* do going forward (Shannon & Shaw, 2005), thus embracing Kleiber et al.’s (2002) fourth proposition of using leisure as a vehicle for personal transformation. Glenda, in a sense, adopted Karnilowicz’s (2011) assertion of the importance of ‘psychological ownership’ of illness, in that it must be embraced as a turning point for positive action. Karnilowicz went on to say that psychological ownership is a socially shared reality that can be enhanced through collective interaction; the more people have positive exchanges with others in meaningful leisure activities, the more likely they are to develop better outlooks and grow from their negative life event (Morris et al., 2011, 2012).

Towards the end of our interview I asked Glenda for a closing comment. She grinned, let out a brief smile, looked out into the sun and was silent for a moment. She then turned to me and said, ‘I feel happiness in nature. I feel happiness when hiking. Sometimes it is better to be with people in nature and not talk. Share the experience and the awe; that is restorative and beneficial, both personally, and to the friendship.’ For Glenda and many others, the hikes were a ‘retreat’ from their medicalized experiences (Glover & Parry, 2009) where they could find both friendship and solitude in safe, beautiful, natural environments with people who had gone through similar experiences. And while their illness and treatment regimens came up from time to time, they were never the focus of the hikes. It was implicit why everyone was there, and there was no need to say anything further unless you wanted to (Morris et al., 2011). Immersion in nature, then, allowed participants to revel in awe through the therapeutic and restorative elements of the local wilderness landscapes to celebrate their trail to recovery (Wolsko & Hoyt, 2012).

Joy

“Remember that trail we did on my second hike, the Peninsula Trail, I think? Could we go back there soon? I just remember when I set foot on the firm but supple soil I wasn’t sure whether or not my walker would support me, but it was as if a soothing calm transferred from the earth to my body. It was simply rejuvenating. I’ve been having a struggle with my chemo lately, so I could use that again real soon!” – (email from Joy, 58, breast cancer and osteosarcoma)

One of the clinical social workers at the nearby cancer center invited me to speak and sit in on a Stage IV cancer group meeting shortly after I started the hiking program. She told me that everyone in the room will ‘expect to die from cancer, some much sooner than others’ and that most would likely not be able to participate. She wanted me to be prepared for what I would encounter: a lot of people who were very ill, but somehow still managed to keep their sense of humor intact. I left information about the hiking program with all seven in the group, but most did not seem like it was something they would be able to undertake, even if they wanted to.

One member of the group, Joy, struck me as charismatic. She was so overtly positive that I found it hard to believe that she had as many issues as she did. What started as breast cancer had metastasized to her bones and spread throughout her body. At that point she was undergoing radiation every day, but soon was going to transition to an oral chemo medicine. She grabbed me at the end of the meeting and said, 'I don't know if I can keep up, but I want to try.' Joy had a long and harrowing journey of illness and complications, and while she was often confronted with death, she sought to make the best of her life in the time she had left (Martin & Kleiber, 2005). She emailed me later that day, and wrote:

I no longer have cancer in each of my pelvis regions; it's gone from the two spots in my spine, and now from my breast and lymph node. My cancer is breast to bone. I am using assistive devices for balance based on my adrenoleukodystrophy (a genetic disorder that leads to dysfunction in the adrenal gland). This was diagnosed about 10 years ago and I was told that over time, my balance and lower extremity strength would become weaker. It's important that I stay active in order to stay strong. I miss sports like tennis and cross-country skiing, but love the outdoors so I'm hoping I can participate in your program.

Joy was certain she could not keep up with the group on Saturdays because of the pace and distance. She also spent as much time on the weekends with her husband as she could, so that made it harder for her to come out. Though I had planned to start a midweek hike, at that point I had not yet; not until I met Joy. We settled on Wednesdays as the best day for her because of her numerous treatments.

It was a brisk early February morning when Joy and I met up for the first time. We met on a paved 'trail' to accommodate her walker and meandered along the greenway taking in the scenery. We learned a lot about one another on that first hike, and her positive spirit was infectious; it still is every time I see her. She told me that when she was first diagnosed with breast cancer she was in shock. When it later spread to her bones, she was traumatized. She described herself as a 'ghost' when she would go to treatment and support groups, scared of what was happening to her, always worrying that she was 'on death's doorstep.' But somewhere she decided she had a choice in the matter: to accept her state and be positive, or to accept her state and be negative. From then on she embraced her positive disposition, one she had proudly displayed before her health issues started (Martin & Kleiber, 2005).

Joy said that her ability to have a positive outlook was in part due to the resources available to her. She was active in her church, participated in the Livestrong program, walked in her neighborhood with friends whenever possible, and was now hoping to become a fixture of the hiking program. In short, she wanted to 'balance [her] life with just as many positive inputs as there are negative ones, hopefully more.' In doing this she felt she would become more 'hopeful and optimistic' because she would be 'constantly reminded of the good in the world' (Hutchinson, Loy, Kleiber, & Dattilo, 2003). Joy was also in the early stages of establishing a traditional cancer support group at her church. She wanted to help others 'see the beauty' the way she had become able to; something she found to make all the difference in the world (Morris et al., 2011, 2012).

Joy embraced all of Kleiber et al.'s (2002) four properties of leisure as a coping mechanism: to buffer the impact of negative life events through providing healthy distractions; to generate optimism; to facilitate the reconstruction of one's personal story; and to serve as a vehicle for personal transformation. Joy would be on oral chemo for the remainder of her life since her 'cancer is not curable' – but she did not want that to define her or her enjoyment of life. Because of this she sought out growth, and for her, the hiking program became a staple of her ability to continue to look to the future with hope.

Limitations and future directions

A limitation of this study includes the dual role of researcher and hike facilitator of the author. Because of the closeness of author and hikers, it is possible that those who participated in interviews responded in ways that were perceived as 'desirable' by the author. Another limitation is that this study involved approximately only one third of the participants (to date); those other hikers may have entirely different responses in regards to their participation. Finally, there have been a number of people who have come out for only one or two hikes. Developing an understanding about why they did not return could help to improve both the hiking program and other non-traditional support options for people diagnosed with cancer.

Future studies in this area should explore whether or not the program encourages autonomy in other areas of leisure, including hiking on an individual basis and other forms of self-empowerment that facilitate PTG. Another important area for future research would be to work closely with oncologists to see how participation in the hiking program corresponds with clinically measured improvement related to blood pressure, heart rate, cortisol levels, depression, and anxiety; this could result in 'prescriptions' for exercise in nature to help combat the ramifications of a cancer diagnosis.

Conclusion

Over two decades ago Kaplan (1995) established what makes an environment restorative. He said there were three components: being away, which involved a conceptual transformation for the individual; that the environment must have 'extent' in that it inspires a feeling of a 'whole other world'; and the need for compatibility in that the environment must fit what it is the person is trying to do or accomplish (p. 173). For the participants of this study, including those with a history of hiking and wilderness immersion and those without, the weekly jaunts out into the local trail systems provided opportunities for each element of Kaplan's thesis.

The hiking program served as an informal support group that helped participants increase their confidence and slowly alter their view of themselves from one as 'victim' to one as 'agent' of their future selves (Ussher et al., 2006). This was demonstrated by Paula when she said,

I like the fact that we're not really focused on everybody's diagnosis. If we want to talk about it we do, but I like that there is no agenda. I still like to hear people's stories from time-to-time, but I like that we don't dwell on them. The focus of the group is not to talk about the cancer experience so much. Just reconnect with what our bodies can do and that they can feel good again.

Through consistent interaction with people who had been through similar life experiences, the hikers were able to cope with the associated stress of diagnosis, treatment, and recovery (Hoey et al., 2008), as well as to normalize their life with cancer, their ‘new normal,’ or their self-identification as a survivor (Campbell et al., 2004). That they were able to do this in diverse natural environments throughout the city and county signaled for many the importance of not only having these resources, but also of being able to use them for their health and wellbeing (Lee et al., 2014; Morita et al., 2007; Song et al., 2016). The combination of having fellow travelers in natural environments helped to stimulate individuals’ personal growth as they built their lives after diagnosis of cancer through meaningful leisure in nature (Janke & Jones, 2016).

Kleiber et al.’s (2002) four properties helped to highlight the importance of leisure activities to facilitate hope and alleviate depression following diagnosis of cancer. Kleiber and colleagues stated that, ‘perception plays a powerful role in defining negative life events’ (p. 220), thus highlighting the importance of community resources for people fighting cancer or adjusting to life after diagnosis and treatment. If one perceives that there are adequate, and desirable, options for support, it follows that the coping and recovery stages following diagnosis and treatment have the potential to be more successful. While current models of cancer support groups need to continue to be available (focusing on the trauma of diagnosis and treatment procedures, often in medicalized venues), there needs to be further efforts to develop and make accessible non-traditional and alternative modes of therapy and support for people with cancer.

The experiences of the participants are evidence that therapeutic support can be found both outside in the wilderness and implicitly; the illness does not always have to be the focus of socialization and peer-group interactions (Morris et al., 2011). For these hikers, growth was found, and built, on the trail, thus suggesting that non-traditional forms of active, healthy exercise in natural environments can be a much-needed complement to clinical treatment for those diagnosed with cancer.

Disclosure statement

No potential conflict of interest was reported by the author.

Notes

1. ‘I’ refers to the author.

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