The Perfect Storm: The good, The Bad, and The Ugly of In-Patient Mental Health Recovery
(Trauma and Substance-Use): A Narrative Exploration

by

Jaylyn Leighton

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis including any required final revisions, as accepted by my examiners. I understand that my thesis may be electronically available to the public.

ABSTRACT

Given the marginalizing effects of a mental health diagnosis, individuals with a mental health diagnosis, more specifically those in early recovery of post-traumatic stress disorder (PTSD) and substance-use disorders (SUDs), are not provided opportunities to share their stories. This comes from a long-held view of the dominant medical model that currently operates within our societal systems. PTSD and SUDs were once considered to effect a small, concrete population, but has since grown to represent the greatest number of individuals accessing mental health resources (Muskett, 2014). To address this concern, complementary therapeutic modalities have begun to emerge including the field of outdoor experiential programming, nature experiences, and modalities pulled from the field of psychotherapy (Ewert, McCormick & Voight, 2001). Outdoor therapeutic practices utilize an outdoor setting to enhance an individual's physical, social, and psychological well-being through the application of structured experiential activities (Ewert et al., 2001). Yet what is not as well understood is how this type of complementary therapeutic practices can be used in an in-patient care setting. To bridge a needed understanding of the lived experiences of individuals' living with PTSD and SUDs while engaging in an outdoor experiential psychotherapy workshop, I used narrative inquiry as a platform for the 'voice in the cracks' to be heard (Jackson & Mazzei, 2005). This project describes my narrative experience of engaging in the workshop with individuals currently attending the in-patient care program for integrated alcohol and drug addiction and trauma at Homewood Health Centre in Guelph, Ontario. Focus groups and in-depth semi-structured narrative life-story interviews were used to story individuals' lived experiences of engaging in an outdoor experiential psychotherapy workshop in early recovery. Positioning this research within a pragmatic worldview, I worked towards understanding the use of complementary forms of therapeutic practices, including outdoor experiential psychotherapy, within an in-patient care setting. In turn, this will continue the conversation around the rising issues in the field of mental health recovery and in-patient care and illuminate a dialogue that brings forth the stories of individuals living with a mental health diagnosis to create positive social change.

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In line with this, I would like to thank the six volunteer participants of this study. I hope each one of you is living your lives of recovery. Thank you for sharing your stories and experiences of the workshop. I hope this thesis honours your stories and illuminates some of the complex aspects of living in recovery. My hope is that this conversation will somehow extend past the pages of this document to inform positive social change within an in-patient setting and continue a dialogue that provides a platform for the voices of recovery to be heard.

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CHAPTER ONE: INTRODUCTION

When I close my eyes and I can take myself back to that "ah ha" moment. The moment I realized this is my calling. It was nearing the end of summer and I would soon be finishing my placement at Homewood Health Centre in the Addiction Medicine Services (AMS) unit. It was a beautiful August day. The sun was peeking out behind the clouds and there was a light chilly breeze in the air. Walking to the lower grounds, I couldn't help but take in the beautiful nature around me. The tall green trees outlined the property. Behind me, stood the hospital, with its many beautiful historic buildings that only accentuated its beauty. To my right, is what is known as the "clubhouse," where individuals meet to engage in a wide range of therapeutic recreation services offered at the hospital including: baseball, volleyball, tennis etc. To my left, is the horticulture gardens with beautiful flowers, vegetables, and herbs growing. Walking down the path, I am humbled by the fact that I had the opportunity to complete my internship placement at such a beautiful hospital setting. In the moment, I find myself reminiscing on all the things I have learned about myself over the past four months, as a professional, an academic, and a human being. As a group we gather in a small clearing at the bottom of the hill, just under a tree for shade. I can sense the hesitancy coming from everyone as I begin to explain the outdoor experiential program. We dive right into the activities, starting with ice breaker activities and moving into more vulnerable trust and team building activities. After each activity, we stop to reflect on how everyone is feeling. I can feel myself in my element as we create dialogue. I smile to myself as I watch individuals make connections between the activities at hand and their own personal journeys of recovery from addictions. Following that experience, I knew that this was an important piece of recovery that was missing from in-patient settings. In concluding the activities for the day, I received positive feedback from the patients, addiction counsellors, recreation therapists, and social workers. It gave me a rush of excitement and pride to reflect on

the outdoor experiential program. As we are walking back towards the hospital, a patient by the name of Craig (pseudonym) walks beside me. From my experience of working on Craig's interdisciplinary team, Craig has been very quiet and closed off to the program at the hospital. As we begin small chat, I ask him what he thought of the program as he didn't seem as engaged as some of the other individuals. For the first time since meeting Craig, he smiled. He turns to me and says, "I haven't laughed like I did today in six years and it feels good." Reflecting on this story marks an important and critical point in my career both as a professional and an academic. It is odd to think that something that was said to me could have such a huge impact on my life. It was only one sentence. Fourteen words. Seventeen syllables. And yet, it changed my outlook on everything.

The impact of post-traumatic stress disorder (PTSD) and substance-use disorders (SUDs) within our society was once considered a small, concrete population but has since grown to represent the greatest population of individuals seeking and accessing mental health services (Muskett, 2014). The effects of PTSD and SUDs have been highly viewed and discussed in the media through various stories of the aftermath of terrorism and war, as well as stories of sexual and physical assault. From the 9/11 US Terrorism attack, the 2016 Orlando nightclub shooting, the 2017 concert bombing at Ariana Grande's concert to celebrities such as Lady Gaga coming forward to tell her story of being sexually assaulted at a young age. As a society, we are constantly hearing and seeing traumatic experiences happening around the world. Yet, what we do not hear about is the aftermath of these experiences for the individuals who live them. The research conducted on the psychosocial effects of the war in Bosnia and its aftermath for children and adolescents show that individuals who experience high-levels of war-related exposure to trauma and extreme adversity are associated with an increased risk for post-

traumatic stress disorder (PTSD) (prevalence rates ranging from 8.3% to 75%) as well as substance-use disorders (SUDs), depression and a variety of other adverse outcomes (Layne et al., 2001). Collectively this documents the growing prevalence rates of trauma-informed experiences that may lead to a PTSD-SUD diagnosis, as well as the growing rates of individuals seeking out professional help. Yet, there is evidence to support, "the proposition that many acute inpatient units are experienced as counter-therapeutic" due to their 'one-fits-all' mindset (Muskett, 2014, p. 58). To better meet the needs of individuals seeking help, as a healthcare system must work to provide complementary treatment modalities that aim to augment traditional interventions, but not replace standard practice (Wynn, 2015).

We are all the authors of our own stories. Yet, often times, individuals with a mental health diagnosis, more specifically those in early recovery of PTSD and SUDs, are not given an opportunity to share their stories due to the marginalization and stigma surrounding PTSD, SUDs, and mental health in general. Positioning this research within a pragmatic worldview, this research works to understand the rising issues in the field of mental health recovery and in-patient care and begin a dialogue that works to provide insight into the marginalization and stigma that currently surrounds a mental health diagnosis. In doing so, I hope to create positive social change and action from within this particular field and population of individuals. A pragmatic worldview works to unpack the knowledge and understanding of a social setting (Creswell, 2013). Pragmatism is not committed to any one system of philosophy, but gives researchers the freedom of choice (Creswell, 2013). "The pragmatists researchers look to the *what* and *how* to research based on the intended consequences- where they want to go with it" (Creswell, 2013, p. 11). As a researcher working within a pragmatic worldview, it allows me to explore the historical, political, and social contexts from within the field of mental health

recovery and in-patient care, to provide a platform for the 'voice in the cracks' that are so often lost in today's society to be heard. The 'voice in the cracks' is a term discussed by Jackson and Mazzei (2005) as being the individuals in society who are often rendered voiceless. Throughout this thesis, the 'voice in the crack' is something that I was drawn to as a researcher. It was important for me to acknowledge the need for hearing the 'voice in the cracks' that are often rendered silent in society. Yet, it is also important to understand the implications this can have as it assumes a difference in 'voice.' Acknowledging this, the intention behind using the 'voice in the cracks' in this research is to showcase the need to hear the voices of individuals living in recovery. In addition, it provides a platform for positive social action to occur within this particular setting and population of individuals. By un-packing and de-constructing the understandings of the conflicting medical and social models that currently exist within our health care system, my research will work to provide a study for the "people" first and foremost, in addition to the "system." Throughout this thesis it will be important to understand the shift in thinking that occurs as we move away from a medicalized understanding of care toward a social model of care. I will use this platform as a way to critique the system, from within the system with the hope of fostering positive social change for this specific population.

Literature surrounding the marginalization of voice shows that, as a consequent of society's understanding of a mental health diagnosis, individuals are seen as incompetent and unable to achieve life goals (Van Den Tillaart, 2009). Scholars argue that, "it is clear that those who are mentally disabled, those with specific addictive diseases, and those who are classified as criminals are stigmatized and remain stigmatized even after entering into and remaining in effective treatment" (Kreek, 2011, p.66). Through my experience of working with individuals with PTSD and SUDs within an in-patient care setting, I have witnessed this marginalization of

voice affect individual's personal recovery. From my experience of working at Homewood Health Centre, I came to learn that everyone has a voice, and everyone should have the opportunity to share and inspire others with their stories and experiences of early recovery. Using a social constructionism epistemological stance and drawing on narrative inquiry strategies, this research will work to create dialogue around the marginalization of a mental health diagnosis by providing a platform for individuals to share their voices, stories, and experiences through an exploration of the personal meaning derived from engaging in outdoor experiential psychotherapy.

There is an well-established link between PTSD and SUDs that is reflected in the literature (Ford & Russo, 2005; Ouimetter et al., 1998 Wiechelt & Straussner, 2015; Volpicelli et al., 1999). Although scholars have identified the complexity and commonality of a PTSD-SUD diagnosis, it has not yet been established whether any set functional relationship exists between these disorders (Conrod & Stewart, 2006). In some cases, an individual who experiences a trauma may turn to alcohol and drugs to alleviative the negative psychological symptoms they are experiencing (Ouimette, 2010; Reynolds et al., 2005). In other cases, scholars have suggested that a substance using lifestyle may predispose an individual to traumatic exposure (Reynolds et al., 2005). Regardless of the disposition of a PTSD-SUD co-morbid diagnosis, scholars have worked to understand the associated social, psychological, spiritual, and medical consequences for individuals affected by such a diagnosis (Khantzian & Albanese, 2008). This relationship between PTSD and SUDs has been well documented in the literature for specific populations including: Vietnam combat veterans with PTSD showing signs of alcohol addictions (Bremmer et al., 1996), women who have experienced sexual assault turning to alcohol to reduce symptoms

of PTSD (Epstein et al., 1998), and those receiving treatment for SUDs also meeting the criteria for PTSD (Dansky et al., 1997).

Literature surrounding effective treatment of a co-morbid PTSD-SUD diagnosis within an in-patient care setting is well documented (Brown et al., 1996; Brown & Stout, 1995; Ouimette, Finney &Moos, 1997; Ouimette et al., 1998; Volpicelli et al., 1999). Much research has explored the physical and psychological treatment of PTSD and SUDs in an in-patient setting (Brown et al., 1995; Hien et al., 1995; Ouimette & Brown, 2003; Navajitis et al., 1996). Scholars claim that the treatment of PTSD and SUDs involves simultaneously addressing both disorders as they are highly interwoven. Individuals in therapy are taught to cope with their past traumas to better cope with their daily lives (Volpicelli et al., 1999). One such treatment modality that has been used within an in-patient setting to address the psychological, emotional, and social needs of individuals has been recreation and leisure services. More specifically, therapeutic recreation (TR) is used as a conceptual tool to assist individuals in achieving optimal healthily function and independence through the design and facilitation of recreational services (Sylvester, 1987). A range of TR services exist to serve this need, including the use of outdoor and nature based therapies, adventure therapy, experiential activity, and psychotherapy.

Outdoor experiential therapy (OET) has been used in a healing context for a variety of health concerns and has moved into the realm of normative therapeutic practices (Ewert et al., 2001). The range of this type of therapy can be useful in a many different settings and with a broad array of clients (Ewert et al., 2001). OET is defined as, "a treatment modality which utilized or emulates an outdoor setting or natural environment for the purposes of rehabilitation, growth, development, and enhancement of an individual's physical, social and psychological well-being through application of structured activities involving direct experience" (p. 109). The

use and therapeutic context of OET has been acknowledged in the literature with a broad range of settings including: nature therapy with children with a learning difficulty (Berger, 2008), adventurous outdoor experiences with self-reported anxiety and depression (Kyriakopoulos, 2011), adventure-based experiential therapy with inpatients in child and adolescent psychiatry (Eckstein & Ruth, 2015), benefits of outdoor canoeing activities for vulnerable first nations children (Skwarok, 2013), and finally, the benefit for outdoor programs for juvenile male offenders (Bruyere, 2002). The growing awareness of nature-based therapy has shown the effect that nature can have on individuals emotional well-being (Jordan, 2014). The outdoors has been viewed as a co-therapist in therapy that provides opportunity for individuals to feel a spiritual connection to their environment (Berger & McLeod, 2006).

The field of psychotherapy has explored the use of the outdoors as a way to challenge traditional ideas of psychotherapy. Scholars have discussed the idea of moving psychotherapy practise into the outdoors to open up new ways of thinking and healing in nature (Buzzell & Chalquist, 2009). Pulling on ideas from different forms of psychotherapy including relational, and sensorimotor psychotherapy, as well group processing techniques to inform practice can create effective therapeutic processes for a variety of populations (Overholser, 2005; Yalom, 2005). However, what remains to be explored is how these different forms of therapy can be intertwined to explore a new way to do therapy within an outdoor setting within an in-patient context.

Despite this research, scant studies have explored the personal meaning derived from in-patient outdoor experiential psychotherapy that targets individuals in early recovery of PTSD and SUDs within an in-patient context. More specifically, what is missing in the literature is the actual lived experiences of individuals' in early recovery of PTSD and SUDs as they engage

with outdoor experiential psychotherapy through their own voices, stories, and experiences due to the marginalization of voice of individuals living with a mental health diagnosis (Clearly et al., 2014). Therefore, to address this gap, the purpose of my narrative inquiry is to understand the lived experiences of individuals' living with PTSD and SUDs while engaging in outdoor experiential psychotherapy and to provide a platform for the 'voice in the cracks' to be heard. The following research question will be explored:

1. How does the use of outdoor experiential psychotherapy within an in-patient care setting, influence individuals' experiences of early recovery?

Narrative inquiry will be used to explore the voices of individuals currently attending the in-patient care program for integrated alcohol and drug addiction and trauma at Homewood Health Centre in Guelph, Ontario, as they reflect on their personal recovery. With a focus on experience-centered narrative inquiry, an understanding of the meaning derived from engaging in outdoor experiential psychotherapy is further explored to gain insights that may serve as a basis of positive social change into everyday practice within mental health in-patient care settings. This process provides an opportunity for individuals to create meaning around a specific experience to invoke personal growth and change (Squire, 2008). The significance of this study is to understand personal meaning derived from outdoor experiential psychotherapy to transform the way healthcare professionals think about therapeutic practices within an in-patient care setting. In addition, this study works to shed light on the importance of providing opportunities for marginalized individuals to share their stories and experiences to inspire others living with a mental health diagnosis, and start to challenge the stigma around mental health and create social change.

As an academic and researcher, it is important to position myself within my research and understand the role that my position plays in the outcome of this research. My experience of working at Homewood Health Centre both in the Post-traumatic stress recovery (PTSR) unit for a three-week placement, as well as my four-month placement in the AMS unit has led me to where I am today. These experiences opened my eyes up to the fact that as a field, we need to provide the best possible care for individuals to reach their recovery goals. To do this, we must acknowledge that an 'one-fits-all' treatment plan may not be useful to everyone. Therefore, we need to explore complementary modalities to treatment. One such treatment modality I felt was missing from the programming was the use of the outdoors as a human-nature connection. This is something that has always been an important part of my own life. In hardships, I often turn to nature-based activities to find solitude and peace. I seek out this type of activity as a way to rejuvenate and feel refreshed. Therefore, this was something that I felt was being deeply overlooked within the in-patient context. Further, from my experience of working at Homewood, it was clear to me the importance of providing a platform for individuals living in recovery to be heard and share their stories to inspire others to seek help. It is these understandings and thoughts that have pushed me to seek out academia as a platform to provide individuals with the opportunities to share their stories of engaging in outdoor experiential psychotherapy in early recovery.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this research is not to say outdoor experiential psychotherapy should replace traditional treatment modalities, but that it be used as a complementary therapeutic practices to instill hope and change for individuals living with a PTSD-SUD diagnosis within an in-patient setting. By engaging in and exploring the role of outdoor experiential activity, nature-based therapy, and group psychotherapy, I hope to understand the shared meanings created within an in-patient therapeutic context. It is important to note that this literature review will focus on these three large bodies of literature to be used as vehicles to facilitation for the outdoor experiential psychotherapy workshop. Scant studies have explored the personal meaning derived from complementary therapeutic modalities that targets individuals' in early recovery PTSD and SUDs. More specifically, what is missing in the literature is the actual lived experiences of individuals' in early recovery of PTSD and SUDs as they engage with outdoor experiential psychotherapy processes through their own voices, stories, and experiences. Therefore, to address this gap, the purpose of my narrative inquiry is to understand the lived experiences of individuals living with PTSD and SUDs while engaging in outdoor experiential psychotherapy and to provide a platform for the 'voice in the cracks' to be heard. The following research question was explored through a pragmatic social constructionism lens:

1. How does the use of outdoor experiential psychotherapy within an in-patient care setting, influence individuals experiences of early recovery?

In reviewing the scholarship throughout this literature review, I situate my study in contemporary literature. First, I discuss the marginalization and stigma that surrounds a mental health diagnosis within society and argue for the importance of qualitative research as a way to emphasize voices often under-represented in society. Second, I explain the psychosocial and biological understandings of PTSD and SUDs, as well as the connection and co-morbid

diagnosis of PTSD and SUDs, including both treatment and healing processes. Third, I explore the field of recreation and leisure and the use of TR as a treatment modality for individuals living with a PTSD-SUD diagnosis including the connection between TR and recovery. Fourth, I discuss the use of outdoor experiential activity, drawing on the influence of nature-based therapy and adventure therapy. Finally, I detail the field of psychotherapy including relational, and sensorimotor psychotherapy, group processing techniques within psychotherapy, and the way these processes might be infiltrated within an in-patient setting.

Marginalization and Stigma of a Mental Health Diagnosis

According to the DSM-5, mental health illnesses are considered to be a "disability" (DSM-5, 2013). Yet, according to the Centre for Addiction and Mental Health (CAMH) website, 1 in 5 Canadians experience a mental health or addiction problem (http://www.camh.ca). This represents a large population of individuals within our society that are considered to be "disabled." The emerging field of disability studies challenges these assumptions by fostering discussions around the social construction of disability within society (Shogan, 1998). "Social construction of disability refers to the social history of disability and the social contexts that both enable and disable individuals who negotiate these contexts" (Shogan, 1998, p. 269). With this said, the experience of stigma and the social and cultural practices of stigmatization leads to a critical theoretical point. Scholars distinguish between, "'virtual social identity' and 'actual social identity'; that is, between the normative expectations by others and the actual attributes that person possesses" (Goffman, 1963, p.2). Due to the universal stance and structure of knowledge and accepted "truths" in society, individuals are not provided an opportunity to voice their own experiences. Such ablest ideals place burdens on individuals who are experiencing stigma and marginalization in society. Therefore, as a society, need to being to challenge these

traditional notions of what constitutes a "disability" in society and begin to create a dialogue that addresses these issues.

Within society, the conversations surrounding the stigma of a mental health diagnosis has begun to surface with more individuals beginning to create dialogue around this topic as compared to fifty years ago (Corrigan, 2004). Yet, as a society, we continue to legitimatize and accept stigmatizing behaviours, cues, and stereotypes (Corrigan, 2004). As a result, individuals living with various mental health issues are choosing not to seek out help in fear of being stigmatized (Corrigan, 2004). This stigma associated with a mental health diagnosis can place a burden on individuals. Societal stigma is described as creating social dysfunctions and a losses of opportunities for individuals experiencing a mental health diagnosis (Corrigan et al., 2000). Stigmatizing behaviours, such as avoidance, non-inclusion, rudeness, patronizing symptoms, or a "superior" attitude, can result in feelings of helplessness or hopelessness for individuals living with a mental health diagnosis (Cleary et al., 2004). The "us" versus "them" mentality, along with the narrow lens of acceptable "normality" makes for a divided society (Cleary et al., 2004). Research suggests that when individuals in society have opportunities to have contact and relationships with individuals living with mental health issues, it may in turn help to discount stigma (Corrigan et al., 2000). It is important to not just create conversations and dialogues around this issue, but to take action and actively break down the stigmatizing behaviours that burden our society.

The stigma that is perpetuated and legitimatized as "truth" and "normal" in society leads to extreme marginalization of this population of individuals. The extreme marginalization of individuals living with mental health issues and the stigma associated with this population can cause severe social stressors that can haunt individuals (Kreek, 2011). Marginalization is defined

as, "the context in which those who routinely experience inequality, injustice, and exploitation live their lives" (Brown & Strega, 2005, p.6). Marginalization is produced in society through the ways knowledge is legitimatized and accepted as "truth" (Brown & Strega, 2005). Additionally, marginalization is discussed as contributing, "directly to physical and emotional health inequalities via lifestyle limitations, challenges and isolations, and indirectly via alienation and disempowerment" (Cleary, Horsfall & Escott, 2014, p. 224). Such marginalization often renders individuals with a mental health, voiceless, silenced, ignored, and dehumanized (Van Den Tiilaart, Kurtz & Cash, 2009).

The extreme stigma and marginalization that surrounds a mental health diagnosis results in lower participation rates in treatment and rehabilitation programs (Cleary et al., 2014). For example, individuals living with PTSD and SUDs within society may choose not to get help due to the stigma of a mental health diagnosis. Scholars discuss that change needs to happen to address the marginalization and stigma within society (Cleary et al., 2004). In order to critique the idea of "normalization" and challenge the stigmatization and marginalization of a mental health diagnosis, we need to provide counter-narratives that work to provide spaces for individuals to voice their shared feelings (Diedrich, 2007). By providing a platform for individuals living with mental health issues, more specifically, individuals living with a comorbid PTSD-SUD diagnosis to share their stories and embodied experiences of recovery, we can begin a dialogue to understand what individuals are saying about their own personal recovery. To invoke positive social change, it is important to hear the voices, stories, and experiences of individuals' living with a PTSD-SUD diagnosis as they live their journeys of recovery. To do so, as a field, we must provide a platform for individuals to share these stories through the use of qualitative research processes. By adapting a qualitative research lens to my

research, more specifically the use of experience-centered narrative inquiry, I hope to provide an

opportunity for individuals' living in recovery to share their stories.

Post-Traumatic Stress Disorder (PTSD) and Substance Abuse Disorders (SUD)

The Medical Model

The biological understandings of a mental health diagnosis come from a long-held view

of the dominant medical model that currently operates within our societal systems. Operating

within a medical model requires knowledge and language that works from within this umbrella

of understanding. The medical model within our society plays an important role in terms of

increasing the well-being and vitality of many "disabled" individuals (Linton, 1998). Yet, along

with these benefits are enormous negative consequences for individuals considered to be

"disabled" in society (Linton, 1998). The biomedical model of disability approaches disability as

a problem that science and medicine can and must fix; disabled people must be normalized

through the disciplinary practices of medicine (Diedrich, 2007). The medicalization of

"disability" casts human variation as deviance from the "norm," as a burden and personal

tragedy (Linton, 1998). Further, the medical model exercises its effects on both an individual and

institutional level (Mobily, Walter & Finley, 2014). This way of understanding, "assumes that

the *person must* change not society, that the person wants his disability to be "healed," and that

"therapy" *will* make him better (Mobily et al., 2014). However, there is no "disabled" without

the social construction of what constitutes "able," no "abnormal" without "normal" (Davis,

2013). According to the recent statistics surrounding mental health and addiction, most of us at

some point in our lives will be considered "disabled." Therefore, it is important to investigate the

experiences of "disability" to give us insight into the complicated and changing relationship

between the selves, bodies, and the worlds (Diedrich, 2007). The next section of this literature

will work to shed light on the biological underpinnings of PTSD and SUD from a medicalized

standpoint. Therefore, the language used focus heavily on the use of medicalized terms. It is important to understand this, as we move forward to gain further insight into how we can shift away from this type of thinking, towards the social model of care.

Post-Traumatic Stress Disorder (PTSD)

PTSD has become a global health issue, with the estimated prevalence of individuals living with PTSD in Canada to be 9.2% (Van Ameringen, Mancini, Patterson, & Boyle, 2008). PTSD is a prolonged, and often incapacitating condition, that is a direct result of experiencing a traumatic event (Van Ameringen et al., 2008). A diagnosis of PTSD occurs when an individual is exposed to an extreme stressor or traumatic event in which he or she responded with fear, helplessness, or horror (Yehuda, 2002). According to the *American Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM-5) (2013) traumatic stressors involve actual or threatened death, serious injury, or sexual violence by either directly experiencing or witnessing a traumatic event or learning that the traumatic event occurred to a close family member or friend. Medically speaking, the characteristics of a PTSD diagnosis are encompassed by specific criteria as outlined by the DSM-5 (2013). First, recurrent, involuntary, and intrusive distressing memories of the event in which the individual feels or acts as if the traumatic event(s) are recurring and avoidance of these memories, thoughts, or feelings are associated (DSM-5, 2013). Second, negative alterations in cognitions and mood associated with the traumatic event(s) including: persistent negative emotional states, feelings of estrangement from others, inability to experience positive emotions, self-blaming, irritability, angry outbursts, self-destruction, hypervigilance, problems with concentration, and sleep disturbance (DSM-5, 2013). Finally, in addition to meeting the criteria outline above, symptoms must be present for one month or longer and cause clinically significant distress or impairment in social, occupational, or other areas of functioning (DMS-5, 2013).

PTSD is characterized by three distinct yet co-occurring symptom clusters including: 1) re-experiencing symptoms, 2) avoidance symptoms which involve restricting thoughts and distancing oneself from any reminders of the event as well as social withdrawal, and 3) hyperarousal symptoms such as insomnia and irritability. Following exposure to a traumatic event, some individuals experience a physiological response that causes PTSD (Yehuda & LeDoux, 2007). Some trauma-exposed persons do not develop PTSD, therefore examination of pre- and posttraumatic risk factors that work to understand and explain the development of the disorder is critical. Such identified risk factors may include: event characteristics (e.g. the severity of the trauma), individualistic characteristics (e.g. preexisting traits, pre- or posttraumatic life events), family history of psychopathology, cognitive factors (e.g. lower IQ levels), childhood adversity, pre-existing personality or behavioural problems, and poor social support (Yehuda and LeDoux, 2007).

An organized framework around a PTSD diagnosis helps professionals frame how an individual's biological factors, understanding of the world around them, and personalities are connected by their experiences (van der Kolk & McFarlane, 1996). In the aftermath of experiencing a trauma, an individual may construct the traumatic experience in their lives in a negative framework (Ostertag & Ortiz, 2013). Following a traumatic event, individuals may become gripped with the memory of the event to the point that it is repeated in one's head (van der Kolk & McFarlene, 1996). The term "trigger" is used to refer to an unwelcomed reminder of the event that provokes unwelcomed invasions (Schiraldi, 2000). Such "triggers" can elicit feelings of fear, vulnerability, sadness, disgust, and guilt, and create higher levels of anxiety (Schrialdi, 2000). For example, nightmares are a common "trigger" for individuals to re-experience their trauma (Ouimette, Finney & Moos, 1998). In such cases, the past trauma is re-

lived with a sensory and emotional intensity that causes the individual to feel as if the event(s) are actually re-occurring (van der Kolk & McFarlene, 1996). Within this context, avoidance of circumstances that may trigger these types of experiences is a typical response (Schiraldi, 2000). As such, unhealthy coping strategies, such as alcohol and/or substance use, may emerge (Volpicelli, Balaraman, Hahn, Wallace & Bux, 1999).

Substance Use Disorders (SUDs)

Addiction has become one of the largest public and mental health problems that affect individuals from all walks of life (Khantzian & Albanese, 2008; Reid, 2012). SUDs, "refers to a cluster of cognitive, behavioural, and psychological symptoms, and maladaptive patterns of substance use that result in recurrent and negative consequences for the individual or for others around him or her" (Ouimette & Brown, 2003, p. 3). These behaviours and symptoms can alter brain activity and have varying consequences for a person's health and well-being (Pace & Samet, 2016). Substance misuse is related to a range of physical, psychological, and social problems (Reynolds et al., 2005), in addition to work and personal role functioning consequences (Ouimette & Brown, 2003). The DSM-5 (2013) refers to SUDs as either mild, moderate, or severe. These categories indicate the level of severity with which one is experiencing an SUD and are determined by eleven different diagnostic criteria including: taking a substance in large amounts; inability to manage substance use; amount of time spent getting, using or recovering from the use of the substance; cravings and urges to use the substance; inability to manage work and personal life; continuing use despite problems in relationships; giving up social, occupational or recreational activities due to use; risky use, tolerance of substance use, and development of withdrawal symptoms (DSM-5, 2013). Clinicians specify the severity of the SUD depends on how many symptoms are identified for an individual (DSM-5, 2013). A diagnosis of a SUD is based on evidence of impaired control, social impairment, risky use, and

pharmacological criteria (DSM-5, 2013). Although treatment may result in a significant improvement in a variety of outcomes, relapse rates in such populations are relatively high (Reynolds et al., 2005).

An important development has shown progress in the biology and anatomy of the brain and how prescribed and non-prescribed drugs react in the brain (Khantzian & Albanese, 2008). Scholars discuss, "the complex interaction of the person, the underlying dysregulation that he or she experiences, and the way an addictive substance serves to address and perpetuate the dysregulation cannot be accounted for by biological models alone" (Khantzian & Albanese, 2008, p. 8). Instead, it is important to appreciate how biological, social, and psychological factors interact to create such disorders (Khantzian & Albanese, 2008). Biologically speaking, "substances of abuse produce their effects by taking advantage of neurochemical transmitters and receptor sites in the brain" (Khantzian & Albanese, 2008, p. 97). Further, studies suggest that genetic variations are at play in certain individuals (Khantzian & Albanese, 2008). With ongoing substance use, over time the neurotransmitter and receptor systems change, therefore individuals begin to build up a tolerance for the drug and require higher doses to feel the same effects (Khantzian & Albanese, 2008). When a person decreases or stops their drug use, they begin to experience symptoms opposite to those experienced when intoxicated, referred to as "withdrawal" (Khantzian & Albanese, 2008). In turn, this cycle can act as a promoter to continued drug use to feel "normal" (Khantzian & Albanese, 2008). Consequently, psychiatrists have come to appreciate that there is a high association between other psychiatric disorders and addictive disorders, including that of a diagnosed trauma disorder (Khantzian & Albanese, 2008).

The Connection between PTSD and SUDs

There is a well-established body of literature surrounding the comorbid diagnosis of PTSD and SUDs (Brown, Recupero & Stout, 1995; Kofoed, Friedman, & Peck, 1993; Ouimette & Brown, 2003; Reynolds et al., 2005). The combination of both PTSD and SUDs is a common and complex problem that clinicians face (Kofoed et al., 1993). Scholars have established that PTSD and SUDs are related, however, it has not yet established whether any set functional relationship exists between the two disorders (Conrod & Stewart, 2006). Two main processes of a comorbid PTSD-SUD diagnosis are outlined in the literature. First, drugs and alcohol are often used by individuals experiencing trauma to alleviate the disturbing psychological symptoms tied to their traumatic event (Ouimette, 2010; Reynolds et al., 2005). Individuals who experience a trauma, whether it be a childhood sexual assault, or combat, are more likely succumb to addictive disorders as the emotions they are experiencing are so severe that they can be overwhelming, numbing, or unbearable (Khantzian & Albanese, 2008). In fact, individuals' who experience PTSD are four times more likely to acquire a SUD than are individuals' who have not experienced a trauma (Khantzian & Albanese, 2008). For example, according to one study, 60-80% of Vietnam veterans seeking treatment for PTSD, also exhibited a concurrent diagnosis of drug or alcohol abuse or dependence (Kofoed et al., 1993). Alternatively, it has also been suggested that a substance using lifestyle may predispose an individual to trauma exposure (Reynolds et al., 2005). In other words, the addiction lifestyle itself can contribute to an ongoing pattern of trauma experiences in one's life (Khantzian & Albanese, 2008). Individuals can perpetuate their negative feelings by continuing in an addictive lifestyle (Khantzian & Albanese, 2008). For example, one study reported on thirty-one women receiving in-patient substance abuse treatment, found that 42% were also experiencing symptoms of PTSD (Brown et al., 1995). Therefore, it is not to say that one always precedes the other, but a combination of the two

in some context forms a comorbid PTSD-SUD diagnosis. The comorbidity of a PTSD-SUD is also associated with social, psychological, and medical consequences (Khantzian & Albanese, 2008).

The understanding and knowledge of a comorbid PTSD-SUD diagnosis as applied to various populations is well documented (Giaconia, Reinherz, Paradis & Stashwick, 2003; Guiterrez & Winsor, 2003; Ruzek, 2003). For example, there have been studies conducted on PTSD and SUDs among veterans (Ruzek, 2003), incarcerated women (Gutierrez & Winsor, 2003), and adolescents (Giaconia et al., 2003). Such studies have focused on the strong prevalence of a comorbid PTSD-SUD diagnosis as well as the significance it has for individuals within these populations. Additionally, these studies focused specifically on unique clinical issues related with a PTSD-SUD diagnosis to understand effective treatment for both disorders that should be integrated into clinical practices as it applies to these specific populations.

Treatment and Healing from a Co-morbid PTSD-SUD Diagnosis

The combination of a PTSD-SUD diagnosis is both common and problematic, and therefore the treatment, healing, and outcomes of this diagnosis within a clinical setting are complex (Kofoed et al., 1993). In general, clinicians dominantly rely on the medical model to approach addiction and trauma treatment (Hiebert-Murphy &Woytkiw, 2000). However, recent years have seen an increase in the use of complementary and alternative medicine to address the growing number of individuals living with PTSD and SUDs (Wynn, 2015). Clinical researchers emphasize the need for concurrent treatment of both PTSD and SUD symptoms (Ouimette et al., 1998). As such, group and individual therapies for PTSD with aspects of "Twelve Step" programs such as Alcoholics Anonymous (AA) are being implemented (Kofoed et al., 1993). The primary focus of a program such as this is on staying sober for the individual to begin to feel healthier and be able to manage their lives (Miller, 2002). Sadly, for individuals who live with a

dual PTSD-SUD diagnosis, it may seem impossible to be abstinent due to the emotional and psychological patterns and stressors caused by their trauma (Miller, 2002). Evidence in the literature suggests that once comorbidity is established, "each disorder can serve to maintain the other with patients self-medicating for PTSD symptoms with substances but repeated substance withdrawal ultimately heightening PTSD symptoms" (Conrod & Stewart, 2006, p. 53). This vicious circle, calls for treatment to clearly address symptoms of both disorders (Conrod & Stewart, 2006). Consequently, when working with individuals living with a PTSD-SUD diagnosis within a clinical setting, it is essential to be aware of both the PTSD and the SUD symptoms.

Research shows that therapy within this context is useful to help individuals learn to cope with their previous traumas, as well as handle situations that may remind them of traumatic events (Volpicelli et al., 1999). Several cognitive-behavioural treatments are shown to be valuable in treating PTSD-SUD diagnosis including cognitive therapy, anxiety management, and exposure therapy (Ouimette, Moos, and Brown, 2003). Scholars discuss a process of motivational coping skills intervention in which individuals explore the functional relations between their PTSD and SUD behaviours and work to learn alternative ways of coping (Conrod & Stewart, 2006). The purpose of this approach is to integrate both emotional and cognitive experiences related to trauma while simultaneously cultivating motivation towards an abstinent lifestyle (Kofoed et al., 1993). Additionally, PTSD and SUD treatment is often offered in a group format for both in-patient and out-patient programs (Kofoed et al., 1993). The dynamics of offering programs in a group format provides a cornerstone for group support and confrontation (Kofoed et al., 1993). For example, therapeutic interventions such as cognitive behaviour therapy, psychodynamic therapy, sensorimotor psychotherapies, and art and music therapies

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have been used to address trauma symptoms (CAMH, 2009). Although there is a great deal of research concerning the variety of and usefulness of treatment for a comorbid PTSD-SUD diagnosis, there is very little that speaks to treatment efficacy for this population of individuals (Jacobsen, Southwick & Kosten, 2001). Clinical studies confirm the comorbidity of PTSD-SUD diagnosis is common, and that the symptoms of individuals with this diagnosis tend to be more severe than those living with either disorder alone (Jacobsen et al., 2001). However, we need to explore complementary types of treatment modalities, such as the use of therapeutic recreation, the outdoors, and experiential learning, as it relates to an in-patient context.

Through an understanding of the connection between PTSD and SUDs as well as the treatment and healing from such a diagnosis, it is important to understand the roles recreation and leisure plays in recovery. More specifically, I will explore the use of TR modalities including outdoor experiential therapy and nature-based therapy and the connection to using different types of complementary psychotherapies within an in-patient setting for individuals' in recovery of a PTSD-SUD diagnosis.

The Field of Recreation and Leisure

As the Greek philosopher Aristotle said, recreation and leisure is, "the way to happiness and quality of life because it provides a means to self-fulfillment through intellectual, physical, and spiritual growth" (Austin, 2011a, p.15). The process of understanding the field of recreation and leisure is often associated with terms including: voluntary action and activity, positive emotions, enjoyment, fun, feelings of accomplishment etc. (Austin, Crawford, McCormick, Puymbroeck, 2015). Further, these ideas have been linked to ideas of restoration, refreshment, or re-creation for individuals (Austin et al., 2015). Leisure is frequently plagued by conceptual confusion as it can be described in many different ways, such as free time, freedom, an activity, a

state of mind, or a license of some sort (Sylvester, 1999). The classical view of leisure describes it as a state of being that reflects an individual's contemplation, enjoyment of self in search of knowledge and cultural enlightenment (McCarville & MacKay, 2007). The manner and organization that leisure plays in our lives depends on who we are, where we live, the circumstances surrounding our lives, opportunities and resources available to us, and ultimately the choices we make in our leisure time (McCarville & MacKay, 2007).

Leisure can affect individuals on many varying levels including that of the individual, and societal levels (McCarville & MacKay, 2007). Individually, leisure can have a variety of positive outcomes ranging from enhanced moods to feelings of accomplishment or mastery (McCarville & MacKay, 2007). Leisure can provide the following benefits: engaging in opportunities that allows for personal enjoyment, identity development, skill development, and personal wellness (McCarville & MacKay, 2007). To unpack this statement, first, leisure serves as a source of enjoyment that is intrinsically motivating and provides opportunities to use skills and strengths in interesting ways (McCarville & MacKay, 2007). Intrinsic motivation is seen as energizing behaviours that are internally, or psychologically rewarding (Austin et al., 2015). In this sense, individuals are motivated to participate for their own sake rather than a means to an extrinsic reward (Austin et al., 2015). Second, leisure serves as a platform for identity development in that individuals may discover a sense of self through the choices they make in their leisure time (McCarville & MacKay, 2007). Third, leisure contributes to skill development by providing an environment that is rich with the potential for skill development (McCarville & MacKay, 2007). Within this, the idea of self-actualizing behaviours are understood as a way for individuals to promote growth, change, and maturation (Austin et al., 2015). Leisure is seen as an opportunity for individuals to experience self-actualization as it offers opportunities for

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individuals to be successful in intrinsically motivated activities (Austin et al., 2015). Lastly, leisure interacts with dimensions of personal wellness including that of physical, social, emotional, intellectual, and spiritual domains (McCarville & MacKay, 2007). On a societal level, leisure may include a sense of belonging or identity within society, a body of deeply shared values or beliefs, a system or social organization, and a sense of interdependency (McCarville & MacKay, 2007).

Leisure can be used as a foundation for gaining or finding valued meanings through individual leisure choices and behaviours (Kleiber, Hutchison & Williams., 2002). Such meanings are critical for both our collective and individual well-being (McCarville & MacKay, 2007). Engaging in leisure to cope with the stressors of life can in turn provide the potential for human development and positive transformation (Caldwell, 2005). Despite stressful and sometime traumatic experiences in life, many individuals are able to overcome the difficulties and challenges they face in life through the use of leisure pursuits (McCarville & MacKay, 2007). Other positive outcomes of engaging in leisure as a means of coping from stress may include enhanced quality of life, and human development (Kleiber et al., 2002). Leisure can be an important source for confirming and establishing human strengths (Kleiber et al., 2002). For example, coping with loss of a loved one through leisure enables individuals to develop a new, exciting social connection with others (McCarville & MacKay, 2007).

Leisure as a Form of Recovery- The Use of Therapeutic Recreation (TR) Practices
        Shifting to the social model. The dominant medical model that operates in many of our "institutional" settings conflicts with that of a social model of care. As a student, practitioner, and researcher, the tension between the medical and social model directly impact my research. The tension exists while working within a system that heavily relies on a medical model of understanding and not having my values and beliefs align with such assumptions. Although I do

recognize the usefulness and benefit of the medical model in some cases, my values and beliefs align within a social model of understanding that works to de-construct the social construction and stigma that surrounds "disability" in our field. For example, I do not believe that mental health should be considered a "disability." Further, I do not believe that we should "other" ourselves from the individuals we work with by labelling them as "patients' or "clients." However, it is important to recognize that it is this language that is considered "acceptable" when working from within a medical model.

There is a shift in thinking that occurs as healthcare professionals move away from a medical model of understanding toward the social model. As a field we have often searched for legitimacy through validation of medical practices (Kestenbaum,2005; Lahey, 1987; Sylvester 2005a, 2015b). These assumptions of the medical model remain unchallenged as they assume we are able to define "best practices" despite the complex human contexts and systems in our society (Arai et al., 2015). When we look at care with this understanding and knowledge we shift away from the biomedical model towards a biopsychosocial model (Shank & Coyle, 2002). As discussed above, the biomedical model focuses on approaching disability as a problem that can be "fixed" in order to "normalize" individuals (Diedrich, 2007). Shifting to the biopsychosocial model to approach care, we can begin to deconstruct the way that "disability" is socially constructed within societal discourses (Mobily et al., 2014). As a student, I came to understand the shift in thinking that occurs as we move away from the medical model. As a practitioner, this shift became more apparent to me through my experiences of working in the field of TR. From my experience at Homewood, I saw first-hand the tension TR practitioners faced every day from positioning themselves under a social model of care but operating within a heavy medical system. The understanding of this shift has been a long-held issue that

practitioners have faced in the field of TR. TR services have historically operated from within a medical model of understanding (Mobily et al., 2014). TR, in this sense, has reproduced medicalized views of care from within an in-patient setting (Mobily et al., 2014). Scholars discuss that helping professions, like TR, can unknowingly cause harm by producing negative results that reproduce stigma (Mobily et al., 2014). In many ways, the field of TR has perpetuated the dominant discourses that surround disability by oppressing, stigmatizing, and labeling individuals we work with (Mobily et al., 2014). In response to this, more recent years have shown more practitioners and scholars fighting back by creating dialogue around the ways in which disability is socially constructed and the impact this has for the profession of TR (Mobily et al., 2014). The social model maintains that, "most of the difficulties encountered by disabled persons relate to a socially constructed environment that oppresses" (Mobily et al., 2014). By recognizing this understanding, practitioners in the field have begun to advocate for the individuals we work with in order to reconstruct society's view of "normal" and "abnormal" (Mobily et al., 2014). Yet, it is important to acknowledge that this is not an ideal that has been maintained across the field. Many practitioners in the field work within a system that operates within the medical model and feel the tension of the conflicting models. As a researcher, this only illuminates the need for practitioners to gain further insight into the medical model assumptions and showcase the need for the social model. Speaking from within a social model, the solution to this tension is to address the environment, social institutions, attitudes, and narratives that marginalize the "disabled" person (Mobily et al., 2014).

Therapeutic Recreation (TR). One of the mainstream aspects of recreation and leisure services and organizations is the use of TR. Throughout the literature, scholars have worked to conceptualize and define TR. TR has historically been viewed as a tool to assist individuals in

achieving optimal healthy functioning and independence through interventions designed to bring about a desired change in behavior (Sylvester, 1987). Although the field of TR has adapted and changed in the past few decades, this still remains to be a core understanding of the clinical practice of TR. One scholar describes TR as the use of recreation and leisure as a purposeful intervention designed to elicit positive change (Luckner & Nadler, 1995). Other scholars define TR as, "the systematic and planned uses of recreation and other activity interventions and a helping relationship in an environment of support with the intent of effecting change in an individuals' attitudes, beliefs, behaviours, and skills necessary for psychosocial adaption, health, and well-being" (Shank & Coyle, 2002, p. 54).

The professionalization of TR began during World War II through the efforts of recreation workers in civilian and military hospitals, as the use of TR was seen to have, "curative value" (Austin et al., 2015, p. 36). Following WWII, TR services were initiated throughout America in psychiatric hospitals and institutions for individuals with intellectual disabilities (Austin et al., 2015). As a product of the process of professionalization, professional organizations were formed. In Canada, the Canadian Therapeutic Recreation Association (CTRA) is a national association of practitioners in the field of TR since 1996 (https://canadian-tr.org). The CTRA philosophy states that TR is a profession which recognizes leisure, recreation, and play as integral components of quality of life that provides services to individuals with physical, mental, social, or emotional limitations (https://canadian-tr.org).Within a clinical setting, TR professionals work with other health care professionals and are a part of the interdisciplinary team that has become widespread throughout the health care system (Austin et al., 2015). There are five core competencies outlined in the literature for all health care professionals including: providing patient-centered care, working within interdisciplinary teams,

employing evidence-based practice, applying quality improvement and utilizing informatics for communicating and managing (Strumbo & Peterson, 2009). It is important for practitioners to, "understand recreation as voluntary activity that has restorative practices and leisure as a phenomenon that provides the individual with perceived control, the opportunity to meet intrinsically motivated needs, and a means to actualize potentials and achieve high-level well-being" (Austin et al., 2015, p. 7).

Clinical TR. Within a clinical setting, the design and delivery of programs and services is the main focus of TR (Strumbo & Peterson, 2009). Clinical TR, "refers to deliberate and purposeful use of an intervention process aimed at helping people with illnesses and disabilities improve their health and increase their capacity to use play, recreation, and leisure for ongoing health and life quality" (Shank & Coyle, 2002, p. 53). Recreation and other related activities are used as a means for achieving outcomes, positive change, and enhance health and well-being (Shank & Coyle, 2002). Further, clinical practice targets both individuals and their environments in order to improve functioning, coping, adaptation, and the pursuit of health and well-being through leisure (Shank & Coyle, 2002). A clinical setting or practice involves a dynamic process of change (Shank & Coyle, 2002).

Within the clinical setting, the TR process is applied as a systematic problem-solving procedure that was first conceptualized and introduced by Gerard O'Morrow (1976) (Austin et al., 2015). The process unfolds in four phases, which focus on person-centered and goal-directed initiatives (Austin et al., 2015). The four phases of the process include: assessment, planning, intervention, and evaluation (APIE) (Austin et al., 2015). This process is the cornerstone for the delivery of TR within a clinical setting and is the base from which all processes occur (Austin et al., 2015). Through this process, individuals are assisted to learn, adapt, and grow, in order to

maximize their individual well-being through leisure, recreation, and play (Shank & Coyle, 2002). Throughout the TR process, practitioners start by gathering and identifying information by assessing the individual's strengths, weaknesses, and needs (assessment) (Austin et al., 2015; Strumbo & Peterson, 2009). The practitioner may do this through observation in a natural setting, interviews, or secondary assessments (Austin et al., 2015). The practitioner then goes on to devise an 'action plan' that meets the individual's strengths, weaknesses, and needs (planning) (Austin et al., 2015). This phase may include setting priorities, formulating goals and objectives, determining strategies or actions to meet goals, selecting methods to assess progress made toward goals, and creating a 'blueprint' for action (Austin et al., 2015). More specifically, the practitioner works with the individual to create individual-focused outcomes (Strumbo & Peterson, 2009). Outcomes "are the results or changes in the client that result from participation and involvement in services" (Stumbo & Peterson, 2009, p. 74). Next, the practitioner works to put the plan into action by implementing the designed interventions with the individual (intervention) (Austin et al., 2015). A range of facilitation techniques, from adventure therapy, leisure education and counselling, physical activity, yoga, and pilates to creative arts, horticulture therapy, and video games can be used as interventions to facilitate change (Austin et al., 2015). Finally, the practitioner conducts an assessment of the process with the individual to understand the effectiveness of the interventions (evaluation) (Austin et al., 2015). This final phase of the process reveals whether the 'plan of action' for the individual has been successful and effective or if it requires revisions (Austin et al., 2015). Further, fostering a therapeutic alliance with individuals is vital to the role of the practitioner. Within clinical practice, it is the job of the practitioner to help individuals see the possibility for a satisfying and meaningful life (Shank & Coyle, 2002).

Within clinical TR, the use of evidence-based practice is vital for the practice to ensure the most accumulated practice is facilitated (Strumbo & Wardlaw, 2011). Research provides a foundation for evidence-based practice of TR services by bringing forth knowledge on the best possible information that is available (Strumbo & Wardlaw, 2011). For example, a number of research studies have been conducted to suggest that physical activity and exercise are beneficial in reducing symptoms of depression as compared to no treatment (Cooney, Dawn & Mead, 2014). When practitioners choose to adopt or facilitate an intervention within a clinical setting, it is important to focus on evidence-based practices that have been advocated for strongly to ensure that individuals are receiving the best possible care (Strumbo & Wardlaw, 2011).

  Group interventions within TR. TR services are not limited to one-on-one interventions, but also include small and large group interventions (Carter & Morse, 2011). For example, formal treatment groups are used within in-patient and out-patient interventions (Strumbo & Wardlaw, 2011). Within this, a supportive environment is created to enhance positive change (Shank & Coyle, 2002). Regardless of the intervention, the practitioner works to facilitate human interaction by providing clients with opportunities to improve their health and well-being (Carter & Morse, 2011). Group interventions are used as they are practical, efficient, and effective in accomplishing individual outcomes and work to facilitate individual change and growth (Carter & Morse, 2011). Within a group context, interventions can be therapeutic as they promote group cohesion in which group member bond and feel safe, valued, and accepted (Yalom & Leszcz, 2005). The role of group interventions within TR is similar to that of group processing techniques in psychotherapy practices (Yalom, 2005). The group interventions discussed in this section, as well as the group processing techniques described in a latter section,

inform my approach to this research by providing an understanding of the knowledge translation that occurs in practice.

The role of TR in the healing journey of a PTSD-SUD diagnosis. TR has been used within the treatment of PTSD as a healthy coping resource. Individuals diagnosed with PTSD have a lack of awareness of the role leisure can play as a healthy coping strategy through their recovery and healing (Griffin, 2005; Van Puymbroeck & Lundberg, 2011). Through educational leisure sessions, individuals have the opportunity to learn the roles leisure can have in their lives and the ways in which leisure can provide a sense of personal joy, and fulfillment in everyday life (Griffin, 2005). Griffin (2005) discusses her personal experience of working as a practitioner within a PTSD recovery unit. She notes individuals in recovery of PTSD often use leisure in an unhealthy manner as a way to isolate and reenact patterns of being alone and feeling abandoned, and rejected (Griffin, 2005). Further, she discusses individual's tendency to avoid leisure due to shaming beliefs about un-worthiness and the belief that leisure and play is 'unsafe' (Griffin, 2005). Being aware of individuals' leisure motivations can help promote a healthy leisure experience as opposed to enabling self-harming behaviours (Griffin, 2005).

The use of TR for treatment of SUDs has been well documented by scholars in the literature. The use of TR in a SUD treatment is, "to focus on promoting a drug-free or sober lifestyle, in alignment with the overall goals or outcomes of the agency or facility" (Kunstler, 2015, (from Austin et al., 2015, p. 99). The role of TR for SUD recovery works to increase awareness of leisure; identify leisure barriers, interests, skills and resources; identify alternative rewarding leisure activities to substance use; and implement a plan for leisure involvement (Kunstler, 2015). Other outcomes that TR works to address for individuals with a SUD includes: self-esteem, intrinsic motivation, self-awareness, and self-efficacy (Kunstler, 2015). Evidence of

varying quality exists for the use of adventure therapy, animal assisted therapy, horticulture, photography, and physical activity (Austin, 2013), mindfulness (Wupperman et al., 2012), relaxation and stress management (Drench, Noonan, Sharby & Ventura, 2012) for treatment of SUDs. Further research shows evidence of efficacy of recreation activities related to SUD treatment. For example, a study conducted on a psychiatric unit for nine girls showed that adventure therapy had strong, positive impacts on the girls' emotions including coping, control, trust, and teamwork (Autry, 2001).

The research supports the use of recreation activities in the treatment of both PTSD and SUDs. For example, a study conducted by Scott and Ross (2006) showed that the creative arts have a unique ability to help trauma survivors and addicts navigate through life experiences and self-discover and connect to their feelings, and emotions on a deeper level. Although the use of leisure as a broad platform for coping with stress, and traumatic experiences has been well documented, the use of outdoor experiential activity and therapy as a complementary form of leisure for the healing of trauma and addiction has yet to be deeply explored within an in-patient setting.

Outdoor Experiential Therapy (OET)

Vincent Van Gogh once said, "I am always doing *what I can't do yet* in order to learn how to do it" (Weiner, 1985). In essence, this quote speaks to the understanding of experiential activity, and programming. Experiential education and outdoor adventure activities have become increasingly popular since the foundation of Outward Bound in the USA in the early 1960s (Hahn, 1957). There is no one overarching definition of outdoor therapy, nor an all-inclusive model to understand how to practice therapy within an outdoor context (Jordan, 2015). A plethora of terms exist that work to understand nature and therapy including wilderness therapy (Berman and Berman, 1994), nature therapy (Berger, 2006), nature-guided therapy (Burns,

1998), adventure therapy (Dattilo & McKenney, 2011; Beard & Wilson, 2006; Gass, 1999), experiential therapy (Priest & Gass, 2005), and relational therapy in the outdoors (Santostefano, 2004). In my conceptual framework and research, I will be focusing on adventure therapy, nature-based therapy, and outdoor experiential activity as forms of therapeutic interventions. It is important to note that these ideas will be understood as vehicles to facilitation. Therefore, the purpose of this research is not to focus on these understandings per se, but to understand how these ideas can be incorporated within a therapeutic modality of practice. Outdoor therapies such as adventure therapy aim to provide a therapeutic environment that improves an individual's "self-concept." Adventure therapy focuses on the challenge of contact with the outdoors with some form of activity, such as rock climbing or canoeing, that becomes the medium of the therapeutic work (Jordan, 2015). Adventure based counselling utilizes challenging experiences in a natural environment with some sort of perceived risk as a means of facilitating therapeutic change (Peel & Richards, 2005). Nature-based therapy models are used to endorse nature as a co-therapist in the therapeutic setting (Jordan, 2015). "Nature therapy represents a more democratic space for the therapeutic work to unfold and therefore has an impact on the therapist-client relationship" (Jordan, 2015, p. 32). Furthermore, nature-based therapy offers a way to both assess and work with the body-mind relationship and the emotional efficacy that accompanies this (Jordan, 2015).

Increasingly, the outdoor environment is used as a therapeutic setting within a variety of organizations, and programs that adopt and incorporate therapeutic modalities into outdoor experiential therapy (OET) and nature experiences (Ewert, McCormick & Voight, 2001). OET is an umbrella term that embraces the related modalities of adventure therapy and nature-based therapy (Ewert et al., 2001). For example, one study looked at experiential learning in

psychotherapy through outdoor rope courses and found the challenge of the activity enhanced

individuals coping skills, and facilitated personal growth (Wolf & Mehl, 2011). Inherently, OET

utilizes an outdoor setting to address the following ideas: participant-centered therapy, cognitive

dissonance, reality-based outcomes, assessments, and program structure to foster therapeutic

interventions (Ewert et al., 2001). To unpack this statement, first, participant-centered therapy

refers to individuals engaging in action related outcomes as opposed to spectating (Ewert et al.,

2001). Scholars speak to this idea; when individuals participate in an experience where they are

able to learn in such a way that the action being taken and the learning outcomes are

synonymous (Howden, 2012). For example, when a child is presented with the challenging

activity of learning to ride a bike, an undeniable connection between the physical and the mental

are at odds with each other which directly relates to experiential learning (Howden, 2012).

Second, the idea of cognitive dissonance suggests that OET allows individuals opportunities for

personal growth, team-building, and enhanced communication (Ewert et al., 2001). For example,

during a team-building program, a group may be given a series of complex and challenging

problem-solving initiatives that, "creates opportunities to break down barriers and opens the

potential for self-discovery by individuals and groups" (Howden., 2012, p. 48). Third, reality-

based outcomes, "serve as metaphors for life and as such, allow the participant to learn"

(Howden, 2012, p.110). Individuals are able to have powerful and real embodied experiences

(Howden, 2010). Finally, OET uses assessment techniques to connect individual's needs with

specifically defined outdoor physical and social activities, as it fosters a sense of trust within the

group as well as between the facilitator and participants. OET will use a reflection process to

understand how individual's actions and interactions may transfer into other aspects of their life

(Howden, 2012). OET is facilitated in this sense, to increase levels of trust and allow

opportunities for individuals to learn to cope with fear and anxiety, and deal with unpredictable and uncertain outcomes (Ewert et al., 2001).

Outdoor Therapy and TR

Literature regarding outdoor adventure programming, nature-based therapy, and OET suggests that physical and psychological health can be improved as individuals partake in such activities (Dattilo & McKenney, 2011; Beard & Wilson, 2006). In general, "components of adventure activities (i.e. trust, personal growth, and actual or perceived risk taking) are used in an attempt to help participants experience feelings of personal worth and to assume responsibilities for their own actions" (Autry, 2001, p.289). Nature-based therapy can induce many positive outcomes such as: acting in a benefitting manner, creating high standards and values, demonstrating fairness, consistency, honesty, tolerance, compassion, truthfulness, and discretion (Beard & Wilson, 2006). Additionally, it encourages interpersonal and intrapersonal change within an individual and groups with the focus being on the transfer of new knowledge and understanding into the daily life of participants (Dattilo & McKenney, 2011). Scholars outline benefits of OET as: a participant's ability to value the group autonomy allowing for a sense of independence, fostering an appreciation for the "natural" environment for learning to occur, and preserving a positive environment for individuals to participate in meaningful emotional experiences within a group context (Beard & Wilson, 2006). Due to the fact that nature-based therapy incorporates experiential activities as a means for therapeutic change, it fits well within the paradigm of TR (Autry, 2001).

One study observed the experience of participating in Paralympic military sport camps, and found themes of finding motivation, relatedness, establishing a connected with previous interests, improving overall health and well-being, increasing competency, and autonomy (Hawkins, Cory, Crowe, 2011). Furthermore, complementary outdoor TR therapies such as

hiking, fishing, bird watching, gardening, and a wide variety of sports are used within non-profit programs to support individuals in recovery of trauma (Wynn, 2015). For example, Mowatt and Bennet (2011) gathered and analyzed 67 letters of veterans with confirmed PTSD diagnosis as they concluded their participation in a therapeutic fly-fishing program, finding that the combination of nature and physical activity seemed to have the most salient experience from the treatment of the program. A second study conducted by Dustin, Bricker, Arave, Wall and Wendt (2011) shows positive evidence for using a therapeutic river rafting program for individuals living with PTSD. However, "unfortunately, there is little rigorous research into the potential benefit of these programs" (Wynn, 2015, p. 16).

The concepts of OET has been applied to various populations as a treatment modality (Berger, 2008; Bruyere, 2002; Eckstein & Ruth, 2015; Kyriakopoulos, 2011; Swarok, 2013). For example, a study conducted at the Algonquin Haymarket Relapse Prevention Program looked at thirteen men and women in substance abuse treatment in a three-day residential program experience based on integrated principles from adventure therapy, therapeutic camping, and relapse prevention. The outcomes of this study suggests that an integrated program of therapeutic recreation/adventure therapy, and traditional therapy activities produces better results than the traditional therapy activities alone (Bennet, Cardone & Jarcyzk, 1998). Yet, what has to be explored in literature is the use of OET as an complementary therapeutic recreation practice within an in-patient setting, as it relates to individuals living in recovery of a PTSD-SUD comorbidity.

The Role of the Outdoors in Therapy

The concept of conducting healing work within nature can be traced back to ancient times when individuals lived in communities within nature (Berger & McLeod, 2006). Traditionally, therapy has been viewed as a human-to-human process practiced within the

confines of a building (Dustin et al., 2011). Studies have shown that spending even small amounts of time in a natural environment can improve an individual's attention, mental clarity, and emotional and physical well-being (Clay, 2001). Literature surrounding a theorization of outdoor therapies has begun to emerge around concepts of ecotherapy, ecopsychology and nature therapy (Davis & Atkins, 2004). For example, Ecotherapy and ecopsychology are central underpinnings of implementing psychotherapy within nature as they speak to the reciprocal relationship between humans and nature within this context (Jordan, 2015). There has been different hypothesis and theories used in the literature to understand the role that nature has in therapy. Within my conceptual framework, I have focused on using these theorization of nature as a way to facilitate therapeutic modalities. Therefore, the findings of this study will not focus on the ideas of theorizing nature-based therapies. For the sake of this research, I worked to understand two of the theoretical understandings that are most applicable to my study; psychoevolutinary theory of stress reduction, and the green care movement (Jordan, 2015). Psychoevolutinary theory of stress reduction came from a study conducted in 1984 by Roger Ulrich compared the recovery of individuals who had a view of a blank wall with those who could see trees from their hospital bed (Jordan, 2015). The results of this study showed that there was a positive response to connecting to nature that was beneficial in many ways including: reducing stress, restoring attention, and promoting well-being (Jordan, 2015). Additionally, this study emphasizes how contact with nature is linked to brain chemistry and genes which is essential for human survival (Jordan, 2015). On the other hand, the green care movement seeks to utilize the context and processes of the natural world around us to promote physical and psychological well-being (Jordan, 2015). This movement included a number of interventions such as therapeutic horticulture, animal-assisted therapy, green exercise, and wilderness therapy

in order to promote mental health through contact with nature (Jordan, 2015). Within such interventions, "there is the solace that nature gives both parties, contributing to enhanced positive effects in areas of well-being, psychological states, spirituality, a sense of peace and physical health" (Jordan, 2015, p. 12). Collectively, these theories inform therapeutic practices as they showcase the role the outdoors can take on within therapeutic practices.

There is a growing interest in the relationships between nature and its effect on our emotional well-being (Jordan, 2015). Therapy becomes a co-therapist and educator and thus adds another variable to the therapist-client relationship (Dustin et al., 2011; Jordan, 2009). Through this three-way relationship, "nature can be used to expand a person's patterns and help him or her connect to his or her body, spirit, mind, creativity, and authenticity" (Berger & McLeod, 2006, p. 89). Nature is a live and dynamic environment that is not under control of the therapist as opposed to an indoor setting which is usually owned by the therapist who has furnished it for the purpose of doing therapy (Berger & McLeod, 2006). For example, one study done on the use of adventure based counselling in the outdoors showed that the outdoor transaction was identified as an integral part of the therapeutic endeavour as it provided individuals with the opportunity to experience a range of emotions, while also offering a practical way to become self-aware, and try new things (Kyriakopoulos, 2010). Through nature-based therapies, individuals have opportunities to reconnect with nature, find personal meaning through engagement with the natural environment, and reconnect personal strength and hope within recovery (Berger & McLeod, 2006). Within TR, nature-based interventions use plants, animals, and other living things to address individuals' needs and goals (Shank & Coyle, 2002). Nature-based activities, "provide opportunities for clients to care for and nurture, which can be a welcomed change from being the one cared for by others" (Shank & Coyle, 2002, p. 155). A

variety of outcomes of nature-based therapy exist including: improved physical, cognitive, social and emotional functioning, and increase satisfaction with leisure and life (Shank & Coyle, 2002).

Within a therapeutic setting, a nature-informed approach has been employed as a specific modality of therapy (Berger & McLeod, 2006). One such outward Bound study conducted in1996 on 219 in-patient veterans diagnosed with PTSD participating in a five-day outdoor adventure experience reported areas of impact including: 1) increased positive feelings and perceptions of self-esteem; 2) the ability to enjoy life again; 3) rediscovering enjoyment in the outdoors; overcoming negative emotions and becoming more in control; 5) and enhanced relationships with others, as observed by the facilitators (Hyer, Boyd, Scrufield, Smith, & Burke, 1996). Although there has been much research conducted in terms of the benefits of human-nature connection for recovery, there has been very little research conducted on the use of the outdoors as therapy in connection to a co-morbid PTSD-SUD diagnosis within an in-patient context.

Exploring Psychotherapy

The History of Psychotherapy

There is a vast amount of literature that discusses the field of psychotherapy, stemming from the world of psychology, that dates back to the early 1900s. It is helpful to know and understand where we have come from to inform current understandings and practices of group psychotherapy, and counselling. Scholars discuss that in general, the history of psychotherapy research was brought about by two physicians working with tuberculosis patients; Cochrane and Pratt (Barlow, 2014). Since, psychotherapy has been widely adopted into the field of mental health with professionals searching for effective and efficient treatments for an array of disorders including depression, anxiety, schizophrenia, and other mental health related issues (Barlow, 2014).

Yet, it is important to recognize that the history of psychotherapy has not always been positive. Throughout the years there has been much stigma and marginalization that surround the field of psychotherapy. For example, Canada and other Western countries have a long history of *institutionalizing people,* which studies have shown has a profound effect on people's sense of power (Lord & Hutchinson, 2007). As a result, social outcomes such as segregation, rejection, isolation, and loneliness accompany this response to being "different" (Lord & Hutchinson, 2007). These types of social outcomes come from the actions, behaviour, and language that we associate with individuals who are experiencing a mental health diagnosis. A social model approach to care discusses the language we use in hospitals settings such as "client" which emphasizes an "us" versus "them" mentality (Lord & Hutchinson, 2007). Therefore, understanding how labelling, assessment, and language impact individuals status is central to creating new approaches (Lord & Hutchinson, 2007). Further, many social services operate on the belief that compliance and control are a necessity for ensuring the effectiveness of their organization (Lord & Hutchinson, 2007). It is important to explore the good, bad, and ugly of the field of psychotherapy and how it is understood within this research project. As a researcher, I recognize that the field of psychotherapy has had a long history of institutionalization which has led to further oppression and isolation of individuals living with a mental health diagnosis. As discussed above, I will be drawing on concepts from within the field of psychotherapy as vehicle to facilitation and not as a theoretical tool for the sake of this research.

A great deal of empirical research has gathered through the years regarding the effectiveness and efficiency of group psychotherapy and counselling (DeLucia-Waack, Kalodner & Riva, 2014), as well as the use of the outdoors within this type of therapy (Buzzell & Chalquist, 2009). Group psychotherapy has been used to aid those who are in chronic or acute

psychological distress (Burlingame, Whitcomb and Woodland, 2014). Through the years, psychotherapy has been studied as a theoretical tool for recovery for various populations. More specifically, psychotherapy has been identified as a tool for addiction and trauma recovery (Khantzian & Albanese, 2008). A number of types of psychotherapy, including individual, group, couples, and family have been used in the past decade to treat PTSD and SUDs (Khantzian & Albanese, 2008). Although much contemporary research focused on the efficacy and outcomes of psychotherapy in terms of symptom reduction and increased well-being, not much research has been done to understand how the therapeutic process would work in a natural setting (Jordan, 2015). Scholars work to explore and understand the shift in the therapeutic process that occurs when it moves outdoors (Jordan, 2015). Research shows that, "conducting therapy within an outdoor natural space appears to have an effect on the therapeutic relationships between therapist and client" (Jordan, 2015, p. 50). For example, some individuals may feel intimidated by sitting in a closed-off room with a therapist (Jordan, 2015). This idea begins to challenge the traditional ideas of psychotherapy as being conducted within an indoor environment and open it up to new ways of thinking and healing within nature (Buzzell & Chalquist, 2009). This represents a new form of psychotherapy that acknowledges the role of the outdoors and creates opportunity for human-nature relationships (Buzzell & Chalquist, 2009). Therefore, re-imagining the therapeutic shift that can occur when exploring what therapy can look like within the outdoors is essential (Jordan, 2015). Throughout this section of the literature review, the understanding of relational, and sensorimotor psychotherapy will be explored, followed by the role of group processing techniques within psychotherapy.

Relational and Sensorimotor Psychotherapy

Relational psychotherapy. Within relational psychotherapy, the concept of a reciprocal mutual relationships is of upmost importance as the origin of emotional distress is often rooted in

patterns of relational experience (Jordan, 2015). This idea is deeply rooted within the

biopsychosocial model as it works to unpack the relational experiences that unfold on a moment-

to-moment basis (Mobily et al., 2015). Relational psychotherapy relies on having satisfying

mutual relationships with others, the therapist, and the surrounding environment (Jordan, 2015).

The relational context of psychotherapy allows space for the therapist to understand the

individuals unique self-experience and respond in an empathetic manner (Jordan, 2015). In turn,

this creates a new in-depth relationship between the therapist and the individual that is secure,

supportive, and enlightening for the individual (Mitchell, 1998). Through this process of giving

meaning to the experience, individuals can safely re-experience and find freedom (Jordan, 2015).

"The origin of emotional distress is often rooted in patterns of relational experience, past and

present, which have the power to demean and deaden the self" (Jordan, 2015, p. 45). The

therapeutic process within this type of psychotherapy works to interact and co-construct old and

new experiences (Jordan, 2015).

  Sensorimotor psychotherapy. Sensorimotor psychotherapy includes body-oriented

interventions common to other somatic approaches by merging therapy and technique to

implement physical actions fostering enablement, and ability (Ogden & Fisher, 2015).

Sensorimotor psychotherapy encourages the understanding of how the body carries and changes

the legacy of trauma and attachment through somatic awareness and movement, such as

mindfulness and connecting with the body (Ogden & Fisher, 2015). For example, this includes

the use of grounding techniques and hypnosis (Ogden & Fisher, 2015). One key understanding of

therapy for individuals is to realize that it is not important to try to change the past but to change

effects of the past for the future. For example, "mindfulness helps facilitate this task by teaching

clients to orient and focus awareness on the effects of the past events as they emerge in the

present" (Ogden & Fisher, 2015, p. 41). That said, individuals with trauma and attachment issues can go through a loss of disconnection from the body due to past events, therefore the reconnection to the body is an important aspect of somatic experiences (Ogden & Fisher, 2015).

Automatic arousal fluctuates between high and low levels throughout the day in which higher arousals alter us, and lower arousal calms us (Ogden & Fisher, 2015). Identifying triggers, grounding yourself, the use of breath, addressing memories, making sense of emotions, and an atmosphere of play, pleasure, and positive emotions were all identified as various techniques to cope with these fluctuating highs and lows (Ogden & Fisher, 2015). Scholars describe the process of discovering body sensations by providing a menu of sensation vocabulary words to appreciate how, "our body sensations in turn contribute to internal states of well-being or distress" (Ogden & Fisher, 2015, p. 201). For example, individuals may feel tension in their body due to internal feelings of distress and not feeling safe. This process allows individuals to understand both their external body sensations and internal thoughts and feelings to become more aware of present-moment experiences (Ogden & Fisher, 2015). Additionally, verbalizing elements of one's trauma aids in the recovery process as it allows individuals to gain control over their life. Providing individuals with a social support network or "safe base" allows individuals to attempt to break down barriers and feelings of vulnerability and hopelessness (Ogden & Fisher, 2015) This sense of control allows individuals to continue on their recovery path. It is important to understand the different types of psychotherapy to understand how psychotherapy can be implemented within a group setting. Further, it is important to understand the use of group processing techniques as outlined by Yalom (2005) that are molded and adapted into clinical psychotherapy.

Group processing techniques. A persuasive body of knowledge has validated that a highly effective form of therapy occurs within a group setting. Much of the research surrounding clinical psychotherapy has come from scholar Irvin D. Yalom, MD (1983, 2002, 2005). The ideas presented here connect to the use of group therapy within TR as they showcase the ways in which individuals can use group therapy to gain meaning of recovery (Shank & Coyle, 2005). Psychotherapy relies on an interpersonal relationship between the patient and the therapist whereby they work together to remove obstacles for effective growth (Yalom, 2002). Group therapy can be effective in a variety of settings for individuals living with different issues (Overholser, 2005). For example, group therapy has been proven to be effective for addicted patients as they manage their anxiety (Yalom, Bond, Bloch, Zimmerman, & Friedman). Group therapy is, "at least equal to individual psychotherapy in its power to provide meaningful benefit" (Yalom, 2005, p.1).

A typology created by scholars organizes group interventions into four main categories: educational, functional, support, and psychoeducational groups (Shank & Coyle, 2002). For the sake of my conceptual framework, support, and psychoeducational groups will be explored. Support groups provide on-going social and emotional support, opportunities for advocacy, and encourage healthy and appropriate leisure lifestyles (Shank & Coyle, 2002). For example, alcohol anonymous (AA) or peer counselling groups would be considered support groups (Shank & Coyle, 2002). These types of groups usually have open agendas that work to cover a wide variety of issues including: social and emotional issues related to health maintenance, leisure interests and opportunities, and self-advocacy challenges (Shank & Coyle, 2002). Additionally, psychoeducational groups combine education, skill development, and social support in order to, "develop practices that will help clients change and monitor their behaviours" (Shank & Coyle,

2002, p. 213). Psychoeducational groups are usually structured around a topic or theme that is connected to the individuals' overall health and well-being (Shank & Coyle, 2002). This type of group is, "psychoeducational because they combine education about a topic or theme with opportunities to examine underlying physiological issues that affect participants' intentions and abilities to use the information provided (Shank & Coyle, 2002, p. 212). The combined approach of providing information, developing skills, and examining psychological issues in an emotionally and socially supportive environment is effective for group interventions (Shank & Coyle, 2002). For example, a study conducted post-war in Bosnia worked to design and implement a school-based program for war-exposed youth by providing individuals with activities that include psychoeducation, therapeutic exposure, cognitive restructuring, stress management-relaxation skills, and practical problem solving skills in regard to current life events (Layne et al., 2001). The findings of this study provide a degree of promising support for the effectiveness of psychoeducational groups by showing a significant reduction in post-traumatic stress and depression and higher levels of psychosocial adaption (Layne et al., 2001). Further, group processing techniques in psychotherapy allows for group reflection and processing (Shank & Coyle, 2002). Processing, "is a therapeutic technique primarily involving verbal discussion of clients behaviours, as well as their thoughts, feelings, and other external factors that relate to the behavior" (Shank & Coyle, 2002, p. 219). This process helps individuals become aware of their behaviours, and generalize from present activity to life beyond the TR intervention in order to facilitate behavioural change among individuals (Shank & Coyle, 2002). Within group processes, interventions like social skills training, physical activity, adventure therapy, anger and stress management, self-esteem, and grief/loss counselling can be facilitated (Strumbo & Wardlaw, 2011).

Psychotherapy within an In-patient Setting

Psychotherapy has been applied in an in-patient setting for a variety of mental health populations including: border-line personality disorder (Giesen-Bloo et al., 2006), depression (Hopko, Lejuez, Lepage, Hopko & McNeil, 2003), eating disorders (Simon et al., 2013), alcohol-abuse disorders (Finney, Hahn & Moos, 1996), and trauma (Arai, Griffin, Miatello & Greig, 2008). For example, a study conducted by scholars examined individual's experiences and perceptions of leisure and recreation in the journey of healing from trauma though a leisure-based psycho-educational group facilitated by a recreation therapist using experiential group processing with psychotherapy processing techniques (Arai et al., 2008). Such studies have proven the efficacy of psychotherapy techniques within an in-patient setting for individuals in recovery of various illnesses and issues. Yet, much of these studies discuss modern psychotherapy as a human-to-human process, practiced in a square climate-controlled room with artificial lighting (Davis & Atkins, 2004). As discussed above, the use of the outdoors has been shown to have a positive effect for individuals within a recovery process (Jordan, 2015). Therefore, a gap in the literature exists in understanding individual's experiences of engaging in outdoor experiential psychotherapy while in recovery of a PTSD-SUD diagnosis within an in-patient setting. Further, what remains to be explored is the connection between outdoor nature therapies, and psychotherapies as complementary tool in recovery of PTSD and SUDs.

Psychotherapy within an in-patient context has historically been evaluated through self-reported measures to assess changes in symptoms (Levitt, Butler & Hill, 2006). However, this type of evaluation rarely provides information on what this means to the individual on a moment-to-moment basis, as a result, psychotherapy researchers have been calling for qualitative approaches to inquiry (Levitt et all., 2006). I hope to address this gap in the literature by applying qualitative approaches to inquiry, including narrative inquiry and collective narrative refraction

(Berbary & Boles, 2014) to understanding the meaning and experience of engaging in outdoor experiential psychotherapies within an in-patient setting.

Summary

Throughout this literature review, I have identified key gaps in the literature that surround my conceptual framework and position my research within contemporary literature. First, what is missing in the literature are the voices, stories, and lived experiences of individuals living with a comorbid PTSD-SUD diagnosis as it relates to their recovery. My research will work to fill these gaps to explore, 'the voice in the cracks' by providing opportunities for individuals living with a PTSD-SUD comorbidity to share their stories and lived experiences of engaging in outdoor experiential psychotherapy within an in-patient setting. Second, a clear relationship between PTSD and SUDs has been identified in terms of onset and symptoms of both disorders (Jacobsen et al., 2001; Koefoed et al., 1993; Ouimette & Brown, 2003; Ouimette et al., 1998), however very little research has focused on the efficacy of treating both disorders within an in-patient context. Third, the literature has identified TR as a therapeutic modality to effective treatment within a clinical setting (Austin et al., 2011). Yet, what remains to be explored is the use of non-traditional complementary psychotherapies, such as OET and nature-based therapy, as a therapeutic modality for individuals in recovery of PTSD and SUDs. Further, re-imagining how therapy can look differently within an in-patient setting by recognizing the usefulness of nature as a co-therapist remains to be explored (Jordan, 2014). Although, I do not wish to discount modern and traditional modalities of therapy, I want to acknowledge that some individuals may find meaning in the use of outdoor experiential psychotherapy as a complementary therapeutic practice within an in-patient context. Pulling on ideas from TR, outdoor experiential learning, nature-based therapy, and the world of psychotherapy, including relational and sensorimotor

psychotherapy and group processing techniques, this research will work to explore the use of these modalities within an in-patient setting as a therapeutic modality. In doing so, I hope to engage individuals to create dialogue around how we can deconstruct the stigma and marginalizing ideas surrounding a mental health diagnosis, in order to re-imagine what "therapy" can look like. We need to look beyond the voices in society we have come to know and understand and look below the surface of "normalcy," to inform positive social change. By applying a pragmatic lens to my research, I hope to capture the "voices in the cracks," to explore the use of alternative therapeutic modalities for individuals living in recovery of a PTSD-SUD comorbid diagnosis.

CHAPTER THREE: METHODOLOGY

The purpose of this research is to understand the lived experiences of individuals living with PTSD and SUDs while engaging in outdoor experiential psychotherapy and to provide a platform for the 'voice in the cracks' to be heard. Narrative inquiry will be used to explore the voices of individuals currently attending the in-patient care program for integrated alcohol and drug addiction and trauma at Homewood Health Centre in Guelph, Ontario, asking them to reflect on their personal recovery. Using a pragmatic social constructionism lens, the following question was explored:

1. How does the use of outdoor experiential psychotherapy within an in-patient care setting, influence individuals' experiences of early recovery?

An understanding of the personal meaning and stories derived from engaging in outdoor experiential psychotherapy was further explored to gain insights that may serve as a basis of positive social change into everyday practice within mental health in-patient care settings. The significance of this study is to understand personal meaning derived from outdoor experiential psychotherapy from individuals' own stories and experiences of early recovery, to transform the way healthcare professionals think about "therapy" within an in-patient care setting, and to understand how outdoor experiential psychotherapy can be integrated into early recovery. In addition, this study works to gain further insight into the importance of having opportunities for marginalized individuals to share their stories and experiences to inspire others living with a mental health diagnosis, and challenge the stigma around mental health.

Methodology

It is important to positon my research as a commitment to create dialogue and begin to take action to break down the stigma and marginalization that currently surrounds a mental

health diagnosis. It is further important to understand that every step of this research process is interlocked with certain epistemological and ontological beliefs. I hope to inform positive social change within the in-patient mental health community and provide opportunity for marginalized voices that are often un-represented in society, to be heard and supported (Hosking, 2008). By asking the challenging questions, we need to create new ways of thinking and acting, when providing TR services within an in-patient setting for individuals living with a PTSD-SUD diagnosis through the use of complementary therapeutic practices.

My choice in methodology for this research is essential, as it needs to capture the essence of the individuals' shared stories and experiences of living in recovery. The field of recreation and leisure often uses quantitative measures, such as self-reported measures (Levitt, Butler & Hill, 2006). Yet this type of evaluation rarely takes into to account the moment-to-moment interactions that happen as individuals create meaning (Levitt, Butler & Hill, 2006) through outdoor experiential psychotherapy. By adapting a qualitative lens to my research, this research works to provide a platform for individuals living in early recovery of a PTSD-SUD diagnosis, as they come to terms with their experiences and engage in outdoor experiential psychotherapy within an in-patient setting. The use of narrative inquiry is most appropriate for this study of individuals living with a comorbid PTSD-SUD diagnosis, as they engage with outdoor experiential psychotherapy within an in-patient setting due to its fundamental ability to position individuals' embodied and lived experiences at the forefront (Reissman, 2007). More specifically, the use of "experience-centered" narrative will be instilled throughout the research process (Squire, 2008). The "experience-centered" approach to narrative assumes narratives are both meaningful and sequential and work to "re-present" experience, reconstitute experience and express experience to evoke transformation or change (Squire, 2008).

Narrative Inquiry

deMedeiros (2014) stated, "the body has lived, felt, and been hurt, and therefore it houses memories of its own" (p. 48). This quote directly speaks to the use of narrative inquiry as a methodological strategy. Narrative inquiry works to capture the detailed and contextualized stories and voices of a single life or the lives of a group of individuals (Chase, 2005). The use of narrative inquiry as a research approach can empower individuals "by emphasizing their shared humanity through personal stories of joy, sorrow, struggles and activities of daily living" (Johnson & Parry, 2015, p. 50). Narrative research allows individuals to share their own stories in a way they feel is most relevant (Reissman, 2008). Stories are then retold or re-storied by the researcher to combine views from both the participant and researcher's life in a collaborative narrative (Connelly & Clandinin, 1990). This process allows opportunity for narrative research to be used as a tool for eliciting positive change (Johnson & Parry, 2015). Narrative inquiry also provides researchers with critical understandings into how individuals are impacted by disease, illness, injury, care, and treatment (Sutherland & Stroot, 2009).

The predecessors of narrative inquiry today come from the Chicago School Sociologists who have collected life histories and other personal documents in the 1920's and 30's (Chase, 2005). Thomas and Zuaniecki's (1918/1927) used life histories to understand the social life of Polish immigrants into the United States. Following this, other researchers including Shaw (1930/1966) and Sutherland (1937) similarly used a life histories methodology to understand juvenile delinquents and criminals' experiences. Similarly, within the field of anthropology in the 20th century, researchers were using life histories as a way of understanding cultural facts (Chase, 2005). The idea of personal narratives was then picked up by feminism as a way for women to act as social actors in their own right, and to understand the subjective meanings that women assigned to events and conditions within their lives (Chase, 2005). Finally, in the 1960's

the idea of sociolinguistics and oral narratives were brought into light as a platform for diverse explorations of sociolinguistic features and oral discourses within society (Chase, 2005).

Unlike traditional methods of research that put the researcher in full control, narrative inquiry puts the participant in the center of the research process as the "expert" of their own life (Reissman, 2008). By examining narratives as stories of experiences, rather than events, this approach assumes that narratives are sequential and meaningful, definitively human, work to "re-present", reconstitute, express experience, and display transformation or change (Squire, 2008). Scholars discuss that this process allows individuals to create meaning to a specific experience as narratives work to make us humans (Squire, 2008). This type of narrative approach leads researchers to view narratives as just one of many narratable "truths" (Squire, 2008). The use of "experience-centered" narrative is especially pertinent to my focus of individuals meaning making processes of engaging in outdoor experiential psychotherapy as it provides an opportunity for individuals to express their own personal experiences in order to invoke personal growth or change (Squire, 2008). Narratives can be collected through a range of different methods and materials. For example, narrative researchers work to obtain information through observation, written materials, oral conversations and visual representations (Squire, 2008).

Narrative inquiry is increasingly being used in studies of educational experience (Connelly & Clandinin, 1990). Scholars discuss that the main claim for the use of narrative education "is that humans are storytelling organisms who, individually and socially, lead storied lives" (Connelly & Clandinin, 1990, p.2). The goal of narrative inquiry is to collect narratives that work to re-construct meaning through narratives (Berbary & Boles, 2014). Each narrative collected is unique in the fact that everyone has a story to tell and it's his or her own story, therefore each narrative is constructed within the larger society (Berbary & Boles, 2014). Narrative inquiry

works to uncover the story behind specific events and the individuals involved in them (Light, 2015). Narratives allow us to understand our worlds narratively through how we tell, retell, and relive our lives within particular social and cultural plotlines which are directly linked to personal identity (Clandinin & Huber, 2002). Narratives goes hand-in-hand with experience (Jackson & Mazzei, 2005). Individuals often embed their experiences in the stories they tell in interviews (Jackson & Mazzei, 2005). For narrative researchers, the focus is to collect and tell individuals' storied lives through the process of writing narratives of experience (Connelly & Clandinin, 1990).

Regardless of the form that a narrative takes, the philosophical underpinnings of narrative inquiry supports that a single narrative is important in and of itself, and therefore can contribute to the knowledge production of the larger culture (Chase, 2005). Narrative inquiry is tied closely to cultural discourse, ideology, and expectation as it portrays the reflections of experiences for the larger culture (Chase, 2005; Reissman, 2007). The purpose of narrative inquiry as a methodology is to illuminate the stories of individuals, to contribute to the knowledge construction in the larger cultural context through the use of co-construction and re-storying, and to create counter-stories that work to break down the meta-narratives of the culture around us (Chase, 2005). Narratives work to enlighten the way in which culture is reflected in the understandings of ourselves, others, and the larger cultural world around us (Chase, 2005). Additionally, "giving voice" to marginalized individuals and "naming silenced lives" have been primary goals of narrative research for several decades (McLaughlin & Tierney, 1993). Taking another persons' perspective is an essential step in constructing social change (Chase, 2005). Narrative inquiry allows researchers to provide a platform for marginalized groups in society to share their stories and voices (Johnson & Parry, 2015). Through narrative inquiry, we as

researchers are able to begin to break down the walls and boundaries of the cultural discourses and ideologies that surround us, to include the voices that are often rendered silent in society (Chase, 2005). To invoke social change, "we need to think more about who could benefit from, and who needs to hear, *our* research narratives" (Chase, 2005, p. 670-671).

Experience-centered narrative inquiry. More specifically, the use of experience-centered narrative inquiry will be a critical underpinning of my study. The use of experience-centered narrative inquiry works to understand and conceptualize the experience of a specific experience for a group of individuals (Squire, 2008). "Experience-centered narrative research distinguishes personal narratives from other kinds of representations as being sequential in time and meaningful" (Squire, 2008, p. 3). Focusing on experience-centered narratives conceptualizes narratives as means of human sense-making for representation, reconstruction, and transformation for a particular population of individuals (Squire, 2008). This type of narrative inquiry allows researchers to tackle issues stemming from a socially and culturally-directed research framework (Squire, 2008). For the sake of my own research, experience-centered narrative inquiry works to conceptualize individuals' specific experiences of engaging in complementary therapeutic practices from within an in-patient setting.

Narrative inquiry in TR. Although narrative inquiry is becoming increasingly popular, the use of narrative inquiry in the field of TR has not been as thoroughly explored as a research tool within a mental health in-patient setting. Within the field of leisure and therapeutic recreation, narrative inquiry has been used to explore a variety of populations. For example, one study used narrative inquiry as a way to negotiate trans(gender) expressions within leisure spaces (Lewis & Johnson, 2011). A second study used narrative inquiry to explore adolescents' experiences of living with cerebral palsy as they engage in leisure activities (Cussen, Howie &

Imms, 2012). In addition to narrative inquiry as a methodology, the use of narrative strategies has been used as a therapeutic healing tool in the field of TR. For example, a professional working with individuals in recovery of drugs and alcohol, shared his experience of using narratives and stories as an asset in recovery (Weegmann, 2010). He described having individuals generate a narrative through the form of a letter, that starts off with, "*Dear drugs and alcohol*" (Weegmann, 2010). Through this process, he discusses the experience of individuals being able to revise long-held dominant narratives in their head and begin a process of re-building (Weegmann, 2010). Further, an arts-based narrative study looked at the experiences of eight artists as they expressed their own process of transformation through art and narratives (Elliot, 2011).

Although narrative inquiry is becoming increasingly recognized as a useful methodology for conducting qualitative research, the use of narrative inquiry to understand the care being provided in in-patient mental health settings has yet to be explored. A notable example within a therapeutic context includes a study that collected letters from veterans with confirmed PTSD diagnosis of their experience of engaging in a fly fishing program (Mowatt & Bennett, 2011). The purpose of this study was to collect and present a set of narratives and themes related to the experience of fly-fishing that would inform and guide empirical studies on the realities of veterans, program experiences, and perspectives on treatment (Mowatt & Bennett, 2011). The focus of this research is to explore the realities of individuals within an in-patient treatment setting as they engage with therapeutic recreation processes. More specifically, individuals' stories and experiences of receiving in-patient care and the ways in which outdoor experiential psychotherapy can be incorporated to create meaningful leisure practices.

The use of Voice in Qualitative Research

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The context in which voice happens can be more complex than meets the eye (Jackson & Mazzei, 2005). Voice is inherently referred to as spoken utterances that are "voiced" by individuals, however, voice can also happen in other nonverbal ways such as art, dance, or music (Jackson & Mazzei, 2005). This is a process of thinking about voice beyond its humanized and constituted forms (Jackson & Mazzei, 2005). Scholars discuss that qualitative inquiry should work to conceptualize all forms of voice including, "what voices we hear" but also "how we hear them," and then work to "idealize and totalize" (Jackson & Mazzei, 2005, p. 48). An issue with the use of voice in qualitative research is the process of capturing voices and making meaning from them. That is, "we seek familiar voice that does not cause trouble and this is easily translatable. We seek a voice that maps out ways of knowing, understanding, and interpreting" (Jackson & Mazzei, 2005, p. 48). It is important to not just focus on what and how we understand voice, but also to seek the voice that escaped our easy classification, and that challenges our assumptions- "the voice in the crack" (Jackson & Mazzei, 2005, p. 48). Yet, little research has been conducted to understand individual preferences. Scholars discuss that "understanding client preferences is an important factor in determining the best approach to offering treatment" (Janikowski & Glover, 1994, p.81). We must work to understand what individuals living with a PTSD-SUD comorbidity are saying about their own personal recovery within an in-patient treatment setting to better understand how to meet the therapeutic needs of individuals healing from this diagnosis. Therefore, what is missing in the literature is "the voice in the crack."

For the purpose of this research, a narrative approach is most appropriate to address the purpose of my study and answer the research question, as it will provide me the space to hear the voices and stories of individuals living with a PTSD-SUD diagnosis as they engage in outdoor

experiential psychotherapy. The narrative process allows the individuals to be at the forefront of the study to uncover the stories behind the experiences of recovery within an in-patient setting. By having opportunity for individuals living in early recovery of a PTSD-SUD diagnosis to share their voices, stories, and experiences of commentary therapeutic practices, I hope to understand the meaning that is derived from this type of programming within an in-patient context. This will allow me to gain further insight into the connection between the use of outdoor experiential psychotherapy within an in-patient care setting and individuals' experiences of early recovery. In connection to the stigma of mental health and the marginalization of voice in society, this study will seek to explore "the voice in the crack," by applying a pragmatic lens to understand the meaning individuals living with a PTSD-SUD diagnosis derive from engaging in an complementary outdoor experiential psychotherapy. Through this, I hope to gain further insight into the cultural discourses that surround a mental health diagnosis and showcase how outdoor experiential psychotherapies can add to the meaning created within an in-patient recovery program and evoke positive social change within this domain.

Population, Sample Selection, and Social Context
The Outdoor Experiential Psychotherapy Workshop- Program Context

The outdoor experiential psychotherapy workshop was a one-day session facilitated at Homewood Health Centre in Guelph, ON (See Appendix A for workshop schedule). The program ran as a full day workshop and was on a volunteer basis for all participants. Participants had the opportunity to sign-up for the workshop two weeks' prior through the recreation department at the hospital.

To start the day, the participants met at the lower outdoor grounds at the hospital. The main researcher (J.L) had a discussion with the participants about the research project, ethics, and consent, to ensure all participants understand the purpose of the research and consent to

participation. The workshop was facilitated by two recreation therapists (S.K and A.G.) on site. Throughout the day, a variety of experiential activities were facilitated with a focus on growing awareness, trust, and vulnerability. The workshop began with ice breaker activities for participants to start to get to know each other. As the day progressed, the activities challenged the participants to be more trusting of their surroundings and the other participants. De-briefing with participants occurred after activities throughout the day to increase participant's awareness of the activities and allow them the opportunity to acknowledge and reflect on the deeper meaning created for their own recovery (See Appendix B).

To conclude the workshop there was an audio-recorded de-brief facilitated by the recreation therapists (S.K and A.G.) (See appendix B). This space was used as a way to bring the group together and create dialogue around the embodied experience of the outdoor experiential psychotherapy workshop as a general de-briefing/group processing. Within the experiential education literature, the role of de-briefing and processing is important to the therapeutic milieu created throughout this type of programming. Scholars discuss the use of discussion and processing times being utilized to share spiritual experiences in which individuals are create dialogue around personal growth or struggles (Anderson-Hanley, 1997). From these types of conversations, participants had the opportunity to draw parallels between the experiential activity and sense of nature connectedness and their individual real-life (Anderson-Hanley, 1997). Participants had an opportunity to share their own stories and experiences as it relates to others who share similar experiences through the de-briefing and processing. This also served as a space to understand how these experiences may have created meaning for the participants own personal recoveries.

The Site: Homewood Health Centre- Addiction Medicine Services (AMS) Unit

Homewood Health Centre is a 300-bed mental health and addiction facility located in Guelph, ON ("Homewood Health", n.d.). Homewood Health Centre is one of the largest mental health and addiction facilities within Canada ("Homewood Health", n.d.). In addition to addictions services, Homewood Health Centre has programs and services that includes, but it not limited to: comprehensive psychiatric care, eating disorders, integrated mood and anxiety disorders, and a program for older adults ("Homewood Health", n.d.). For the sake of this research project, I focused on the Addictions Medicine Services (AMS) unit at Homewood. This unit provides a range of services including specialty programs and streams that are tailored to meet the individual needs of their patients ("Homewood Health", n.d.). Within the AMS Unit there is a specific Addictions-PTSD Recovery stream. This program directly targets individuals living with a comorbid PTSD-SUD diagnosis to offer an integrated care approach of clinical practice for treatment within a therapeutic treatment setting ("Homewood Health", n.d.). The program serves as an in-patient program in which individuals stay at the facility from five to eight weeks depending on their treatment care plan ("Homewood Health", n.d.). Homewood Health Centre was also used as the home base for the facilitation of the outdoor experiential psychotherapy workshop.

The Participants

Purposeful sampling was used in this project to target individuals in the integrated Addiction-Trauma Recovery Program within the AMS unit at Homewood Health Centre, to participate and engage in the outdoor experiential psychotherapy workshop at the facility. Six participants (three identified as male, three identified as female) were recruited through purposeful sampling procedures. Participants had the opportunity to sign up for the outdoor

experiential psychotherapy workshop as part of their recreation programming at the hospital (See Appendices C, D & I). All participation in the workshop was voluntary by the participants.

In addition to the individuals in the addiction-trauma stream at Homewood Health Centre participating in the workshop, I recruited two recreation therapists (S.K and A.G) from within the AMS unit to co-facilitate the workshop. From my experience of working in the AMS unit, and facilitating similar outdoor experiential programming, having recreation therapists participate alongside the individuals was a positive outcome. The individuals I worked with expressed enjoying this aspect of the program as it provided them the opportunity to gain a sense of shared humanity by stripping away the labels of "professional" and "patient." The purpose of having recreation therapists participate in the workshop was to create a safe place that will make all participants feel comfortable. This provides a space for the "patients" and "professionals" to be on the same level as they engage with the activities. Although, I recognize and understand that this could also be argued to be ineffective to the purpose of this research, from my experience, I have chosen to argue the importance and benefit of having recreation therapists participate.

As the primary researcher, I chose to participate in the outdoor experiential workshop to work to understand the experience of the workshop. As a researcher, it provided me with a platform to speak to the experience of the workshop from my own social position and embodied experience. Throughout the research process, it was important for me to engage in reflexive practices to think through and understand my own social position within the research process.

Ethical and Safety Considerations

Due to the vulnerability of this population, ethical considerations are vital to my research project. First and foremost, all participation in the workshop was voluntary for individuals throughout the entire research process. Individuals had the opportunity to sign up for the workshop two weeks in advance as a part of the recreational department at Homewood Health

Centre (See Appendix C). Recruitment posters were posted on the unit two weeks prior to the workshop (See Appendix D). Additionally, the recreation therapists announced the workshop at the weekly community meeting (See Appendix I). On the day of the workshop, all participants read and signed an informed ethical consent form. (See Appendix F). The informed consent form outlined in detail all information regarding the study. Each participant also received a feedback letter following their participation in the study that provided them with further information regarding the outcomes of the research (See Appendix G).

Confidentiality was of the upmost importance in this study. Although anonymity cannot be promised due to the face-to-face interactions and discussions throughout the workshop and interviews, confidentiality of all data was maintained. Following the workshop, all personal identifiers were stripped from all data and each participant was assigned a pseudonym to ensure confidentiality.

Safety Considerations. Due to the vulnerability of this population, the de-briefing and processing of the activities invoked emotional and psychological thoughts, feelings, and emotions. As the researcher, it was vital to consider the safety considerations that surround this workshop. In order to create a "safe place" for the participants, it was important to dialogue up front prior to the experience of the workshop. I had a conversation with the participants as a group to ensure we were actively creating a safe place for everyone involved in the research process. Yet, it is further important to recognize and acknowledge that creating a "safe place," can also have negative implications, including unintentional exclusion. Throughout the workshop, it was of the upmost importance for me to continue to have reflexive conversations to ensure I was aware of all of the present implications that may affect this particular study. The purpose of facilitating this workshop on the grounds of Homewood was to provide individuals

with a safe and familiar setting. In addition, the recreation therapists have experience and familiarity with this type of programming that lends to my study, and were available to assist with any emotional concerns that arose for individuals. Individuals were invited to engage in a process of de-briefing any thoughts, feelings, or emotions that come up in a safe and supportive environment. This environment provided individuals the opportunity to work on their grounding skills if they felt triggered in any way. In thinking through these safety considerations before the facilitation of the workshop, it was my hope that if issues arose, they would be dealt with in a compassionate and supportive manner.

<h3 align="center">Data Collection Procedures</h3>

As indicated above, the methods used in narrative inquiry are further concerned with the ways in which we co-construct and re-story narratives, specifically counter-narratives, and how these then contribute to the critique of the grand meta-narratives of discourse, language, power, and ideology in our society (Chase, 2005). Data was collected through a focus group and in-depth narrative life-experience interviews.

Phase One: Group Debrief

The focus group occurred directly after the conclusion of the outdoor experiential psychotherapy workshop and was approximately one hour in duration (See Appendix B). This focus group acted as a general group de-briefing/processing after the workshop. Main themes and topics were further explored by the recreation therapists who facilitated the workshop (S.K. & A.G.) to gain an in-depth understanding of individuals' embodied experiences as a group. Focus groups are used to explore and understand common experiences about a specific topic (Johnson & Parry, 2015). This interactional style is used to generate multiple perspectives, new ways of thinking and diversity of experiences of the participants and the researcher (Johnson & Parry, 2016). This type of de-briefing is consistent with debriefing practices as outlined in the

experiential education literature as it provides a space for individuals to reflect, discuss, and process insights into their own realities (Anderson-Hanley, 1997). This process provided a space for participants to communicate their thoughts and feelings, connect, and derive meaning from the outdoors. It further provided individuals the opportunity to share stories and experiences of shared humanity and relate to each other on a personal level within a group context.

Phase Two: Semi-structured Narrative Life-Story Interviews.

The individual narrative-life experience interviews occurred up to one week following the workshop and each interview was approximately one-hour in duration. The interviews were audio-recorded and transcribed by myself. Throughout the interview, participants were asked a set of guided questions (see Appendix J) intended to keep the conversation directed on the experience of the outdoor experiential psychotherapy workshop. The use of qualitative interviews is to have a purposeful conversation that takes place to gather and understand the participant's reality (Johnson & Parry, 2015). Life history and experience-centered interviews were blended together and utilized as a narrative that specifically funnels from an individual's life history to a life event or experience that an individual has had (Chase, 2005). Experience centered narratives focus on the meaning made through a specific experience or context (Squire, 2008). By narrating experience, individuals have the opportunity to "re-story", reconstitute, and express experience to create meaning of that experience (Squire, 2008). This process is especially important for my study as it provided an opportunity for individuals to express the meaning derived from engaging in outdoor experiential psychotherapy within an in-patient setting. Through the form of life-story interviews, experience centered narrative researchers engage in a variety of narrative strategies, including in-depth conversations with their participants. The steps involved in this process of narrative inquiry as outline by scholars include; the construction and interpretation of a story, and composing a personal experience

narrative (McCormack, 2004). The former referring to the collection of the narrative through in-depth interviewing, and the latter referring to the researcher's re-story through interpretation and narration of the participant's story (McCormack, 2004). The use of semi-structured follow up narrative life-story/experience based interviews were used in this research to allow me to prompt specific dialogue of the proposed research questions, as well as provide room for participants to share their own story. For the sake of this research project, participants had a chance to share their life-story experiences in a broader sense and then apply these understandings to the experience of engaging in the outdoor experiential psychotherapy workshop. Interviews occurred approximately one-week after the outdoor experiential psychotherapy workshop to allow individuals the time to reflect on their feelings and behaviours in the experience, as well as how they processed and transferred the experiential knowledge and meaning into their own recovery. Through this, the embodied experiences and stories of the outdoor experiential psychotherapy workshop were understood to conceptualize how these experiences transferred to individuals' own realities of living in early recovery of a PTSD-SUD diagnosis.

Data Analysis Procedures
Phase Three: Analysis, Interpretation and Representation
   Analysis and interpretation. After completion of the transcription of the focus group and individual interviews, line-by-line coding of all the transcripts was completed (See Appendix J. for procedural memo). Next, the identified codes were organized into categories, and the narrative threads that were evident to answer the guiding research question was identified. Throughout this process it was clear that the participants' experiences of the workshop were interwoven and unique. This phase of the analysis was completed by cutting sections of each individual's transcripts and re-organizing it in a way that made sequential sense for each participant's experience. Therefore, the narratives presented to you in chapter four were directly

comprised from the data. Each narrative was constructed in the sense that it comes directly from select quotes from the individuals interviews and focus group. It was important for me, as the researcher, to showcase the overall unique meaning of each story as opposed to the sequential aspect. Through this, the narratives were represented in a way that showcases the individual stories and voices of each participant at the forefront of the research.

After presenting the individual narratives, a process of narrative thematic analysis was used to bridge together participant's experiences of the workshop and create common narrative threads that were woven among the participant's experiences. Thematic narrative analysis is a qualitative analysis approach that is aimed at identifying, analyzing, and reporting patterns (themes) within data (Braun & Clarke, 2006). This type of analysis examines narrative materials from life stories and experiences by breaking the text into smaller understandings (Sparker, 2005). Narrative thematic analysis places an emphasis on "what" is said more than "how" it is said (Reissman, 2005). As a research tool, thematic analysis provides a rich and detailed account of the data by identifying and exploring common threads that extend across a set of interviews (Braun & Clarke, 2006; Desantis & Ugarriza, 2000). Researchers collect stories and inductively create conceptual groupings from the data by focusing on the meaning that is found in the text (Reissman, 2005). This process allowed me to understand how, if at all, individuals' narratives related to the guiding research question. Further, this process specifically applied to my research as it allowed me to: be sensitive to individuals' accounts of past, present, and future events; understand individuals sense of place in those events; understand the stories individuals generate about an event; and understand the significance of the event for the individual (Bryman, Bell & Teevan, 2012). To do this, sections of the transcripts were highlighted with an intentional colour-coded scheme to identify and explore texts that contained significant meanings. The

transcript was then cut to re-organize the data from each participant's unique perspective to create common narrative threads. In total, four narrative threads were identified from individual's experiences of the workshop resulting from this study.

Research Authenticity and Trustworthiness

The process of building authenticity for qualitative narrative inquiry studies varies vastly from that of quantitative measures. Due to the complexity that surrounds the use of narrative, an understanding of authenticity for such research studies is important. Building authenticity will vary based on a researcher's discipline, epistemological, ontological, and theoretical orientations, as well as methodological choices (Johnson & Parry, 2015). For the sake of this research project, it was my responsibility to ensure I was providing an accurate or "true" account of the knowledge constructed through inquiry (Johnson & Parry, 2015). In creating a "true" account of experience for the participants in this workshop, it was necessary to continue to be reflexive throughout the research process in order to attend to the intentions, assumptions, and motivations behind this research project (Johnson & Parry, 2015).

Gibbs (2007) outlines qualitative validity as the researcher checking on the accuracy of the findings by employing certain procedures, while qualitative reliability indicates that the research process is consistent across different researchers and projects. Based on these understandings, I worked to ensure trustworthiness in this project by actively being reflexive in my role. Applying the strategies that applied to this specific study as outlined by Creswell (2014) ensured that I was indicating the ways in which trustworthiness affected the research study presented. First, I used a thick description to convey the findings of my research to ensure the findings become more realistic and richer. Second, I clarified my own interpretations as a researcher and participant in the study to create an open and honest narrative with readers. Third, in addition to presenting the positive narrative threads of the findings, I also actively presented

the negative or discrepant information that runs counter to the themes to make the findings more realistic in nature (Creswell, 2014).

Researcher/Student Role

My role as the researcher was of the upmost importance as it comes to my specific study. As a researcher, it was my job to create a safe place for participants to share their stories and experiences of the outdoor experiential psychotherapy workshop. Through stories of joy, sorrow, vulnerability, and trust, this research works to create a shared sense of humanity among the participants as they continue on their journeys of recovery. It was my job to take the narratives collected and re-story them in a way that accurately portrays the participants. In recent work, scholars have discussed the issues that arise when speaking "for others." For example, it was discussed that the practice of speaking for others, or on behalf of others, has actually resulted in re-enforcing the oppression of the group spoken for (Alcoff, 2009). Speaking from a social constructionist worldview, makes this issue apparent in my own research. It is important to not just focus on the "truth" that is being said, but also who is speaking to whom (Alcoff, 2009). Within a social space, it is vital to take into account both the social location of the person speaking as well as discursive context (Alcoff, 2009). Although this issue is not something that can be "fixed" per se, within my own research it was something to acknowledge and be aware of through the research process. It is important in this context, to ensure I was aware of my own social position, as a researcher, and the effect that position has on the relationships formed in the research to ensure participants are being represented in a just manner.

It was important to be upfront about my own subjectivities, as the primary researcher within the research, in order to recognize myself as part of the story and develop my own voice within the research. This process allowed me work to construct the voices and realities of the participants (Chase, 2005). It is important to note that I am not able to separate my own

experiences, biases, and expectations from the researcher, therefore it is important to reveal my

social position in order to be transparent and reflexive throughout the research project. This

process is referred to as, the researchers "reflexivity" (Johnson & Parry, 2015). A researcher's

reflexivity refers to his or her reflection about how their role in the study, and their personal

background and experiences shape their interpretation of the data (Creswell, 2014). This process

further provides an opportunity to investigate the theoretical and methodological tensions

occurring in the work, to rationalize the decisions made within the research, and lay the ground

work for interpreting and representing the data (Johnson and Parry, 2015). Within my own

research, it was important to be reflexive throughout the research process in order to understand

the implications of the chosen methods, my own values, and my own mere presence as a

researcher have for the understandings generated (Bryman, Teevan & Bell, 2009).

CHAPTER FOUR: NARRATIVES

Summary

The purpose of this study is to explore the use of outdoor experiential psychotherapy for individuals living with PTSD ad SUDs within an in-patient setting. The research question driving this study is: How does the use of outdoor experiential psychotherapy within an in-patient care setting, influence individuals' experiences of early recovery? Exploring ideas from a social constructionism paradigm, it is important to positon my research as a commitment to create dialogue and begin to take action in an attempt to break down the stigma and marginalization that currently surrounds a mental health diagnosis. Experience-centered narrative inquiry was utilized as a guiding framework to explore participant's experiences of the outdoor experiential psychotherapy workshop and represent those findings in a way that "re-presents" experience to evoke positive social change from within an in-patient care setting (Squire, 2008).

At the beginning of this chapter, it is important to re-iterate the purpose of this research project is not to seek a conclusion per se. My hope for this research is to be used as a platform that continues the dialogue around the way we not only view "therapy" from within an in-patient setting but also how we can begin to deconstruct the ways in which individuals living with PTSD and SUDs are viewed. In doing so, it is important to listen to the individuals living in recovery to hear what they have to say for themselves.

Exploring Stories

At the forefront of this section, the individuals who participated in the outdoor experiential psychotherapy workshop will be introduced. Throughout the analysis aspect of this research, it was apparent that each participant's experience was complex and multifaceted and therefore yielded a narrative of its own. The stories presented in this section were constructed in a way that works to give meaning to participants spoken words. Although the stories reflect first-

person language, it is important to note they were not constructed by the participants. Instead, their stories workshop was constructed in a way that also embeds my own reflexive lens as a researcher and participant in the workshop. Therefore, I have chosen to introduce each participant's story presented below from my own interpretation based on my own embodied experience of engaging in the outdoor experiential psychotherapy workshop. Through the process of taking authorial ownership over the narratives, the constructed narratives work to illustrate the participants embodied experiences. Throughout this process the narratives are presented in a way that maintains the participant's voices at the forefront of the research.

In conversation with the participants, I attempted to gain further insight into their own embodied experience of engaging in the outdoor experiential psychotherapy workshop within an in-patient setting. The following stories come directly from the transcript of the focus group and interview conducted with the participants. In a world that it filled with judgment, stigma, and marginalization of a mental health diagnosis, we, as a society, need to begin to hear more of the voices of the individuals living in recovery to understand the complexity of their experiences. In the in-patient care system, individuals living with PTSD and SUDs are often rendered voiceless due to the stigma and marginalization that currently surrounds a mental health diagnosis. These are their stories.

The Story of Ava

My experience throughout the workshop with Ava was positive. Throughout the day Ava presented a very positive and insightful attitude. She continued to shine her light despite the heavy conversations and moments It was her positivity that brought the group back to an affirmative space at times. Ava was able to let herself go and enjoy the activities, laugh, and

share her experiences of the workshop with everyone. Ava, I hope you continue to carry that light with you everywhere you go.

Signing up for the outdoor workshop today was exciting because we were going outside. It was a little chilly today but it was nice to get outside where my mind can be free and be able to try something different. Being able to hear the birds chirping and breathe in the fresh air and see the wind blowing in the trees was a calming feeling for me. It was a nice change to be outside today because being inside all day can be kind of boring. It was nice to do something spontaneous. I didn't know what to expect today which made me nervous, but it gave me a chance to take a leap of faith and jump right in.

Going into the workshop, I was excited to see what types of activities we would be doing. It made me reminisce on the times that I used to play with my own kids and go to places like Canada's Wonderland. Recently those memories have been clouded by drinking. Looking back on that I think to myself, "so why did you have to drink when you had the kids?" It made me feel bad to think of all the times I was going to take the kids somewhere fun but didn't because I had too much to drink that day. Getting back to my normal self is something that makes me excited going into recovery.

Jumping into the activities with the ice breaker and having to put on "chicken goggles" was uncomfortable. Especially having to make eye-contact with the other people while pretending to be a chicken. It made me nervous to mess up the pattern of the activity and have to go around the circle "bokking" like a chicken. When the recreation therapist had to go around and "bok" like a chicken in front of everyone, it was nice to watch her have fun and let out her inner child. Seeing a grown woman and an "authority figure" here be so silly, made me feel like I can be too. This activity made me focus on the task at hand helped ease my racing mind. After

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getting the chance to get to know everyone better, it was easier and made it fun and silly. We were all in it together, so you may as well go with the flow. It also felt good to be able to laugh again. The next activity with the bull-ring where we had to work together to move the ring was interesting because I wasn't allowed to speak, which was a good role for me because I am a better listener than a giver. Being able to let go of what was in my head and let the others take charge and deal with it was helpful. It helped me learn to just shut up and listen. The group juggle activity was enjoyable as well because it was fast paced and it allowed me to focus on the bean bags and the task at hand, instead of all the racing thoughts in my head.

It was a little nerve-wracking and claustrophobic at first in the willow-in-the-wind activity, but once I was in the middle and started swaying, it was nice to feel the other people surrounding me. Going into the middle of the circle first was good for me because it showed everyone else that I had their backs. Choosing to go into the circle first challenged me to try and get out of my own shell. It actually felt relaxing because I was able to close my eyes and it was quiet and the other people were nudging me. It was peaceful being able to listen to the nature around me and not focus on all the racing thoughts in my head. It allowed me the space to get out of my own head. In the moment, it felt like I could have fallen asleep. It felt good be able to trust that the other people were going to catch me. It was comforting to know that someone was there to hold me up. In this activity, everyone was able to learn a little bit of trust, it felt like we are all working our recoveries together.

The last activity, the "eagle, bat, and parrot" was kind of frustrating for me because it felt like sometimes people weren't listening to me. People always tell me that when sharing my thoughts, I talk in circles. So when the other people weren't understanding my direction, it was frustrating. I am really good at taking direction, but not so good at giving direction. That has

been bad for me in the past because it makes it hard to say "no" to people. In the moment, I just tried to stay calm, breathe, and work out how to deal with the situation at hand. At the end of the day, it is just a game. If this was a real-life situation it would have made me shut down and walk away because I am a very passive person. This activity taught me how important it is to vocalize my frustrations in my own recovery. It will be important for me to say "no" when I need to focus on myself. In the role of the "bat," it felt peaceful to be blindfolded and wandering around. My racing thoughts subsided. In that moment, I put my faith and trust that the other people would guide me. Although it was a little nerve-wracking to be blindfolded, I trusted the other participants, which is a different feeling for me.

It was surprising that some people didn't find the activities fun. At the end of the day we all had to do it so you might as well join in. We are all here together, and maybe different paths have brought us here to this moment, but it was nice to try something different rather than doing the normal programming stuff. It surprised me that people vocalized that they didn't have fun with it because although it was weird and different, the whole purpose of it was to let go and have fun. Staying in a positive mood and continuing to have fun, and not let it bother me that other people weren't having fun was important for me. It was sad to think that some of the other participants never got to experience that silliness as a child, and now they can't recognize it as an adult.

It was great to be able to share my experience with others. It was comfortable sharing with everyone because everyone was very respectful which allowed me to really open up. It was awesome to see how we were able to get so much out of a silly game. Throughout the day, I learnt that it is important to be more open and not always focus on other people. In the past I

have always been a people pleaser, and put all my focus on others and not on myself. It feels

great to be able to share my stories and get feedback and not be judged.

Even with some of the heavier discussions and conversations going on throughout the

day, it was important to stay positive. When I said, "let's not let one person ruin the day for the

rest of us and just have fun" one of the other participants told me how much that impacted her.

But it is true, you can't go through life letting one-person ruin something for a group of people.

It was good to see people stay even when they wanted to leave. That way we were able to move

forward together as a group and get over that in the moment.

Coming into recovery, I experienced a lot of trauma in the last couple of months and it

felt like I haven't laughed for a long time. In the moments where I found myself laughing today, it

felt good. It felt good to enjoy myself and watch other people laugh. Some of the other

participants are kind of a tough "nut to crack," but it was good to see them willing to do the

activities. It was especially nice to see other people smiling again because it is rare to see people

smiling when we are walking around the hospital.

This experience was fantastic. It made me feel warm and fuzzy. It is nice to feel like I

have feelings again, instead of feeling cold, alone, and dead inside. This makes me want to share

my story with other people. Knowing that other people know a little bit more about me after this

experience together makes me feel good. Having the space to have conversations and discussions

with everyone was beneficial because it really opened me up. It felt good to be able to connect

with my inner child and be silly, because there is a struggling little girl inside me and it felt good

to see her smiling today. It was nice to get out of my own shell too and not have to act my age. It

was freeing to let go of the responsibilities of being an "adult," and have clean sober fun again.

Being outside and connecting with nature helped because it didn't feel as claustrophobic as the

hospital. It was peaceful and calming for me. It was different being outside today then in normal

programing because everything wasn't rushed. Sometimes it feels like my mind races because I

am racing all over the hospital.

It is important for me to have good sober fun in my recovery and to know that it is okay to

have those feelings. I don't even remember the last time I did something this goofy and silly

sober. Even though it was nerve-wracking to participate in the workshop at first, I just jumped

right in and tried to get over that fear. It felt good to not have those hundred thoughts racing in

my head and be rushing all over the place. It was just fun and leaving here today gives me a

sense of calmness.

The Story of Odin

My experience throughout the workshop with Odin will always give me a sense of

purpose from a research point. Throughout the day Odin was skeptical of the workshop, he but

he was able to let go of some of those feelings and take meaning from the experience. Odin was

insightful and his insights brought out a lot of meaning for the other participants in the

workshop. Odin, thank you for taking a chance on this workshop and being open to try new

things. Odin's story will live on and it will continue to inspire others who are in his shoes as his

story will always drive my own motivation and passion around this research. I hope you continue

to take these feelings with you in recovery remember that you not only have the ability to be a

great person, but that you are a great person.

Going into the workshop today I was not sure what to expect or what was going to

transpire but it felt good to get out of my shell this time around. This is my second stay at

Homewood. In 2010 I was here and managed my sobriety for three years. It was a big learning

experience for me to relapse and then come back here. One of the hardest things was hitting rock

bottom. My biggest mistake last time was that I tried to "white knuckle" it. That kind of thinking

made me think I could be a social drinker, which was manageable for six months but then after a few horrible things happened at work, the isolation began again. I have always been a caring person which lead me into the profession of firefighting to begin with. It was my caring for other people that put me in situations where I saw a lot of horrible things. Seeing what people are capable of jades my outlook on the world. At an AA meeting one person was telling us that he is here with an addiction but also lives with anxiety. One of his doctors told him that his addiction was caused by his anxiety but he talked about how he has come to realize that it doesn't matter which came first. His story resonated with me because I have always thought that my alcoholism was a result of my PTSD diagnosis but now I am surrendering to the fact that it doesn't really matter which caused which. At the end of the day they are both present. So instead of blaming this for that, it is important for me to deal with them both.

Participating in the workshop today made me feel more in touch with the outdoors, nature, the universe, and a higher power. It was a good experience with the research aspect as I am a strong believer that when a person suffers it shouldn't be wasted and they should try and learn from that and help the people that are coming up behind them.

Participating alongside the two recreation therapists was different for me because working with the different counsellors here, I sometimes think, "oh my god it would be nice to just be you." It would be nice to just be able to care about people which is something I lost in my addiction, and it was scary. Coming into the workshop today was anxiety provoking but the answer to my issues lies somewhere outside of my comfort zone and doing something that is different than where I have been in the past. I often identify isolation in my addiction as in the past I often drank at home alone. This makes it hard for me to remember how to act sober.

Being an isolator, it is good for me to challenge myself to try and do more things in a group setting.

Starting the day off with the icebreaker was uncomfortable for me. It was just really out of my element because it has been a long time since I have had fun. In the moment I felt embarrassed. It made me feel like an idiot to think I would have to "bok" in front of people. I was thinking, "what have I gotten myself into, is the whole day going to be like this?" Moving past that activity, the bull-ring activity was challenging because it put me in an uncomfortable role. When something needs to be done, I tend to do it my way. In that moment, I thought, "okay, I will let him do it his way." Taking on that role was a new experience for me because I knew the best way to successfully complete the task was to just have one person take charge because if we all start going back and forth it is going to get complicated.

The willow-in-wind where we had to do the trust fall was quite amazing. Watching the other people do it I thought, "wow, this could be kind of cool." In the middle of the circle I was able to just surrender and have feelings of trust in the group. Not knowing everyone was nerve-wracking but I felt a sense of trust in that moment. Being outside and to being able to close my eyes and hear the wind and the forest was serene and peaceful and my mind wasn't racing. Normally, I have a lot of ruminating thoughts so It was a good moment for me. I don't even know how long I stood in the middle of the circle. It was peaceful being able to trust others and know that someone is there to push me back. This was the first time I have ever experienced anything like that. The thought of the other people around the circle letting me fall never even crossed my mind which was kind of a strange feeling for me to put my trust in a group of strangers. This is a big change in my perspective and it makes me think that people are good and that the world isn't complete shit.

The last activity was interesting because it related a lot my recovery. Being blindfolded in the "bat" role reminded me that recovery is like being "blinded" and you can feel lost at times. The "parrot" is your sponsor helping guide you through and make you aware of what is going on and the "eagle" is your higher power who sees everything that is going on. As the "bat" in this metaphor I don't know how to act sober and so using AA and my sponsor to direct and support me in my sobriety is important.

It was nice to have conversations about each activity because it helped me learn, talk about my feelings, and reflect in the areas I need help in. It was good to get to know the other participants better and feel closer to them as we go back into the regular programming. It felt comfortable throughout the day because we were all in the same boat and we all had an objective to complete together. It was clear to me today throughout the conversations that I often internalize my feelings by just suffering inside. When some of the other participants were sharing their experiences the first thing I tried to do was relate to their experience and, "walk in their shoes" to understand how my life has also been affected in similar ways. I am very receptive to hearing other people's stories which makes me learn a lot about myself. It was good to be able to open up to the other people and have them listen to what I had to say. Seeing the break downs and outbursts that were happening throughout the day was different for me. I found myself struggling at times with that because it was an eye-opener for me to see how trauma symptoms can manifest in different ways.

With my own trauma symptoms, I tend to not let anyone know that I have suffered because it gives me a sense of embarrassment with my profession. Having that connection with other people who also feel that way makes me feel like I am not alone. There is a certain level of acceptance and peace I get from sharing these experiences with other people that allows me to

concentrate more inwardly when other people are sharing. We all had that event that caused our

trauma and how that lead to our addictions and everyone has a different story but the

similarities are uncanny. Today has allowed me to start to get in touch with myself again which

is something I lost coming into the hospital. Coming in here again, I was a walking dead person

and so it is nice to warm up to my own feelings. Moving forward, it is important for me to be a

role-model for my son and be a better person in my own life.

Completing the activities outside was at the centre of the whole experience for me. It was

nerve-wracking at the beginning of the day because it was a new type of programming for me but

as the day went on it was easier to jump right in with both feet. The day was full with activities

and discussions but it didn't feel like we were rushing. With the program here in the hospital it

sometimes feels like you are rushing to shower or a shave and then rushing for lunch. Today

there was none of that so it allowed me to absorb more of what was going on, reflect on myself,

and be receptive to others. We are surrounded by four walls enough in the hospital so it was a

nice change to be outdoors and doing something different. There is a lot of benefit from the

program here, but it was also nice to change it up.

It was really interesting to see what a difference it made from the beginning to the end of

the day. It was nice to get out of my comfort zone and learn a little more about myself. Being

able to trust and surrender myself to the group and let things happen as they may, was a

different feeling for me. This experience solidified what I have been feeling these last four weeks.

I know it important for me to identify isolation in my recovery and continue to work on that

aspect. It will be important for me to be more open with the people around me and not

internalize my loneliness and despair with my trauma and addiction. These answers lie outside

of my comfort zone so I am glad to have the chance to come today and start working on having

fun without drinking. Looking back on my three years of sobriety, I can recognize moments when I was slowly slipping into relapse. Yet, we all learn from our mistakes and a part of me forgot that. Similar to these activities, it's how a child learns too, by making mistakes. Moving forward I need to pay good attention to the fact that those mistakes are there for a reason.

Feeling a sense of happiness today is important because happiness is at the core of being a good human being. Being able to be happy and care about myself is important for my recovery so that I am able to care about others around me. At times I laughed today. It was freeing for me to be able to laugh again. The world isn't just a complete shit hole and that there are good people, which is something I am learning. Living in a 24 hour thinking and knowing that everyone is not out to get me makes it a lot less stressful. It was reassuring for me to know that I can work through a situation like this that may be challenging at times. It makes me feel proud to challenge myself to try something different and follow through with it. There were a lot of lightbulb moments for me today that I want to keep burned in my head. The big one for me is that I have the ability to be a great human being and that it is just a matter of dealing with what is going on in my head and looking forward to being healthier and not giving up on myself. If my stories and experiences can help someone out down the road and change to make things better for people, then that is good.

The Story of Brianna

My experience throughout the day with Brianna was complex at times. Brianna worked to actively get out of her own comfort zone and try something different, that she was not used to. She was very honest to herself in the way she presented herself as well as the experiences she shared with the group. Although Brianna did not find a lot of benefit in this workshop, nor did she really enjoy the whole experience, she stuck it out and she stayed. It is this drive and

determination that will help her be successful in her own recovery, and I hope she always keeps that close to her heart.

A couple of weeks ago I would have never volunteered to participate in a workshop like this because it is out of my comfort zone. Being here at the hospital has taught me to focus on making healthy behaviour changes. Trying something new that makes me uncomfortable is important because there is some benefit in terms of learning and growing. There is a lot of risk-taking when using drugs and alcohol, so I figured today I could take a risk to do a structured activity. For me, it was more focused on the research aspect of the workshop because I work in the research community and it can be difficult to get people to participate in research studies.

Starting the day off it was very cold and I didn't dress properly for this kind of weather which was upsetting. The first activity with the "bokking" like a chicken was uncomfortable. There is something demeaning about those kinds of tasks. It felt like I could have been doing something more constructive with my time then "bokking" like a chicken. The game suited some of the other people better because they are a bit louder than me and so making chicken noises was fun for them. It was nice to see them joining in. I understand why other people would love it but it just doesn't have the same effect for me personally. There are no resentful feelings about that; it just isn't something I can personally channel. As a kid, I never had an opportunity to have those kinds of feelings so they are very unknown to me. It is not that those feelings were denied for me, it just wasn't a thing. Growing up the focus was more on learning something constructive than playing. With games like this, I genuinely don't feel like I have those feelings of being able to be "silly." The only time those feelings have been present for me was when I was using.

When we moved into the "bull-ring" activity, I was in the position of not being able to talk which was good with me because it helped me avoid the back and forth banter with other people. When we moved back outside into the activity with throwing the bean bags, it felt nice to be outside but it didn't change my behaviour. When we were throwing the bean bags back and forth I felt happy, but not peaceful. It was nice to hear the laughter that was happening in that moment and it was fun to multi-task. For me, being able to throw the bean bag in a different direction and have that link or connection with the person was fun. It felt like it was a task to accomplish the goal of passing and catching, which made it feel productive in that sense.

When we started the activity where we had to stand in the middle of the circle and fall and let the others catch me I thought, "I don't want to do this so I know I need to." In the middle of the circle I felt light and kind of supported by the other people because they were catching me. That feeling surprised me because I didn't think I could feel cared for by people. In that one moment those negative preconceptions I had about the other participants dropped and it felt like they were kind people.

When we got back inside and there were heavier conversations happening, it was challenging. I just wanted to say, "eff this and eff that." The whole situation challenged me because it was reminiscent on how I used to handle situations, like a loose cannon. It threw me off my game when there was a bit of an outburst from another person in the group because I am trying so hard not to have that kind of reaction when something upsets me. In the moment my head went to a negative space and it was hard to get back into my own head and into a more positive place. I was able to overcome these negative feelings in the moment by speaking with the rest of the group and expressing my feelings and when they agreed with me, I didn't feel so dramatic.

When we got back outside I just needed a moment to be in my own head and not share my space, time, thoughts, or feelings with anyone. Stepping away for a moment and having my own private alone time in my head allowed me to come back and re-visit the situation. It was almost like I needed to go up in space for a couple minutes and then land back down on earth. When I am struggling with these kinds of feelings throughout the day and I'm not provided the space to get away, it leaves me feeling confined and uncomfortable. It may be my way of mildly dissociating, but that's my solitude. When we started the "eagle, bat, and parrot" activity, it was frustrating to watch the other people on my team get lost because I wasn't directing him effectively. It was stressful in the moment because I felt helpless watching them. It was really uncomfortable for me and it really upset me. Honestly in that moment I just wanted to have a drink right then and there. This reminded me how when I am communicating with someone, I need to be able to trust them. For me, trust and communication go together, I don't communicate unless I trust and I rarely trust so I rarely communicate. That is one of my communication barriers outside of this workshop.

Looking back at how I reacted earlier today, it was clear to me that a lot of the negative emotions and feelings in that moment was a reflection of past behaviours. It took me back to a place where I felt threatened, stressed, or disrespected. In that moment, I responded in a way that pre PTSD treatment Brianna would have. Going back to that place, I had my back up against the wall. I started snapping and putting down the workshop and the activities. When I recognized that, I wanted to make amends because it was inappropriate. Coming into this workshop and participating in recreation and leisure type of activities was kind of like a self-fulfilling prophecy, because I knew something was going to go wrong with this type of programming. In the last activity, I was able to let go of the stress I was feeling and that is why I

had fun it. I just said to myself, "chill, that had nothing to do with it, you're just being a dick." It was surprising for me to not be self-centered for once. Although it was challenging in the moment, it surprised me that I was able to bring myself back so quickly. Getting those feelings off my chest allowed me to stop beating myself up for it. In the past in situations like this I would have just left and went home for the weekend and kept all that anger and frustration inside of me. It would have just been a snowball effect that would have taken me a day or so to get over. It was good to see some good in the day despite the bumps.

The conversations that were happening throughout the day were nice because I got to unload any feelings in between activities and not build up any resentments or frustrations. It allowed me to shake it off and dump any stress or frustrations before moving to the next activity. It was almost like we were starting a new day every time we started a new task. The de-briefing at the end was extremely helpful because I was able to express myself and as a group we were able to talk through some things. It also allowed me to collect some of the other participant's point of views and take on things. For me, this workshop was on the edge of being counter-productive but after talking it through with everyone I was feeling neutral about it. It was cool to see how other people think about the exact same task and just get a better insight into different ways of thinking and seeing the world. It made me think, "okay maybe I am just being dramatic about this or maybe I need to take a look back on this." It felt nice to express my feelings and be able to speak my mind in the moment. There was no right or wrong which allowed me voice my own honest opinion.

I found it challenging at times to connect with some of the other people in the group because there were some strong personalities that were irritating. Signing up for this workshop, I didn't really accommodate the fact that there would be a bunch of people with PTSD in one

room all having their own emotional "uniqueness." It was easier for me to connect with the people who are in my home group because there is history with them. It was also easier to connect with the people that I perceive I can relate to who are determined and put a lot of effort into things. Being around other people who can't relate to me on these feelings, makes me go into a survival mode. The workshop today did tap on the idea of expressing my feelings to others which is on the recovery board. That is a big one for me because I never really expressed my feelings before coming in here in my life and so this workshop gave me the opportunity to practice that skill.

Some of the activities today were challenging for me because didn't feel a sense of accomplishment. The activities were fun at times but it didn't feel like I was achieving anything. This was a struggle for me because I have a tendency of being over-productive. The activities made me irritable and emotionally exhausted. I am more emotionally exhausted from doing this today then group therapy inside. In my own life, I don't really do a lot of leisure and so this was an uncomfortable thing for me. The activities gave me insight as to why people might enjoy these kinds of workshops and it was nice to see how much other people enjoyed it, but I think it would also deter people like me from seeking this kind of treatment.

It was nice to be able to hear the nature in the background throughout the day to keep my head clear and calm. The cold weather was a little inconvenient at times but it kept me focused on what we were doing. A lot of the other people really enjoyed the outdoors and it brought a smile to their face just being outdoors. It allows people to be a little bit more yourself because you don't feel the confines of a rehab facility. I did feel that a little bit for myself but it didn't make me light up the same way as some of the others. This could be because I am not an outdoor person and I don't enjoy teamwork activities. It is like I don't know how to relax. because I am

always preparing for the worst and hoping for the best. Not having been in a relaxed

environment makes me sad to think that I can't enjoy the little things and access those feelings of

peacefulness and serenity. Although the workshop was uncomfortable at times, I was able to stay

and participant and most importantly, I was sober.

The story of Liam

My experience throughout the workshop with Liam was limited. Throughout the day,

Liam took part in most of the workshop, yet at the times he was not engaged. Although the

intention behind the activities and the workshop was not to cause harm, the truth is that when

working with individuals living with PTSD and SUDs sometimes unexpected things can cause a

trigger. Liam opened himself up and shared his struggles with the group in a meaningful way.

Although Liam presented himself as very guarded in the workshop, in conversations with him, it

was clear how much meaning he took from the experience. Liam, I hope you continue to take

this meaning with you in recovery, and take time out of your day to focus on yourself and find

your solitude.

When the recreation therapist on my team told me about the workshop today, I thought it

would be interesting to be active and engaged in an organized recreation activity. It seemed like

a good opportunity to try something different in a comfortable environment with people that I

wouldn't general spend my time with. When asked, I said yes to participating in the workshop

relatively quickly which is a new thing for me. Growing up, I was an awkward kid and would

often avoid organized sports. Despite that, the whole experience was trusting. Going into my

eighth week here at the hospital, things are starting to get a little repetitive. The program runs

on a five-week schedule so today was a good chance to get a change from the regular

programming.

We started the day off with a check-in around the labyrinth. There were cue cards with emotions written on them spread around on the ground and we had the chance to pick a couple of emotions that we felt matched how we were feeling in that moment. It was really nice having the opportunity to actually pick from a defined set of emotions. It helped me because generally I just supress or stuff my emotions. For someone who supresses a lot of their emotions, this was a good way to express my feelings in the moment. Going around the labyrinth and picking my emotions cards was interesting because it allowed me to take the time to figure out which emotions suited me. Being able to choose from a set of emotions really forced me to think that maybe there is a descriptor for the emotion I am feeling right now. Often, I feel flat and emotionless and just describe myself as "happy" or "content."

The second game with the chicken goggles was interesting. I didn't really like the activity because it was demeaning but it was good to have a lot of valid discussion around that. I don't like people invading my personal space, so having someone right in my face was uncomfortable. Moving inside, the "bull-ring" activity was good because we had to work together as a team to move the ball from one side of the room to the other. These types of activities come easy to me and I often find myself dominating in this role as it is in my personality to take control. Overall, as a group we did well with that activity, there may have been opportunity to move the ball quicker but it was cool to see everyone work together to move the ball successfully. In this activity, I was in the position of being able to talk while some of the other people weren't, which worked well for me because it would have been very a struggle for me not to give the direction.

The next activity was the group juggle activity which was kind of fun to see everything flying around. It was amusing to see other people floundering at what to do because it was a simple task, you get it from one person and you pass it to another. It was a little confusing and I

dropped a few beanbags and cursed a little bit, but it was all in fun. After dropping a beanbag, it felt like I wasn't doing the exercise properly. My solution to this was to catch and hoard all the beanbags and then pass then onto the next person when I had the time. That worked for me because my responsibility ended as soon as all the beanbags were passed to the next person. This activity made me think of my own recovery because I have so much up in the air so to speak, just like the beanbags. Going back to two jobs and early recovery, I have to be mindful to keep everything up in the air and not drop things. Also, in my recovery outside of the hospital I am constantly on the go with work and my personal life and so it is important for me to focus on what is coming and then be able to deal with that in the moment.

The activity with the person in the middle of the circle doing a trust fall with the other people around them to support them was a trigger for me. In the moment, I worked through it by initially saying that this is something I am not comfortable with because of the close proximity of the people around me. While observing the activity, it became more of a trigger for me, so I chose to remove myself from the situation in order to cope with those feelings. It was good that I stopped then because it allowed me to manage those feelings and move away from the situation. Following this activity, we had a bit of a tough situation happening in the group with a lot of heavy conversations. When we were able to go back outside after the heavy conversations were done, it felt good to take some deep breaths of fresh air. I was able to intentionally slow my breathing down in that moment and not worry about anything else that was happening around me. It sounds "cheesy" but until you are in that kind of situation, you don't know how much it can help. It changed my mindset, my mind wasn't focused on something negative. I was able to almost erase those negative feelings and be okay to move onto the next activity instead of fixating on what has already happened.

The last activity, the "eagle, bat, and parrot" with the different roles was really cool, because I had to put trust in the other people on my team to guide them. It was nice to see that everyone had to work together, and if one person didn't work effectively it took away from the effectiveness of the group. At first, I struggled giving cues because it was confusing how to understand the other person's gestures. It was interesting to have to deal with someone else's interpretation of what was happening and relate it to my own.

There is a lot of benefit in programming such as this because we had a lot of great discussions afterward, which made me realize that the workshop was about more than just the activity. The discussions were helpful because it allowed me to relate what other people were saying to my own experience, which helped me open up to the group and have healthy discussions. I honestly didn't think that with group activities there could be so much discussion. After every activity people were giving feedback not just on the activity itself but how it links to their recoveries and impacts them on a deeper level. People were just telling their stories which was nice to hear. Through the discussions of the day, I learnt that it is important to be receptive to what other people are saying and not just be the one that always dominates the conversation. This is something that I often do because of my history of being a 9-11 dispatcher and having to be assertive and get to the bottom of things as soon as possible.

I was much more comfortable with people that were in my home group due to the history. It was easier to connect with the people who I felt like I could relate to. For me, I tend to be able to relate to people who share a similar profession as me as a first responder, because they "get it." This common link with some of the participants gave me a sense of trust with them. It is a benchmark for me in becoming personal with someone to have that meaningful conversation when building relationships. This experience just kind of showed me that when I trust someone, I

am able to be wide open with them. If I do not feel comfortable with you, I present my generic scripted self. The setting today was comfortable and so I was able to open up, which is something I do not always do.

It was nice to be in a slower mindset today. It was nice to be able to pause and do something healthy for myself. The conversations happening throughout the day were helpful because they gave me the opportunity to talk about how the activities were impacting me, positively and negatively. Going through moment I was triggered, it was nice to be able to share and discuss that in the moment instead of carrying those feelings throughout the day. With working in such a fast-paced and busy environment, it is important in my recovery to take that time to go for a walk and enjoy the parks and scenery where I work, which is something I don't always let myself do. For me, I am used to structure, schedule, and discipline, which is something that the hospital here focuses on a well. Inside we always go from one program to the next and you don't get away with being a couple minutes late. Sometimes when programming happens in the lecture theatre and you just sit and listen, you don't always have the opportunity to be engaged. Today I had an entirely different experience because we weren't bound by structure or predictability. It wasn't like, "this is my Wednesday schedule, and now I must be here." Instead, today we had a schedule but if we went five minutes longer because we were having a healthy conversation that was okay. It was a fun environment and also very relaxed because it wasn't military structured. It almost felt like a mini-vacation for the day, being completely removed from routine. It was a good and healthy breather, so to speak.

It felt good to be out in nature, it felt more tranquil and peaceful, like I was completely removed from schedule, routine, and structure constantly dictating my day. It was nice to step away and have a completely different change of scenery. It felt physically freeing to be outside. I

don't do that enough for myself. There was no reason for me to be anxious or worrying about the

small things and I was able to move away and let go of those stresses in my life. Being able to

take a moment to relax is important for me moving forward. In my recovery, I need to ensure I

structure time every day to get away and slowdown in my personal life.

Although the one activity was triggering for me, it helped me learn that I need to continue

to be mindful of my triggers. In life there may be things that seem innocent in how they are

presented that may trigger me. This experience was a good reminder for me to be aware of my

surroundings and ensure my own safety. I don't want to be hyper-vigilant but it is also important

for me to look ahead and recognize my triggers when they come up. Going into long-term

recovery, it will be important to be mindful of my triggers and deal with them in the moment. To

do this, it will be important for me to set proper and healthy boundaries.

Today was a very good example for me to push the pause button and realize that I do not

need to be "on" 24-hours a day and that it is important for me to take time for myself. It is

humbling to be able to try something different that isn't normally prioritized in my life in order

to start making those healthy changes. It was just nice to try something different.

The Story of Heather

My experience throughout the workshop with Heather was interesting. Throughout the

day Heather presented many different versions of herself, yet my favourite version of her was

during those she was being true to herself. At times, Heather tried to "fit in" with some of the

other participants and have her own feelings be validated. Heather, I hope you continue to stay

true to yourself and know that you are enough.

I don't usually participate in experiences like this because they are scary. Today was a

good chance to have fun and be outside. I am going to be here at the hospital for eight weeks so

it was nice to do something fun and have a break from doing the same thing every day. It was

nerve-wracking going into today but it is important for me to challenge myself to do something healthy.

I felt a little bit of anticipation this morning because it made me nervous knowing we are going to be outside today, something that is out of my element. I have never really enjoyed being outside, even as a kid. Sometimes I enjoy the solitude of being outside on my own, but being outdoors and doing group activities has always been a tough thing for me.

Going into the activities, we started with an activity where we had to "bok" like a chicken. It felt uncomfortable and weird, which was echoed by some of the other people. As a kid, I often avoided group settings because it is hard for me to tap into a "silly" side. Working through those feeling n the moment, I often just hold my breath and pushed through it. I didn't want to "lose" in this situation because then it would be a feel of being "left out." When we moved into the talking activity, and we were asked to talk about ourselves for three minutes, I felt a little nervous and irritated. For the activity I was partnered with the "researcher" and it seemed like she was distracted. It was nerve-wracking and left me feeling vulnerable in the moment. I don't really know a lot about myself and used this to try to hide. There were so many times during that activity that I tried to not be seen as the "patient" and connect and relate with her as a human being. When it was my time to listen while one of the other participants talked, I related to him because he was also trying to hide himself which was tough because I saw myself in him a bit.

The "bull-ring" activity where we had to move the ball from one side of the room to the other was irritating for me. I was assigned the role that I could speak but one of the other individuals in the group took the lead on it. This annoyed me because he didn't ask other people what they thought and just assumed he knew best. The "group juggle" activity was nice because

we were all working together and it felt like everyone was doing the same thing. It felt good to do this activity right after we did the chicken game because it was nice to move away from something that was uncomfortable toward something more comfortable and fun. It left me feeling a little alone during this activity because I felt like it was my responsibility to catch the bean bag and if I messed it up, it was my fault. I wanted to take all the blame on myself if we were not successful as a group.

I was most nervous for the "willow-in-the-wind" activity because it was an uncomfortable thing for me to go into the middle of the circle and make other people support me. I don't like being a burden on other people. The idea of leaning on other people made me uncomfortable because it felt like I was dragging out the activity. It was nerve-wracking at first but after watching everyone else do it, I didn't want to feel left out. For me, the fear of being an "outsider" suddenly outweighed my fear of doing the activity. I liked that people were pushing me back in the middle because it felt like positive attention. Everyone was focused on supporting me in that moment. Although it was nerve-wracking, I was able to trust the other people which made me feel good after because we all got to share how we felt in that moment and I wasn't left out. Everyone had kind of the same feelings about the activity which was validating.

During the "eagle, bat, and parrot" activity, everyone had a role to play and we each had our strengths. At times my partners weren't really paying attention to me, which left me with some negative feelings. It is a really hard thing for me to feel like I am not being heard and not being listened to. In the moment, I realized my team was trying really hard to understand what I was visually trying to say, which is something that I don't often feel in my own life. It was really nice to have someone who was trying so hard to listen and understand me even if we weren't "getting it." I had a sense of pride when we were able to work together as a team which was fun.

Most of the other participants in the workshop today are not in my home group. Therefore, I felt a little nervous to be around a couple of the other people today. In particular, it was nerve-wracking to be around two of the other participants who I perceived to be "intimidating." I found myself wanting to "fit in" with them. It bothered me to think that other people may be thinking and saying bad things about me. This is something I have always worried about in my life. It is anxiety-provoking to think that someone may react negatively to what I am saying or doing. In that moment, I felt a lot of anxiety and those feelings stayed with me throughout the day. When I was able to connect with some of the other people in the group, I was able to share a bit of these feelings and work through these feelings of anxiousness.

Part of my trauma history is a sexual assault. Due to this, some of my issues surrounding my traumas is how others are perceiving me. I struggle to be around male figures which makes it difficult for me to share in front of men. Especially men who I perceive to be very "masculine" or "powerful." Today at the workshop, there was one man that I was nervous about because he looked very powerful. When we were de-briefing and the recreation therapists encouraged me to share my thoughts and he agreed with me, it was really validated. It is almost like positive male attention. After sharing my feelings with the group in that moment, I felt better. It was like I had people on my side. This reminded me of how I often don't feel like I can feel my own feelings unless they are validated by others, which is not good.

Throughout the day I would often change my views to suit other people to avoid being "different." At one point in the day, one of the other participants got frustrated and I mirrored those frustrations back to her so that she felt comforted in her feelings even if I didn't agree. I chose to echo what other people were feeling because it is easier than feeling "different." When some of the heavier conversations were going on, it was easier to take the blame myself when

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something goes wrong and be sad then let others be sad. I would rather be the one that is feeling shitty about something then have other people feeling shitty. In reflection of the workshop, I realized my habit of copying what other people are saying. In one moment in the workshop when I expressed my own feelings, it felt good. In my recovery, I need to do more of that. Reflecting that on my trauma history, part of my trauma was that if I didn't do what I was told then it would have been very dangerous and violent for me. Knowing all this about myself, it is just hard to know what to do with all that, because these feelings aren't going away, they are still here.

It was nice to see that everyone was relating to each other through the conversations and discussions. Having the opportunity to share my experiences with others helped me because we were able to get much more out of the activities when we were able to figure out what it all meant and how it was therapeutic. When there were some heavier conversations going on throughout the day it was nice to be able to de-brief and talk through those feelings in the moment. It felt good to be working together as a team and feel supported by the other people throughout the day as well. Feeling supported by other people is unfamiliar for me but it felt really good. I often feel very lonely and being able to feel enjoyment today in the activities is something to carry with me in recovery.

Although the outdoors is not something I am comfortable with, there was something nice today about having the room and space to move around. It was relaxing and grounding in a way. It was nice to have all this space and be in a different environment. Inside, I often feel confined to sitting in one room. There was something nice about having a sense of freedom and a change of pace that I don't normally get inside. It was like switching to a different atmosphere switched the feelings a bit. It made me feel a little better and it made me feel a little different as opposed to the stuffy feelings inside all the time. It was also nice to be able to go outside after having some

of the heavier conversations. Even just being able to walk outside and have that change of scenery was nice because when we came back inside it felt different, like we were bringing the energy we had outside back in. It would have been a lot harder throughout the day if we wouldn't have been able to go outside. I would have been stuck in the same emotions all day and would have just carried those negative emotions throughout the day.

I had some epiphany moments today where I learnt new things about myself. It is important for me to not hold myself back from my feelings and allow myself to have my own feelings. Often times, I fake my own emotions, especially around my trauma, because I feel numb. Sometimes I will talk about having intrusive thoughts or bad nightmares, even if I am not actually experiencing them. When I feel emotions, I always second guess and question whether they real. Today when we had some of the heavier conversations and I got upset and started to cry. In that moment, I questioned if I was crying because that's how I felt or if that what other people wanted me to do. I spend a lot of time lying about my feelings because it is the way I am "supposed" to feel so it felt validating today to know it was okay to feel upset and cry. For the first time in a long time, I was feeling my own emotions, and that was okay.

The Story of Joseph

My experience throughout the workshop with Joseph will always make me smile. Throughout the day Joseph presented a positive outlook not only the experience itself, but on life in general. As he shared more about himself, I came to realize how much he has had to deal with in his life, yet he was able to find a way to be silly, have fun, laugh, and connect these feelings to his own recovery. Joseph, was able to bring out his inner child and be playful, something he was deprived of as child. Despite the heaviness of the day at times, Joseph was always anchored in hope and strength. I hope you continue to carry that hope and strength with you no matter where you go.

My mind was racing coming into the workshop today. It was interesting coming into the day and not knowing what we were going to be doing. We started with a game where you had to "bok" like a chicken. Thinking of that game makes me laugh to myself. It gave me a really good belly laugh, which was different because I was playing a game and that inner child in me was coming out. Reflecting on my childhood, it felt good to be able to laugh at a silly game like that. When we did the talking activity and I was listening to the recreation therapist tell me her life story my ears were wide open. It was nice to be able to listen to what she said. Through that experience, it felt good to be able to listen. In that moment, we were out in the fresh air and I just stood still instead of moving around constantly. It was like the roles were reversed because the recreation therapist was telling me her story instead of me always telling her. It was really nice to be able to listen to other people's stories.

The "willow-in-the-wind" activity blew me away. Standing in the middle of the circle, and having everyone was around me allowed me to put my faith and trust in the group, despite the fact that I could see there were holes in the circle. In the moment I closed my eyes, stood up, and felt myself going back and forth with the support of the people around me. Although it was a little nerve-wracking and wobbly at times, I just relaxed which gave me a feeling of freedom. It seemed like time went by so quickly and it was enjoyable. Putting my faith in other people around me and knowing they were not going to drop me was a new feeling for me. It was different for me to put my faith and trust in people who were strangers to me, and know that they wouldn't let me fall. It felt good. I wouldn't have been able to do this before coming here to the hospital, but it gave me hope and strength to get through it.

When we played the "eagle, bat, and parrot" game there was a lot of laughing, which made me feel good. My favourite role was the role of the "eagle" because my eyes were focused

on the task in that moment. At times this activity was frustrating for me because I was getting my lefts and rights mixed up when giving the directions. This made my mind start to race and my inner voice was saying, "you are stupid" and, "you can't do this." It is important for my own recovery and something to continue to work on because I am not stupid, and I am not dumb. I am actually bright in my own way but that kind of thinking is just one of my "stuck points." It will be important for me to continue to work through these "stuck points" on a moment-to-moment. As long as I stay sober and take it one day at a time, it will get easier. In the moment, when my mind was out of control and racing, it made me want to run. I felt triggered to be honest, but then one of the recreation therapists said, "no, you can do this Joseph" and it was that encouragement that made me stay. In the past when I have gotten angry or frustrated in a situation would give up and go out and get drunk. Going into early recovery, it is important for me to identify my alcoholic thinking. It wasn't because of anyone else, it was my own thoughts in my head. But the more time I spend sober, the stronger I get. It was important for me throughout the day to take a couple of deep breaths which allowed me to calm down in those triggering moments.

Reflecting back on my childhood, I never had much to say which makes me realize that I don't know a lot about myself. What happened to me when I was a kid was all twisted but it is important to still have love, kindness, and peace with me. Those "stuck moments" for me have a lot to do with building up my own confidence because that is something I never had growing up. At one point in my life I managed sobriety for two years, which makes me realize that we all learn from our mistakes. Although these were just "silly" games today, it gave me a chance to let my walls down and feel a slow change inside me. In my addiction, I always focused on other people and never put the focus on myself. It felt good to be able to have the chance to be a child again and play "silly" games.

One of my favourite parts of the workshop today was being able to connect with the other people. Everyone had their own issues and some people were upset about certain situations but that's what it is like living on life's terms, sometimes things happen. It was nice to hear people talk because it makes me hear myself talk in a good way. Throughout the day we had the chance to ask people questions and get to know people on a different level. In the moments that I was able to share some of my own experiences and feelings with the group it felt good because it gave me the chance to get whatever was on my mind off. This gave me peace of mind, which was a positive experience for me. Each one of us is different, we were not all born in the same way, but behind each one of us is our stories. We all have the same issues, they may look different, but we all have the same issues at the end of the day. We are all users of drugs or alcohol. For me, the more sobriety I get the more opportunity to break out of my shell and feel better about myself. In terms of my own recovery, it is important for me to anchor myself in and know that whatever comes my way, that too shall pass.

It was nice today to experience a different program then the ones we have here in the hospital. It was a good break from being in class all day. Being out in the fresh air gave me the chance to take some deep breaths and settle my racing mind. The games were good because they kept my anxiety out and kept my brain going. It was really nice to be outside because I could see the snow and the trees around me, and hear the crows, the different kinds of birds, and the river. When I was an active drinker or drugger, it was hard to hear those things. It felt good to get away from the hospital and get away from my alcoholism. It allowed me to have a different energy, and gave me peace and joy. Instead of my mind being focused up in the hospital, it was focused here in the moment. Today gave my mind a rest from the doctors and psychologists. I was able to slow my mind which usually goes 60 miles-an-hour. It gave me the chance to hold

onto my chain and put my feet down and ground myself with deep breaths which gave me hope and strength. Everyone needs a break from the hospital sometimes because then we can go back in and have fresh thoughts and feelings. It is hard to explain but breathing in that fresh air in my lungs brightened me up and it put a smile on my face.

For the first time in a while, I had a smile on my face today and felt happy. It was fun to play some of the games and it gave me a lot of belly laughs, which I haven't had for a very long time. Those feelings anchored me down and gave me strength and hope in recovery. Being able to laugh like that today was good for my heart and soul. Today, I remembered that I am alive, I am human and I have feelings. That's my story, and I am sticking to it.

CHAPTER FIVE: FINDINGS
Exploring Narrative Threads

The present study contributes to the general body of knowledge related to mental health recovery, in-patient therapy, and outdoor experiential psychotherapy by adding a rich narrative of the embodied experiences of individuals who participated in the outdoor experiential workshop. As a society we have come to a time of great vulnerability for individuals living with a mental health diagnosis. Often, such groups are stigmatized and marginalized in a way that further oppresses their lived experiences of recovery. Therefore, the use of complementary therapeutic practices, such as outdoor experiential psychotherapy, may serve as a valuable outlet for personal learning and healing and work to provide a platform for the 'voices in the cracks' to be heard.

In the previous section readers were introduced to the six participants through their own embodied experience-centered narratives. Presenting the data in this manner was critical to understanding each individuals unique experience as well as keeping their individuals voices at the forefront of the research. After completing this process, four narrative threads were identified through a narrative thematic analysis process. The purpose of this section is to showcase the common narrative threads through the power of a metaphor. Throughout this process, it is important for me to note my own embodied experience of participating in the workshop alongside the participants. The findings section of the research presented below, provides me the space to move away from the role of a "participant" in the workshop and take on more of a "researcher" role by actively working to conceptualize and identify the narrative threads that arose in the data. The findings of this study will be discussed in a way that pulls on the stories of all individuals experiences of the outdoor experiential psychotherapy workshop. Following the completion of the narrative thematic analysis of the collected data, further deliberation of how

the unique and complex aspects of the workshop related to the research question was important. Further, understanding how to represent these narrative threads in a way that showcased the complexity of the experiences of in-patient care was vital. In an attempt to gain better insight, I began by creating a Venn diagram with four circles. At this time, there were four identified meaningful aspects of the individual's unique experiences: working through past behaviours, the role of the outdoors, connecting with others through stories, and the lived experience of the workshop. (See Figure 1.).
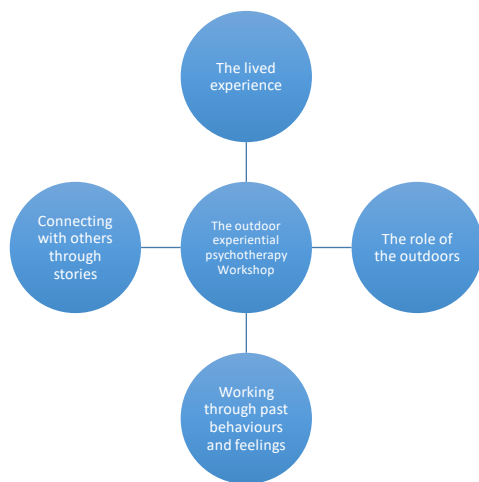
Figure 1. Visual conceptual map representation of identified narrative threads

However, after further thought, it became clear that the unique experience of the workshop was at the core of the understandings and meaning derived from the workshop. Additionally, the "chunkiness" of the themes presented in this representation did not capture the participants lived experience in a way that spoke to the guiding research question. Therefore, the Venn diagram was re-worked to have only three circles, with the core of the diagram being that of the experience of the workshop (*the perfect storm*). (See figure 2.).
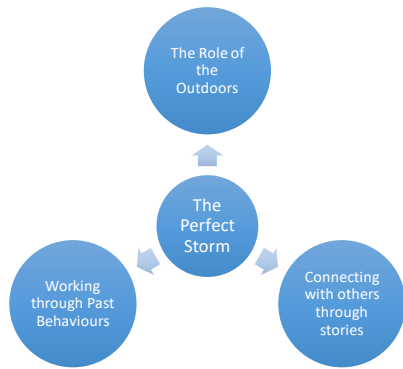
Figure 2. Re-worked visual conceptual map representation of identified narrative threads

The conceptual experience of each individual's story of the workshop was envisioned to be told within a "bubble." The bubble in this diagram represents both the interpersonal and intrapersonal forces that are acting upon the individual as they experience the workshop. In discussion of this, it became apparent that this "bubble" needs to be further broken down to represent the different levels of "skin" of the bubble. On the first layer of skin on the "bubble" is the intrapersonal lenses that individuals wear to view their own individuality (i.e. *mental health diagnosis "label," past and childhood experiences, individuality, morals and values, etc.)*. On the outer layer of the "bubble" are the societal level lenses that place an impact on how each individual view themselves (*in-patient care, societal stigma, societal marginalization*). As you cross through the different levels of the "skin" around the "bubble," it is important to understand that these different levels do not mix with one another, and yet, both play an important role in the understanding of each individual's unique experience of the workshop. (See Figure 3.).
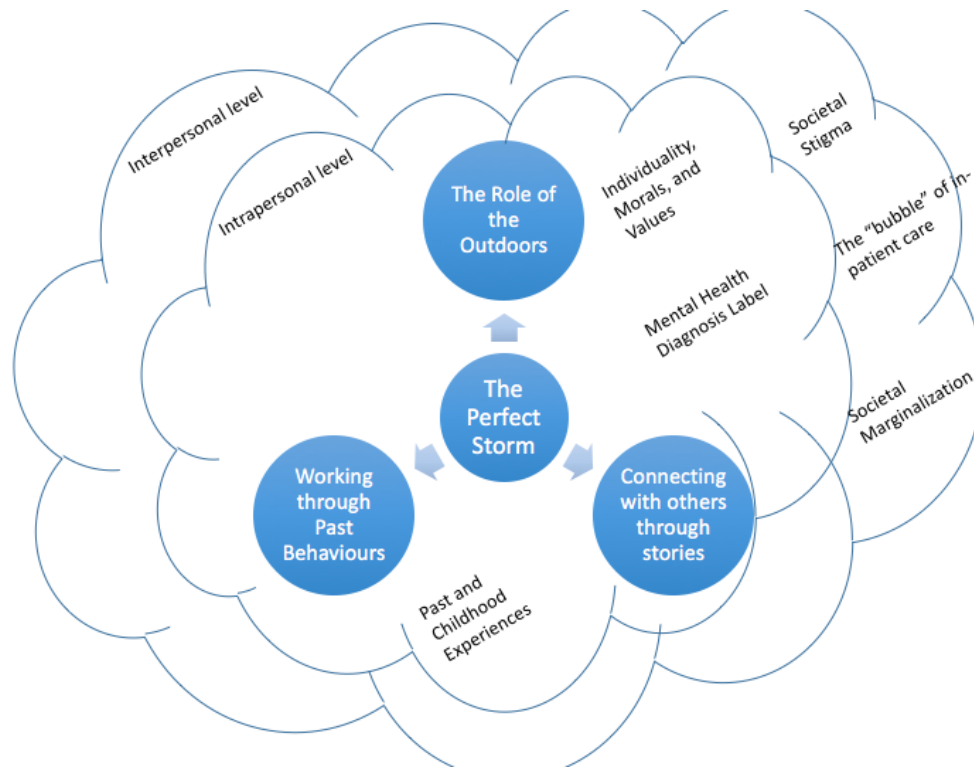
Figure 3. Visual representation of the "bubble" of in-patient care

It was at this time that the other identified themes (*working through past behaviours, the role of the outdoors,* and *connecting with others through stories)* were understood as being interconnected not only with each other, but the overall experience of the workshop. In order to showcase the experience of the workshop that not only highlighted the good that came from it but also the bad and the ugly, I came to the realization that working within an in-patient mental health setting is not always going to go as planned. Therefore, as practitioners in the field, we also need to work through the bad and the ugly aspects of care to make the experience of recovery more therapeutic and meaningful. Together, the good, the bad, and the ugly, of in-patient care create the metaphorical "perfect storm."

The metaphor of the perfect storm started on the day of the workshop. Throughout the experience of the workshop there were challenging moments experienced by all of the participants involved, myself included. Going into this research, I thought I had a clear vision of

where it would go and what outcomes would come of this. However, even with my experience and understanding of the field, the outcome of the data was shocking. On Friday February 16th, 2018, a room full of people gathered to participate in an outdoor experiential psychotherapy workshop for the purpose of collecting research data. The events of the day unfolded in an unexpected manner. The day was challenging, and at times, I struggled to deal with my own emotions. Although the experience of the workshop wasn't what was anticipated, it adds a deep level of insight into the field of in-patient care. After getting home from the workshop and having the opportunity to reflect back on the day's events, I received a text message from one of the recreation therapists that was involved in the facilitation of the workshop. The text read, *"Unfortunately, I think it was just a perfect storm. It was a learning experience for me too."* Receiving this message gave me further insight into the meaning of the workshop which became clearer with further reflection. The experience of the workshop was like a "perfect storm." Metaphorically speaking, the day started with clear skies and the sun was shining. Yet, a storm rolled in unexpectedly and quickly, casting dark shadows on moments throughout the day. At times, there was heavy rain and as a group, we had to take cover and weather the storm. Yet similar to how storms roll in, they roll out. As a group, we were left to evaluate and deal with the damage it caused. (See Figure 4.).

Choosing to present the findings of this research with a metaphor serves to provide a space for readers to understand, reflect, and connect to the metaphor on a more personal level. The power of a "metaphor" is something that has been understood as an effective vehicle to deliver powerful stories (Berman & Brown, 2000). As humans, it is our ability to make metaphorical connections that allow us to learn (Berman & Brown, 2000). "When something new is like something we have done before, we take what we know from the first situation and

transfer our knowledge to the new situation" (Brown & Berman, 2000, p. 3-4). By adapting the metaphor of the perfect storm throughout the findings of my research, readers are able to relate to the ideas presented and draw parallels for their own lives.
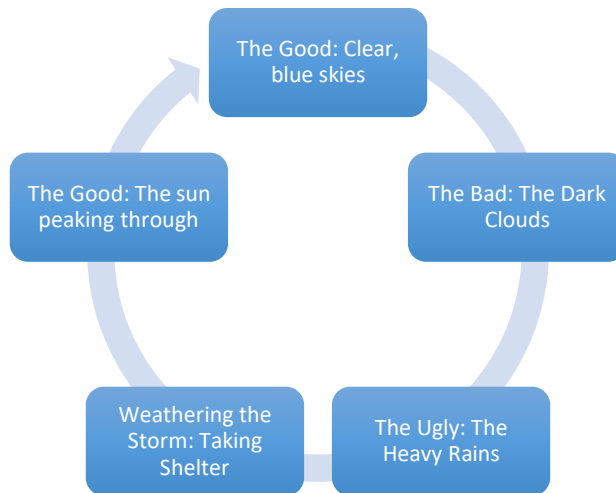
Figure 4. Visual Representation of the Perfect Storm

After further reflection and discussion on the metaphor of the perfect storm, it came to my attention that the story of the perfect storm does not follow a linear path as shown this visual representation. Due to the complex and multifaceted experiences of in-patient care, the story of the perfect storm will look different in different situations. The story may not always follow the same path. Therefore, another component to this visual representation was added to reflect this idea of a multi-dimensional, complex, and sometimes broken experience of working though the good, the bad, and the ugly aspects of the workshop. (See Figure 5.).
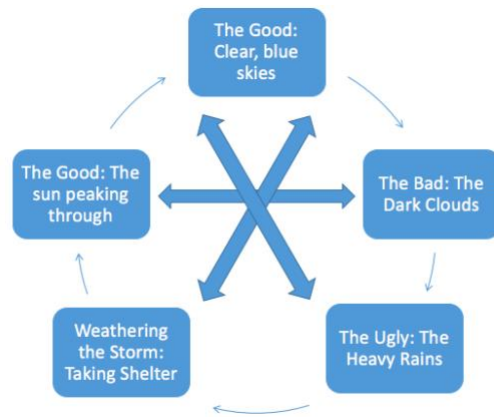
Figure 5. Visual representation of the Perfect Storm re-worked

This is what is presented to you; the good, the bad, and the ugly of the perfect storm. It is important to note how I, as a participant and researcher, embodied the experience of the workshop. This sense of embodied experience acts as a third level of analysis, as spoken works are transitioned into the written narratives of the physical and emotional manifestations of the workshop from my own personal understandings. It is further important to note the ways in which the voices of the participants are represented in the data. Due to the unique experiences of each participant, the representation of these voices manifest in a way that provides a space for each participant to share their experiences. Therefore, throughout the findings of this research, it is important to understand that at times participants are under- and over-represented depending on the topic being discussed. In writing this section it was important for me to be mindful of this, and continue to check in to ensure I was representing all individuals in an equal manner. In order to understand these conceptualizations, you need to be able to feel the storm yourself.

The Perfect Storm: The Good, the Bad, and the Ugly of In-patient Care
The good: The Clear Skies of the Storm

The day started off with clear, blue skies. As a group, the participants were eager to jump in and try something new and different that related to their own personal recoveries. In the moment, I felt a sense of uneasiness as the day began. From my experience of working at

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Homewood, and having the opportunity to facilitate similar workshops, I had a guided understanding of what the day would look like. As the researcher, it was important for me to actively let go of these preconceptions and allow the day of the workshop to unfold on a moment-to-moment basis. The experience of the workshop was unique for many of the participants as it provided the opportunity to engage in therapeutic processes in an outdoor setting. I start by presenting to you the "good" of the perfect storm. (See Figure 6.).
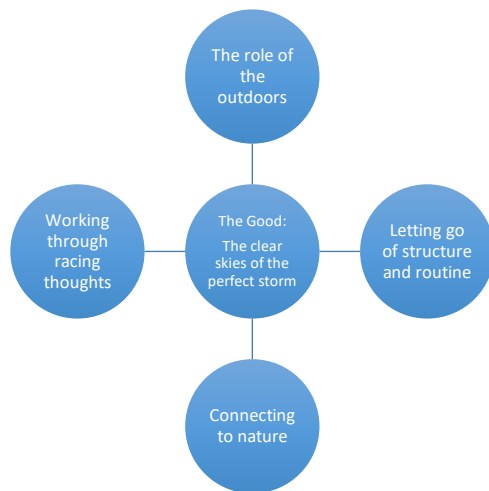
Figure 6. Visual Representation of the "good" of the perfect storm

Many of the participants discussed the anticipation they felt for coming into the workshop, not knowing what they were going to be doing. Ava shared, "I went in there blindfolded…I thought I may as well just jump in and try and it gave me a leap of faith." Odin further said, "at first I was thinking what are we going to be doing next but as the day went on I found it easier to jump right in with both feet." Liam related to this idea when he said that he was, "trusting despite not knowing a lot about the program…I thought it would be a good opportunity to try something new." The experience of trying something new and different gave the participants an opportunity to continue to work on changing past behaviours to create new

and healthier behaviours for their recovery. Liam shared, "I felt like I was taking a good step to challenge myself and doing something right."

The role of the outdoors. For many of the participants the idea of, "being away from the hospital," was a positive experience. For example, Joseph discussed that being away from the hospital gave him fresh thoughts and feelings before going back into the regular programming. He said, "it felt good to get away from the building, [it felt like] I was away from my alcoholism and I was away from not talking about it so much and it just gave me a peace of mind." The experience of being away from the hospital and getting a "change of scenery" provided participants to feel a sense of relaxation. Despite the coldness of the winter day, I could feel the sense of anticipation that came from being in an outdoor setting. Some of the participants described this change as giving them a peace of mind to feel something different. For example, Heather shared that being able to have a change in environment, "[made] me feel a little different as opposed to these stuffy feelings inside all the time." Participants further described that the "openness" of the outdoor environment gave them space to move around which in turn made them feel more grounded in the moment. These discussed feelings of freedom provided participants the space to break away from the confines of the four-walls in the hospital. Brianna shared that being outside, "allowed people to be themselves a little more because you don't feel the confines of a rehab facility." Odin related to this idea when he said, "we are surrounded by four walls enough in this program," therefore the outdoors was a nice change. Being able to escape the four-walls of the hospital setting gave participants the opportunity to use the workshop as a place to connect and find deeper meanings in nature.

Amidst the disrupting behaviours and heavy conversations that happened throughout the workshop, participants discussed using the outdoors as a cleansing space. For example, one participant shared,

> I think if we haven't been able to go outside that would have been really tough to get over…even just walking outside felt better… than going back inside felt totally different because we brought the energy we had outside in (Heather).

Having the opportunity to engage in the workshop in an outdoor setting provided an opportunity for participants to participate in something new and different, which kept individuals externally stimulated and helped eased their ruminating and racing thoughts.

Letting go of structure and routine. It was further discussed that participants experience of the workshop outdoors provided the opportunity to let go of the structure and routine of the "regular" programming inside the hospital. For example, Liam talked about how he has been in the current programming for eight-weeks and is finding it to be, "getting a little repetitive…especially because it runs on a five-week schedule." Brianna further noted that being outside kept her focused on the task at hand because she wasn't able to be distracted by anything. The experience of being able to let go of structure and routine also tied into the idea of letting go of the predictability of the hospital programming. Liam discussed how it, "was an entirely different feeling because we weren't bound not only by structure but predictability as well."

Having the opportunity to let go of this structure and routine provided participants the sense of freedom to not only break down the sense of confinement from the walls of the hospital, but also the schedule of the programming. Ava discussed that she enjoyed the workshop outside as she didn't feel rushed to be somewhere as there was no time limit to the day. She shared, "my mind races [indoors] because I am racing all over the place so I just had a moment to sit or stand

and just be quiet." Odin related to this idea of being able to slow down allowed him to, "absorb more throughout the day and reflect more on [himself] and be more receptive to others." This sense of freedom gave the participants a break, and allowed their racing minds the opportunity to slow down. Joseph described from his own experience that, "it gave [his] brain a rest from the doctors and psychologists." Further, Liam said "[it was] nice to be out in nature its more tranquil, you automatically feel a breath of fresh air, you feel at peace, you feel like you are removed from schedule, routine, and structure."

Working through the racing thoughts. Participants described the workshop as being a safe place to get out of their own head. Ava shared, "It was great to finally get out of my own head." One of the main "stuck points" participants shared was having to deal with ruminating and "racing thoughts" in their recoveries. For example, Joseph discussed that his, "head is going 60 miles an hour" throughout the day. He further shared that one of his "stuck points" is his own perception that he "is not smart enough." Joseph shared struggling with his own perception and having to take control of his own mind at times throughout the activities of the workshop. In these instances, participants discussed that throughout the workshop they were able to "let go" of these racing thoughts in their head. For example, Ava said that she often has racing thoughts going through her head when going to bed. When she was able to let go of these thoughts in the moment, it gave her a sense of peace and serenity.

Connecting to nature. Having the opportunity to connect to the outdoors and nature around was a beneficial aspect of the workshop for most of the participant's experiences. Being able to stop, breathe, and take a minute to be in nature was described as refreshing and calming. Joseph shared that he, "felt calm because he was away from the building up there." Further, being able to connect to the outdoors and have clean, crisp air in their lungs was something

different from "regular programing." Ava described that, "it was better just being outside and having the crisp air put you in a different mind frame." This sense of calmness put a smile on their face and provided them to be more relaxed in their surroundings. For example, Joseph discussed that, "when you are outside and you get that fresh air in your lungs, it's hard to explain but it just brightens you up and puts a smile on your face… when I am out there I smile more." In this regard, the idea of being able to connect to the nature around them was stimulating.

Many of the participants talked about the enjoyment they got from being able to hear and see the nature around them. Joseph described listening to the wind in the trees, the chirping birds, and the flow of the water from the river. Brianna related to this by saying she was, "able to hear nature in the background [kept] our heads kind of clear and calm." For Joseph, this idea of being able to listen to the nature around made him realize how he had lost this sense when he was in active addiction. Despite the coldness of the wintery day, participants were able to be more in touch with the nature around them.

It was further described that being able to take deep breaths in nature was a "healthy escape." At one moment in the day, as a group, we paused to do some breathing exercises outside. Heather discussed that having this opportunity to take slow, deep breaths in nature helped her deal with the emotions she was feeling in that moment. Further, Ava shared that this experience was, "easier than sitting and doing breathing exercises inside and breathing in the stale air." From my own experience, I found this moment in the workshop to be very powerful for many of the participants. It further gave me the chance to close my eyes and reset which allowed me to feel a sense of calmness as we continued through the day.

The Bad: The Dark Clouds of the Storm.
Although the day of the workshop started off with clear, blue skies, it quickly became apparent that there was a storm brewing. As with any "perfect storm," sometimes dark clouds

unexpectedly roll in. The workshop had moments in which these clouds casted a dark shadow on the experience of the day. It was in these moments of dark shadow, that participants shared some of the "bad" they experienced in the workshop. Having the opportunity to engage in the workshop alongside the other participants allowed me to feel the dark clouds for myself. Participating in this type of workshop was identified as nerve-wracking as it asked participants to be vulnerable and test the limits of their comfort zones. Odin shared that when he agreed to participate in the workshop, "there was a bit of trepidations, I didn't know what was going to transpire but I am trying to come out of my shell this time around." The experience of this workshop was a new a different way of doing "therapy" that had moments of challenge and struggle for the participants. It was in these moments of challenge and struggle that clouded the experience of the workshop. I now present to you, "the bad" of the perfect storm. (See Figure 7.).
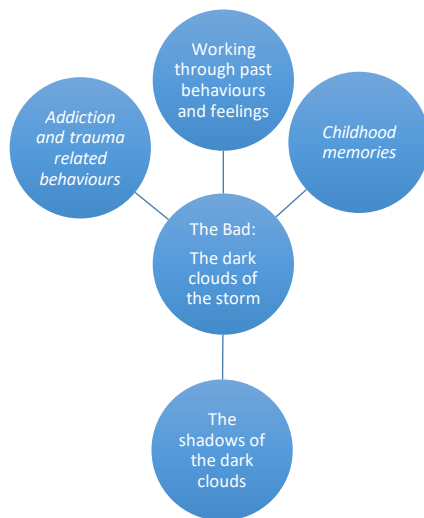
Figure 7. Visual Representation of the "bad" of the perfect storm.

Through the experience of the workshop, each participant shared unique moments in which they felt they were struggling. For example, the "chicken goggles" activity and the task of "bokking" like a chicken in front of other people in a group setting was described by most of the participants as "demeaning" and "uncomfortable." Brianna shared, "I feel like those kinds of

tasks…there is something demeaning about them…I could be doing something more constructive then quacking around and making everyone uncomfortable." For Brianna, the idea of not being able to, "feel a sense of accomplishment" from some of the activities was challenging. Odin related to these feelings by saying, "I was worried about losing and feeling like an idiot…in the moment I was thinking I don't want to do that, I felt embarrassed and uncomfortable." Heather further shared, "that one was uncomfortable for me because of not wanting to put myself out there and I really don't want to lose because then I would be the one that was left out, and I really didn't want that at all." It was at this moment in the day that the dark clouds rolled in and began to cast dark shadows on the experience of the workshop.

Moving forward, the dark shadows continued to challenge the participants in the following activities. For example, Heather shared a moment she had in the "willow-in-the-wind" activity in which she felt challenged to put her faith and trust in the other participants to catch her from falling in the middle of the circle. The challenge for Heather was whether she feared being an "outsider" by not completing the task-at-hand or taking a risk to complete the task. She shared, "the fear of being an outsider suddenly outweighed me fear of doing the activity, so I had to decide like what I am going to be more afraid of, doing the activity or being an outsider." Brianna further discussed a moment she experienced in the "eagle, bat, and parrot" activity in which she struggled because she felt "helpless" when she felt she was failing to successfully direct one of the other individuals in her group. She said, "it stressed me out, I didn't like that I could see him getting lost…I felt helpless, I couldn't help him, I just felt like it stressed me out." For Joseph, there was also a moment in this activity that he felt "triggered" because he was getting his directions mixed up and felt "stupid," which he described as a "stuck point" for him. He shared that in the moment, he "struggled to work through these feelings and wanted to "give

up" and "walk away." The dark clouds of the storm rolled in unexpectedly and brought up many feelings and emotions for the participants. Some of these feelings and emotions related to the participants past addiction and trauma behaviours and feelings that was also reminiscent of their own childhood memories.

Working through past behaviours and feelings. Many of the participants shared the ways in which their experience of the workshop connected to their own personal stories of past alcoholic and drug using behaviours. For example, Joseph identified some of his, "alcoholic thinking" and "stuck points" throughout the day as being important for him to continue to work through in recovery. He further shared that he often felt himself dealing with, "outside issues" stemming from his alcoholic and drug-using behaviours. One of these behaviours being his "racing mind."

Negative emotions were identified by participants throughout the workshop in times of challenge and struggle. During a moment of struggle Brianna said, "[I am] being honest and saying this makes me want to drink so expressing my feelings." Participants discussed feeling challenged at times throughout the workshop when disrupting behaviours were happening around them. For some, the way in which they reacted to these challenges was reminiscent of how they handled situations prior to recovery. In the moment, Brianna described being, "challenged because it was reminiscent of how I used to handle situations… like [I] was a loose cannon." Ava further shared that before treatment, in situations she felt challenged she would often "storm away" and continue to dwell in those negative emotions. The negative feelings that participants expressed working through on a moment-to-moment basis throughout the workshop were identified as being past alcoholic and trauma behaviours, which affect the way they view

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the world around them. For example, Odin shared that one of his trauma thinking behaviours is that the world is "jaded" and is a "complete shit hole."

*** Addiction and trauma related feelings.*** In addition to participants identifying their past addictive behaviours, they shared some of the negative feelings that pertain to their addictions and trauma. Odin shared that he internalizes his feelings, identifies isolation in his addiction, and actively works to not let people know that he is suffering inside. He said, "I have been suffering inside and no one knows on the outside that I am suffering." Liam also related to this idea as he shared that he supresses a lot of emotions and often feels flat and emotionless. He shared, "[I am] someone who often feels stuck in their depressed emotions [and] I quite often struggle with what I am actually feeling." Identifying these negative feelings throughout the day was a direct result of some of the emotions that participants felt throughout the experiential activities. For example, Heather shared that she often has trouble "feeling" her own emotions because she spends a lot of her time "faking" emotions in front of others. She discussed that she often fakes her emotions because she often feels "numb," making her question her own feelings. She said, "I spend a lot of time faking emotions because I don't feel them." When Heather was able to let go of this preconception for a short minute, she discussed being able to feel her own feelings which made her emotional in the moment.

Many of the participants discussed that the experience of the workshop gave them new learnings and understandings about themselves and their own person recovery. For example, Odin shared that before coming into the hospital he felt like he had completely lost touch with who he was. Through the experience of the workshop, Odin discussed that, "it [was] actually nice to warm up to [my own] feelings." Liam further said, "it's a lot more than the activity and I think that's the goal [of the workshop]." Additionally, the participants discussed wanting to "step

out of their comfort zone" and try something they normally wouldn't have in "active addiction."

Brianna said, "I figured I took a lot of risks when I was using drugs and alcohol so I could take a

risk to do a structured activity that would benefit [my recovery]." Although everyone took

unique learnings, both positive and negative for their own recovery, each participant shared a

common understanding of how the workshop applied to their own person recoveries.

Childhood memories. Throughout the workshop some of the participants discussed the

role that their childhood played in the experience of the workshop. Participants shared that they

never had the chance to be "playful" and "childish" in their childhood which makes them unable

to recognize those feelings as an adult. Joseph shared that he, "never had much of a childhood"

and so the experience of the workshop, "brought out the kid in [him]." Brianna further discussed

that she has, "never been in a relaxed environment in her life" so she struggled throughout the

workshop to access those feelings of "playfulness." Through the experiential activities of the

day, participants were able to find joy and laughter. Ava shared that she knows there is a,

"struggling little girl inside" her and that it felt good throughout the workshop to smile and laugh

and see that. "struggling little girl" smiling and laughing too. Joseph further related to this idea

when he discussed that he had the ability to have a "good belly laugh" during the activities of the

workshop which is something he has struggled to feel for a long time. While the experience of

the workshop was unique for each participant, the participants shared a sense of understanding in

the sense that they have come from different paths in life, yet they share a common bond of

living in early recovery.

The shadows of the dark clouds. Many of the participants discussed the challenges and

struggles they faced throughout the experience of the workshop due to the shadows of the dark

clouds. On a moment-to-moment basis, I was able to feel as these dark clouds casted shadows on

the experience of the workshop. For many of the participants, this was a process of working through these feelings, in order to move forward. For example, in a moment of challenge while being blindfolded, one participant shared:

> I had full trust and I knew you wouldn't let me walk into a tree but I just had quite the feeling that I was getting close to something so maybe a little insecurity on my part but I trusted and had faith (Ava).

Brianna related to this idea when she shared that she struggled to get into the middle of the circle for the "willow-in-the-wind" activity. For Brianna, she was able to identify and recognize that this activity was something she was not comfortable with, but that she knew she needed to work through. Working through this in the moment was a new experience for her. She shared, "the more sober time I have, my brain doesn't feel like it is going to explode, like steam coming out of it, so I was able to have that space between my thoughts and my reactions." For Brianna, in the moment of struggle she described needing to "get lost in space" and "step away" from the activities of the day to allow her the space to "get lost in her head" and then come back to the activities. Additionally, Odin shared a moment in the "bull-ring" activity in which he took on a role he was not used to by stepping back and letting another person take "control." This was something new for Odin and he shared that he felt "frustrated" in the moment. Yet, he described being able to "surrender" to these feelings and recognize that as a group they were going to be able to complete the task together, even if he was not the one in "control." For Ava, in the moment of struggle she shared that she used her breathing as a way to ground herself. She said, "I was just trying to stay calm and have fun with it and laugh it off… it is out of my control so I just [went] with the flow." As a group, it was important for the participants to identify and recognize the shadows that were casted due to the dark clouds of the storm. As the dark clouds

rolled in and took over the experience of the workshop, the pressure of the clouds began to build up and the heavy rains began.

The Ugly: The Heavy Rains of the Storm

In the moment that the dark clouds rolled through the workshop, there were also moments of heavy rains. In the moment, I could feel the precipitation beginning as the heavy rains began. This shift in the workshop caused a shift in the atmosphere and mood of the workshop. It was in these moments that the "ugliness" of the experience happened both unintentionally and unexpectedly. I now present to you the "ugly" of the perfect storm. (See figure 8. & 9.).
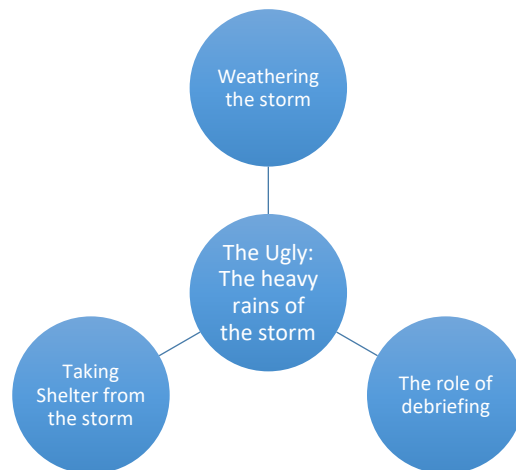
Figure 8. Visual representation of the "ugly" of the perfect storm

From my own experience of the engaging in the workshop, there was one moment of "ugliness" that brought on the heavy rains of the workshop. It is important to understand this moment in the workshop that caused a huge shift in the overall mood and experience of the workshop for many of the participants. I want to share with readers my own experience of this moment and remind them that this understanding comes from my own embodied experience of the workshop. During one of the activities, one of the participants was triggered. The participant worked through these feelings in the moment in a healthy manner by removing himself from the

activity and taking time to ground himself. When de-briefing this specific activity, the participant shared with the rest of the group what was going on with him. While the intention behind this discussion was not meant to be harmful, the raw dialogue that was created in that moment stirred up many disruptive feelings for the other participants. As I stood back and watched this moment unfold, it felt like it was happening in slow motion. I watched and listened as the participants were challenged by what was happening around them. In this moment, I too struggled to deal with my own emotions and feelings as the conversation began to shift towards a negative conception of the research project. At one point, one of the participants began to speak very negatively of my own intentions behind the experience of the workshop. At that moment my emotions took over and I had to step away from the situation to compose myself. This left me with feelings of disconnection from the group. It was at this time in the workshop, that the heavy rains poured as participants embodied feelings of anger, frustration, sadness, confusion.

In moments of "ugliness," each participant reacted to what was happening around them in a unique way. For example, Brianna shared that finds that she is always, "preparing for the worst and hoping for the best." She further said, "it threw me off for the day… I felt emotionally exhausted and emotionally drained." Many raw conversations were happening that caused unintended "triggers" and "harm" to the experience of the workshop. For example, Heather shared that she was surprised by her own personal reaction to what was happening around her. For Heather, this moment was upsetting and caused an emotional reaction that she was not used to. Yet, she discussed that through this she was able to learn that it is okay to feel her feelings. She said, "I am allowed to be upset, it's a good thing and I have to take that with me… If I am upset, then I am allowed to be upset."

Weathering the storm. Working through these moments of "bad" and "ugly" in the workshop was a powerful moment for the participants. As a group, there were many open and raw conversations happening that gave participants a sense of closure before moving forward with the activities. Liam shared that this experience, "gave the opportunity to…talk about how the activities were impacting positively or negatively." In these moments, participants came together to weather the storm together. I now present the ways in which participants took shelter from the storm together.

Taking shelter from the storm. Through this process participants were able to take shelter from the dark clouds and heavy rains happening in the storm. Liam shared that being able to work through this together gave everyone time to have "healthy conversations." By engaging in healthy conversations, participants were able to move away from something "uncomfortable" to a better place. Heather shared, "there was something uncomfortable that happened in here so it was like we got to move away from that so it was like moving towards a more comfortable place that felt better." Brianna echoed these feelings by sharing that prior to having these "heathy conversations" she was on the edge of feeling that the workshop itself was "counterproductive" to her recovery. However, by having the "bad" and "ugly" conversations, she was able to feel more "neutral" about the experience.

The role of de-briefing. Participants shared that the experience of de-briefing after each activity was a positive aspect of the workshop as it gave them the opportunity to unload how they were feeling on a moment-to-moment basis. For example, Brianna discussed that, "the debriefing was nice because then I got to unload any feelings I had in between and not build up any resentments or frustrations." She further shared that this was a good experience because when she felt like she was being challenged and, "got to dump any sort of stress attached to it…

then keep it moving… instead of having steam coming out of my ears." This aspect of the workshop was discussed to be a healthy process as there was no "right" or "wrong" answer.

Through the experience of de-briefing, participants were provided the opportunity to voice their struggles and challenges. Even in moments of dark clouds and heavy rain, participants shared working through these feelings. For example, Brianna said, "I definitely had to push myself out of my box… I was apprehensive but when I said whatever that's how it goes, I can't just be an 8-year-old and stuck in my ways." This experience taught participants new things about themselves in terms of how they react to certain situations that bring up "bad" and "ugly" feelings and emotions. Heather shared, "I did feel a little alone in what I learned about myself…I don't think other people echoed that as much so I felt a little alone in that feeling." Yet, in the moment, Heather was able to identify and recognize that these "bad" and "ugly" feelings that were holding her back are something that related to the loneliness she feels. She further shared, "the sort of epiphany moments or the things that I learnt about myself… I shouldn't hold myself back when I want to say something… I should allow myself to have those feelings." Ava related to this idea when she discussed that she was able to use the negative struggles, emotions, and behaviours that she felt in the moment of the experience as a learning curve. She shared, "I am trying to overcome my fears because it really wasn't that bad and why was I so afraid to do it… maybe I should try to learn more new things." Liam further discussed that through the challenges of the day, he came to the understanding that in his own recovery he has a lot to "juggle" and that in early recovery he needs to be mindful of the "bad" and "ugly" emotions and feelings that can arise from things that seem innocent in how they are presented, but may be a trigger. Amidst the dark clouds and heavy rains that caused the storm, participants

were able to come together to take shelter from the storm by sharing, listening, relating, and connecting their experiences. (See Figure 9.).
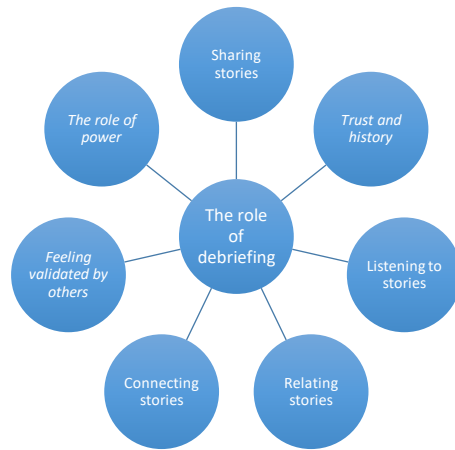
Figure 9. Visual representation of the role of debriefing

Sharing stories. Participants reflected on often avoiding sharing their feelings with the people around them in their active addiction. For example, Ava said, "I take it all in and I don't share." Therefore, the experience of de-briefing throughout the workshop was uncomfortable for some of the participants. Ava further discussed that she is usually shy and has difficulty getting "out of her shell." Odin related to this when he said that he has the tendency of isolating from others and not talking about what is going on inside. For Odin, this experience gave him the opportunity to open up and to try something different in a small group setting. He said, "I found that in my addiction it was all about me…I have always internalized that loneliness and despair with the PTSD and addiction." The experience of the workshop provided a safe place for participants to feel more "open" to sharing how they were feeling. Following the workshop, Ava shared that she found that she was able to stand up in a AA meeting and share out loud, which is something she had not previously done before. Ava further discussed that this experience left her feeing warm and fuzzy. She said, "I have feelings again and I don't feel dead inside… I don't feel cold and alone, I feel happy and giddy." For Ava, being able to share her feelings of the

activities with the other participants was a positive experience and it allowed her to really open up. Yet, with being open and sharing feelings with others comes the idea of being vulnerable around others.

Trust and History. It was further discussed by the participants that in order to share with others, they need to have a sense of trust and history with that person. Brianna shared, "for me trust and communication go together, I don't communicate unless I trust and I rarely trust so I rarely communicate." Liam also related to this idea when he shared that he felt more comfortable sharing with the individuals he perceived could relate to his own experiences. For him, the participants who shared a common link in terms of their first responder careers were easier to share in front of because they "got it." These perceptions of trust and commonality with others sometimes made some of the participants put up a "wall" or "front" to the people they perceived they could not trust or share common experiences with. For example, Liam shared, "how I open up and trust people… it makes a big difference if I present my generic self… or my scripted self". Brianna related to this idea when she said she often, "keeps the conversation really shallow" in front of people she doesn't perceive she has a lot in common with so that they, "never have the chance to get to know" her. Having the opportunity to engage in the experiential activities and build up that sense of trust with the other participants through the activities allowed participants to feel more comfortable sharing. For example, Odin discussed, "I felt myself being able to trust the group and surrender myself to the group and let things happen as they may."

Participants further shared that they did not have any issues sharing with this specific group of individuals because they were all experiencing the workshop together. Ava discussed that due to the small and intimate group setting, she felt the group was very respectful of other people's points of view which made it more comfortable to share. Further, Odin noted that it was

nice to be able to share and not be on a strict timeline, everyone had the chance to share how they were feeling on a moment-to-moment basis.

Listening to stories. For some of the participants, being able to share their feelings and feel like they are being heard by others is a difficult thing. For example, Heather discussed that, "one thing that is a really hard thing for me is feeling like I am not heard and feeling like no one is listening to me." For Heather, the activities of the workshop were challenging at times but when some of the other participants made an effort to really listen to what she was saying it was a meaningful experience for her. Odin further related to this idea when he discussed that he felt like when he shared he was being listened to by the people around him which made him more apt to share what he was experiencing in the moment. He said, "I enjoy when people actually take the time to listen to what I have to say." This sense of being listened to by the other participants while sharing their unique experience of the workshop was discussed by most of the participants as being a positive and meaningful aspect of the day.

Further, participants shared that having the ability to listen to what other people around them were saying was something that they often lost touch with in active addiction. For Joseph, this experience of being able to "really listen" to what other people were saying was something he felt like he loss in his addiction. Through the experience of the workshop he was able to take the time to stop, and listen, which was a powerful moment for him. This also ties into the idea of being "open minded" to what some of the other participants were sharing. For example, Liam discussed that one of the things he needs to work on for his own recovery is being receptive to what other people are saying, and not always assuming he knows what is best.

Relating stories. Being able to share and listen to what other people were saying provided participants the opportunity to relate to what others were sharing in a meaningful way. One participant shared,

> I find that when people are talking about their experiences the first thing I try to do is relate to their experience, kind of like walking in their shoes… like how had my life been affected in similar ways (Odin).

This process gave individuals a chance to learn more about themselves and others to create a shared sense of universality. For example, Odin discussed, "having that connection with other people you know you are not alone and it makes it easier." He further shared, "just knowing I am not alone with what is going on here… it allows me to connect." Brianna related to this idea when she discussed that the experience of the workshop was, "cool to see how other people think about the exact same task and just get a better insight to different ways of thinking and seeing the world." Although at times the participants did not share the same feelings or opinions, many of them discussed being able to understand and relate to where each other were coming from. For example, Ava said, "that's what sharing is all about, we don't always have to agree, we can agree to disagree." Liam further noted that he, "could usually relate something to my own experience… that would cause me to be able to open up more."

Being able to share, listen, and relate to the other participants in the workshop when some of the negative emotions and behaviours were coming up gave everyone the opportunity to understand how other people were feeling in that moment. Joseph noted that things aren't always going to go as planned but that is what it is like "living on life's terms." Through the challenging moments of the day, participants continued to share, listen, and relate to each other on a level that brought them back together. Even through this process, individuals were able to find a

common ground of respect for each other's opinions and move forward as a group in the workshop.

Connecting stories. Participants expressed feeling a sense of connectedness with the other participants through the process of sharing, listening, and relating. Through this sense of connectedness, participants were able to come to the realization that "people are good." This was a powerful realization for Odin as he shared that by connecting with the other participants he was able to know that, "people are good, the world isn't always shit." Ava further discussed that through the experience, she felt like she was able to learn more about the other participants which she would carry with her as she went back into the hospital setting. This sense of connectedness came from the idea that as a group, everyone had the same common goal, which connected individuals on a deeper level. For example, Odin said, "we are all in the same boat and we have an objective to complete today." This sense of connectedness further brought people together to understand that although different paths brought them here to this moment, they are all "working their recoveries together."

It was through the dialogue of sharing, listening, relating, and connecting that I was able to feel another shift in the atmosphere of the workshop back to a more positive place. From my own experience of sharing my own feelings with the other participants, I felt more connected to many of them. Having the opportunity to not only share my experience of the workshop, but also my intentions behind the workshop was important for me. It was through these conversations that I felt we, as a group, were able to come back together and weather the storm that was happening around us together.

Feeling validated by others. Through the discussions of relating and connecting with the other participants, individuals had the chance understand how their experiences tied into the

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other participant's experiences of the workshop. Heather shared that at times she would change her views to suit others views out of fear that she would be "left out." She said, "I try to not be different from other people." This fear came from wanting to feel validated by the other participants. This sense of validation for Heather came from her own perception of wanting to "fit in." For example, Heather said, "It is hard for me to share my experiences…but because a lot of other people were saying the same things as me it made it easier." In the moment, Heather identified often taking on the role of a "chameleon" to suit the needs of the people she is around. When she was able to open up and share her feelings and those feelings were echoed by some of the other participants, she felt validated, like she "had other people on my side." Brianna also related to these feelings by saying, "with speaking with the rest of the group and expressing my feelings… and them agreeing with me… It made me feel like I wasn't being dramatic." This perceived sense of validation from the group comes from wanting to connect with the other participants on a deeper level. Through the experience of the activities, participants had the opportunity to share, listen, relate, and connect to others to seek out that sense of validation.

The role of "power." The role of perceived "power" was understood through the idea of relating and connecting with other participants. For example, on one hand, some of the participants discussed that having the opportunity to connect with the recreation therapists in such an intimate setting allowed them to begin to "soften the barrier." Some of the participants felt that by having the recreation therapists engaging in the workshop alongside them allowed them to connect amidst these "power" dynamics. For example, Joseph shared a powerful moment in which he felt the roles of "power" were reversed with one of the recreation therapists. He said, "I just listened and heard…that was almost like turned around… she was telling me her story instead of me telling her my story." Ava further related to these feelings when she

discussed that seeing the recreation therapists let loose and engage in the workshop allowed her to do the same. On the other hand, this perceived sense of "power" made the relationships challenging at times. For example, Heather shared that at times she tried not to be seen as a "patient," instead she wanted to relate and connect with the individuals she perceived in "power" on a more equal level. Brianna further discussed that she felt like her "mom" was there as there was a clear "power" dynamic happening within the group. Although this experiences proved to be both positive and negative for the participants, having more discussions around the role of perceived "power" started to break down some of those boundaries often found in "professional" and "patient" relationships.

In addition to these "power" dynamics among the "professionals" and "patients", there also proved to be some "power" dynamics among the participants. Heather shared that the perception of being very "masculine" and "powerful" was a challenging thing for her and something that ties into her trauma history. She spoke to the idea that at times she felt intimidated by other participants she perceived to be "powerful" leaving her feeling nervous in these moments to share with these individuals. This was something Heather discussed that she worked through on a moment-to-moment basis throughout the workshop, but that this was easier for her when she was able to relate, connect and feel validated by the individuals she perceived to be "powerful."

The good: The Sun Peeking Through the Clouds

Amidst the bad, and sometimes ugly aspects of the workshop, many of the participants discussed common shared positive experiences of the activities. Although the dark clouds and heavy rains of the storm never cleared completely, it was in these moments that the sun began to peak through the dark clouds. I now re-present to you the "good" of the perfect storm. (See Figure 10.).

Figure 10. Visual representation of the "good" of the perfect storm

The aftermath of the storm. The experience of dealing with the dark clouds and heavy rains of the workshop reminded participants that no matter where they go, they will always encounter "ugliness" in their reality. Liam shared that this experience reminded him that he still needs to be mindful of his triggers. He explained,

> I need to be aware of my surroundings, I need to be safe, I don't want to be hyper-vigilant but I also need to know if there is a potential to avoid something that is going to cause a trigger, I need to be looking ahead for it (Liam).

In this moment of "ugliness" Brianna described that she felt so stressed out by what was happening around her to the point where she felt like she needed to drink. She shared, "it was so stressful to be honest that I even said I feel like I want to drink." Identifying these "bad" and "ugly" feelings and behaviours in the moment was especially powerful for Brianna. She described her response to the dark clouds and heavy rains reminded her of "pre-treatment" behaviours in which she would "snap" in moments of irritation. Brianna further described that she was able to recognize and own up to her actions and behaviours by identifying these past feelings and behaviours. She said, "I have to stop beating myself up about it… I needed to make

amends for it". Through the process of making amends for her words and actions in the moment of stress, Brianna was able to continue with the group throughout the remainder of the workshop.

By experiencing moments of "bad" and "ugly" together as a group, participants were able to move forward in the workshop. Liam discussed that this whole process of de-briefing the "ugly" aspects of the workshop changed his mind set to not just focus on the "ugly" that was happening around him. He shared,

> That kind of changed my mindset a little bit, my mind is not focused on something negative per se and I can erase that and I am okay to go on to the next activity and I don't need to fixate on what has already happened (Liam).

Taking shelter from the dark clouds and heavy rains as a group, brought the participants together to openly share the raw feelings that were happening in the moment, and then work to move forward in the workshop.

Although the activities were challenging and stressful in how they were presented to the participants at times, they were discussed as having positive outcomes that related to their own personal journeys of recovery. For example, the "willow-in-the-wind" activity proved to be a powerful experience for many of the participants. Some shared a sense of peace and serenity they felt while standing in a circle of people they didn't know that well and trusting that they wouldn't let them fall. Odin shared, "I am closing my eyes and I have no idea who is pushing me and just thinking don't worry someone is on the other side to push me back… it was peaceful." For Odin, the experience of this activity solidified his feelings of needing to continue to be open with his feelings and leaning on his support system when needed. Ava also related to these feelings when she shared, "it was relaxing because I had my eyes shut and it was quiet and people were just nudging me but I didn't have the racing thoughts in my head so it was

peaceful." The experience of putting trust in the group to catch them was expressed as nerve-wracking for many of the participants. Brianna shared a powerful story of knowing she needed to push herself to get out of her comfort zone. She said, "I don't want to do this so I know I need to." For Brianna specifically, she discussed being surprised that she could feel "cared for" by the other participants as they supported her. In that moment, Brianna was able to let go of the negative preconceptions she held in her head and allow herself to feel cared for by others.

Additionally, some of the participants discussed the enjoyment that they got out of the "eagle, bat, and parrot" activity as being peaceful and comfortable despite the fact that they were blindfolded and having to put their trust in their group members. Ava shared, "I still felt at peace, it was good, even with the blindfold on, I didn't have the racing thoughts because I was trying to listen." Odin further shared how this specific activity was reminiscent of early recovery as he feels "blinded" at times and he needs to rely on his personal support system to keep himself safe in recovery. This specific activity was challenging at times as it asked participants to trust and communicate effectively as a group in order to reach their goal successfully. For Liam, this experience was really interesting as it challenged him to learn, interpret, and translate what other people were saying and then relate and connect this to his own personal understandings.

A new found sense of fun. Overall, the intention behind many of the activities in the workshop was to provide participants the opportunity to not only learn about themselves but also to "let go," be "silly," and "have fun." For example, Ava shared, "yeah it was fun and goofy, I don't remember doing something fun and goofy like that sober." Odin and Joseph also related to these feelings when they shared that they experience moments through the day when they were "actually laughing" and having a "good belly laugh." For some of the participants, this sense of "having fun" was different from what they were used to feeling. For example, Heather shared

that she felt "supported" by the other participants in the group which felt "unusual" and "unfamiliar" to her in a good way.

Although this experience of "having fun" and "being silly" was not universal among all of the participants, all of the participants shared a common understanding of the intention behind the activities. Some of the participants felt like they were unable to channel feelings of "fun" and "silliness" throughout the activities, most of the participants were able to recognize those feelings in others. For example, Brianna discussed, "I thought it was so nice to see everyone else enjoying it, I wasn't resentful, but for myself, I just couldn't channel those feelings." For Brianna specifically, this experience of "letting go" and "having fun" was challenging. She shared that at times throughout the activities she felt "happy" but that she was still struggling to feel that sense of "having fun." Many of the participants that were able to recognize the fun in these types of activities discussed being surprised by the way other people interpreted the intention of the workshop. For example, Ava shared, "It surprised me because I thought it was all silly and fun and games and I guess I can see how they think it's different and weird for our age but not to have fun with it shocked me because that was the whole purpose of it."

Transferring the perfect storm into recovery. Although the workshop was presented as "silly" in nature, it provided participants the opportunity to explore the outdoors and learn more about themselves in the process. For example, Ava shared, "you don't think you're going to get anything out of it but you really do at the end of the day… it felt good to be silly." Liam related to these feelings by saying, "I was surprised to see that some of the activities that appeared to be simplistic in nature really got people talking."

Many of the participants were able to take personal learnings from the experience of the workshop and apply it to their lives in the hospital, in particular, but also their realities outside of

the in-patient setting, in general. For example, Odin shared that in order to be successful in his own early recovery he needs to continue to, "trust in fellow mates that there are good people out there, stay away from the slippery ones and find the good ones and keep them close." Odin further discussed that It is important for him to continue to live for "today" and not let the past and future limit what he is capable of in recovery. Liam related to this when he discussed that the experience of the workshop was, "physically freeing… it feels like your stresses are kind of moving away and… there's no need to be anxious, there's no need to worry about things, you can just let go." For Liam, the experience of the workshop was a powerful realization to "push the pause button" and know the importance of incorporating these new found healthy behaviours in his recovery in order to be successful. Joseph also related to this when he shared that the experience of the workshop for him related to his recovery as it, "gave me strength and it gave me hope."

A new found sense of learning. Through the experience of the activities, participants shared that they were able to find a new sense of learning about themselves that directly related to their recovery. One common thread that was shared by the participants throughout the day was the idea of "taking down their walls" and pushing themselves "out of their comfort zone." For example, Odin shared that, "sometimes the answer lies just outside your comfort zone… I am glad I came today… I got to work at it slowly and get back to being around other people and having fun without drinking." By providing a space for participants to go out of their comfort zones, this experience worked to build up a sense of trust within the group. Odin further shared that the experience of getting out of his comfort zone was "difficult" at the beginning of the day, but that he "started to get more comfortable as the day went on." Brianna related to this by saying, "I wanted to step outside of comfort zone because I have been focusing on trying to make

some healthy changes to me behaviour… I know there is some benefit in being made uncomfortable, that's how you learn and grow."

In addition to this experience of being "outside of their comfort zone," some of the participants shared that the experience allowed them an opportunity to get more in touch with themselves on a deeper level. For example, Odin discussed that this experience was "freeing" for him in the sense that he was able to recognize that he has the ability to "be a great human being." For Odin, this was a powerful realization as he came to terms with being able to deal with what is going on in his life and look forward to being "healthy again." Liam further echoed these feelings when he discussed the enjoyment he got from the "check-in" activity around the labyrinth. Liam shared that he often feels "stuck" in his "depressed emotions" and so having the opportunity to take the time and learn how he was feeling on a moment-to-moment basis was beneficial throughout the workshop.

Summary

Overall, the good, the bad, and the ugly experiences involved in the workshop were all understood in a way that gave participants the opportunity to have those "lightbulb moments," that related to their recovery. Despite the dark clouds and heavy rain of the storm that happened throughout the day, participants continued to work through the experience together and "weather" the storm together. For example, Brianna shared, "I saw some people still see the good in it despite the bumps." Joseph further related to these feelings by saying despite working through challenges and struggles in the day, he will take what he has learned through the experience of the workshop and never forget this.

Through the experience of the workshop, participants shared that there were many meaningful discussions and conversations happening in the moment that related to their own recoveries. Liam shared, "I honestly didn't think that from group activities you could get that

much discussion going." Virtually after every activity, individuals had the opportunity to share and listen to other people's experiences of the workshop. This in turn, gave individuals the chance to relate and connect to the other participants in the workshop. For example, Heather said, "the experience of sharing with others I think helped… if we had just done the activities and not talked it wouldn't have had the same impact." Despite the challenges, struggles, and differences that happened throughout the day, by sharing, listening, and relating their stories, participants were able to find a deeper meaning to the activities of the workshop that connected to their own personal recoveries. For example, Joseph said, "each one of us is born different… but behind everyone is our stories." To conclude, Odin spoke to it best when he said, "If I can help someone down the road… change things for the better there is always progress to be made."

The narrative threads highlighted in this section showcase the need for complementary and alternative forms of psychotherapy to be incorporated within an in-patient mental health setting. Connecting the metaphorical idea of the "perfect storm" back to the guiding research question allows us to begin to understand the idea of providing alternative modalities of care within an in-patient care setting. The narrative threads presented in this section of the thesis play a role in the understanding of how we can view "therapy" differently. By understanding the connection between the role of the outdoors, the idea of working through past addiction and trauma behaviours, and the use of story-telling within this context, we can begin to create dialogue around the experience of the workshop as a whole.

CHAPTER SIX: DISCUSSION

The purpose of this section is to discuss the narrative threads in relation to existing literature. Working within a pragmatic worldview allows me to explore the historical, political, and social contexts through a critical lens as it relates to participants lived experiences of the outdoor experiential psychotherapy workshop (Creswell, 2013). The participant's stories of the workshop are consistent with, but not exclusive to the conceptualizations of therapeutic recreation (TR), outdoor experiential therapy (OET), and approaches used in psychotherapy presented in chapter two. Pulling on ideas from these three large bodies of literature provided a conceptual framework of meaning created through participant's stories. The conceptual ideas discussed in the literature review of this study will be compared and contrasted to the findings. Connecting the analysis of the findings back to the guiding research question led to an exploration of the meaning derived from engaging in outdoor experiential psychotherapy for individual's experiences of early recovery. Specifically, understanding the role of commentary therapeutic modalities, as well as providing a platform for individual's voices, stories, and experiences of early recovery to be heard will also be explored as it relates back to the surrounding field of literature.

The Role of Outdoor Experiential Psychotherapy within an In-patient Setting

Through an understanding of current in-patient care practices, the data presented in this study works to understand the ways we can view "therapy" differently. The findings of this research showcase an example of how outdoor experiential therapeutic modalities can be incorporated into early recovery. The following section works to unpack the findings of this research by understanding the shift in thinking towards social model approaches to care, the cycle and complexity of a PTSD-SUD diagnosis, as well as the role of TR, the outdoors, and 'fun' in care.

Medical versus Social Approaches to Care

At the forefront of this discussion, it is important to re-visit the theoretical models that inform in-patient practice. Current "best-practices" to treating a co-morbid PTSD-SUD diagnosis assume a very medicalized lens (Conrod & Stewart, 2006; Hiebert-Murphy &Woytkiw, 2000; Ouimette, Moos and Brown, 2003). As outlined in chapter two, there is a shift in the way we think about and view "therapy" when we move away from a medicalized lens, towards social approaches to care. This research study attempts to be an example of this shift in thinking within practice to showcase how we can view "therapy" differently. The intention behind this research was not to provide readers with another "best-practice" that can be used within this type of setting, but to showcase how we can pull on different fields of literature to be used as vehicles to facilitation. Therefore, I have actively worked to not use the word "therapy" as a discussion point from this research.

Participants voiced their experiences of "trying something different," and "stepping outside of their comfort zones," to engage in outdoor experiential psychotherapy brought up different feelings of freedom from the regular programming. This is not to say that these different feelings are beneficial, but that the experience of the workshop as a whole provided participants with the opportunity to gain insightful meaning into their own personal recoveries. The findings discussed in this study add to this field of knowledge by showcasing how we can view "therapy" differently within an in-patient setting. This gives us an understanding as to how we can move away from this "medicalized" way of viewing therapy to incorporate more social model approaches to care. Although this idea is not new per se, it is something that has yet to be adopted within clinical in-patient settings. Many scholars have actively supported the use of a social model of approach in care from a TR standpoint (Arai et al., 2015; Kestenbaum,2005; Lahey, 1987; Mobily et al., 2014 Sylvester 2005a, 2015b). Within this context, the research

presented here works to further support the benefit of a social model approach in care by showcasing how we can view "therapy" differently.

The use of leisure as a broad platform for coping with stress, and traumatic experiences has been well documented in the literature (Austin, 2013; Autry, 200; Drench et al., 2012; Griffin, 2005; Kunstler, 2015; Scott & Ross, 2006; Van Puymbroeck & Lundberg, 2011; Wupperman et al., 2012). What remains to be explored is the use of complementary forms of therapeutic practices as an approach to facilitate social and relationship-centered programs for the healing of trauma and addiction within an in-patient setting. The present study is only one example of what these practices can look like within a clinical setting. In order to understand the ways in which this can be incorporated in practice, we need to start to see more research in the literature that works to understand the shift that occurs when we adopt social model approaches into care. Therefore, I do not want readers to view this research as another study that only re-iterates the idea of informing "best-practices" in care, instead, I want this study to be used as a way to showcase how we can view therapeutic practices differently within an in-patient setting.

The Cycle of a PTSD-SUD Diagnosis in Care

The literature surrounding the cycle of a PTSD-SUD diagnosis notes that a functional relationship between these two disorders has not yet been established (Conrod & Stewart, 2006). In some cases, individuals living with PTSD symptoms may turn to alcohol and drugs as a coping mechanism (Ouimette, 2010; Reynolds et al., 2005). In other cases, scholars have suggested that a substance using lifestyle may predispose an individual to traumatic experiences (Reynolds et al., 2005). Regardless of the disposition of a PTSD-SUD diagnosis, it is important to understand that we must be providing care that actively works to cope with both disorders simultaneously. Odin speaks to this idea when he shared that he is, "surrendering to the fact that

it doesn't matter which caused which," because at the end of the day it is important to deal with symptoms from both disorders.

The spoken lived experiences of participants illustrate the complexity surrounding a co-morbid PTSD-SUD diagnosis. Conrod & Stewart (2006) describe the commonality of these disorders maintaining the other as being a "vicious cycle." The complexity of this cycle is showcased in this research through the experiences participants shared of past addiction and trauma related behaviours and feelings. It is these behaviours and feelings that illustrate the "bad" and "ugly" aspects of the workshop. Ava shared her experience of working through "racing thoughts" on a moment-to-moment basis that often hindered her ability to fully connect and derive meaning from the activities. Being able to let go of these ruminating and "racing thoughts" provided participants the opportunity to feel a sense of peace within their own head and come to terms with how they are feeling on a moment-to-moment basis. The experiences of the "bad" and the "ugly" gave participants an opportunity to share the raw and powerful moments that directly related to their reality outside of the workshop.

Working through these negative emotions and feelings that arose in the moment provided participants with an understanding of how it may relate to their own recovery. Within in-patient treatment, working through both trauma and addiction related behaviours and feelings seems to be a misunderstood area (Ouimette, 2010; Reynolds et al., 2005) as it is difficult to understand the complexity of this cycle without having direct experience working with this population. The findings presented in this research demonstrate the complexity of working with individuals living with both disorders. Further, the findings illustrate the importance and significance of incorporating both trauma and addiction related behaviours and feelings into care for individuals living with a co-morbid diagnosis.

Within practice, we need to ensure we are providing care to individuals that meets the needs of both disorders. That said, the complexity of both of these disorders serving the other, makes it difficult to provide care that targets both. Similarly, literature regarding the use of sensorimotor psychotherapy practices, begs us to understand that we cannot change the past, but we can change effects of the past for the future (Ogden & Fisher, 2015). Therefore, as practitioners and advocates in the field, it is important to understand the role of both disorders when working within individuals with a PTSD-SUD diagnosis, to ensure we are properly equipped to manage and cope with the feelings that may arise in practice.

The Understanding and Role of TR in Care

When considering the findings of this study, it is clear the clinical definitions of "leisure" do not conceptualize the complexity of applying these practices within an in-patient setting. The literature conceptualizes TR as a process used to improve functioning, coping, adaptation, and the pursuit of health and well-being through leisure practices in order to facilitate growth and change within this type of setting (Carter & Morse, 2011; Caldwell, 2005; Kleiber et al., 2002; McCarville &MacKay, 2007; Shank and Coyle, 2002). Although this definition provides a general description of TR services, it appears to be idealistic in nature as the findings of this study showcase the complexity of facilitating programs within this setting and population. As practitioners in the field, we need to be more aware of these idealistic conceptualizations of TR and move into a more realistic understanding of practice. The benefit of incorporating research, such as this study, into current literature is to begin to understand the ways that TR unfolds in an in-patient care setting for individuals living in recovery on a moment-to-moment basis.

The metaphor of the, "perfect storm" presented in this research speaks to this idea as it unpacks the complications that can arise from utilizing alternative TR practices. By unpacking the role of the good, the bad, and the ugly of using alternative TR modalities, we can come to

understand ways in which these practices may not always be beneficial. In some instances, TR practices may cause harm if we are not aware of the outcomes. Showcasing research such as this in the literature, not only speaks to the role TR can take on within an in-patient setting, but also how challenges can arise both unintentionally and unexpectedly. This asks us to question how we can work through these challenges as they come up to provide further meaning into early recovery. Brianna spoke to this when she shared, "I know there is some benefit in being made uncomfortable, that's how you learn and grow." Through an understanding of the realistic outcomes of working in this type of setting, it is important for us to prepare ourselves to derive meaning from the challenges we may face in care.

The current study can be used to extend these understandings in practice by demonstrating the ways in which outdoor experiential psychotherapy can be utilized within an in-patient setting. It is clear, through the findings of this study, that the conceptual understanding of leisure is often misunderstood within a therapeutic context. In this sense, TR practices can be used in practice as a way to foster positive learning and change for individuals living in recovery. It is important to further unpack how we can view "therapy" differently within an in-patient setting. Although traditional modalities to practice are widely accepted within mental health treatment, it is important that we also begin to look outside of the box of "normal" or "best" practices to understand how we can create a meaningful space for individuals on their journeys of recovery. In practice, it is important for us to take research like this as a guiding framework to understanding how we can incorporate non-traditional modalities of care into our practice and create positive social change within this setting.

As a researcher, the ideas presented in this section challenged my own understandings and knowledge by asking me to critically reflect on my own philosophies of TR. Coming from a TR

background, I often align myself within this way of thinking. However, this research has challenged me to look beyond this scope of understanding. It has further begged me to question the ways I may align myself away from TR understandings. I hope this research continues to be an on-going process of learning and growth for readers to critically reflect on their own philosophies and understandings when practicing within this setting. As a field, this is something we need to continue to create powerful and critical dialogue around as we move forward.

The Role of the Outdoors in Care

Current literature within outdoor education uses nature-based models to endorse nature as a co-therapist within a therapeutic setting (Jordan, 2015). Further, the use of experiential activity has been documented to provide individuals with the opportunity for personal growth, team-work, and enhanced communication (Ewert et al., 2001). Within a group setting, these types of activities can foster a sense of trust between the facilitator, the other participants, and the surrounding environment (Howden et al., 2012). The findings of this study add a rich narrative to this literature by showcasing how these ideas play out within an in-patient setting. Although much of the current research aligns with the outcomes of this study, what is missing is the ways that these can be adopted into current in-patient practice. Through the lived experiences of the workshop, participants had the opportunity to use the outdoors as a healing context to deal with unpredictable and uncertain outcomes that may arise within care (Ewer et al., 2001).

Structure and Routine

Letting go of structure and routine was a common shared experience for participants. The premise of the workshop was to provide a space and place for participants to let go of the structure and routine they have come accustom to within the in-patient setting. Within current literature, traditionally "therapy" has been viewed as a human-to-human process that is practised within the confines of a building (Dustin et al., 2011). Through the experience of the workshop

participants expressed being able to break away from the confinement of the walls of the hospital setting and have the time and space to reflect on how they were feeling on a moment-to-moment basis. Being able to let go of the 'military structured' and 'controlled environment' of regular programming and be in a fun, relaxed, and different environment was shared by participants as beneficial. The outdoors was further discussed as giving participants a change of scenery and sense of freedom from being in the hospital. From my experience of working at Homewood Health Centre in the AMS unit, the idea of re-incorporating structure and routine into early recovery is something that is viewed as highly constructive for individuals living with a mental health diagnosis. Yet, the findings of this study showcase the meaning that comes from breaking down this idea of "confinement" within an in-patient setting and provide a space for individuals to gain a sense of freedom. This provides a powerful example of how we can begin to incorporate alternative and complementary modalities into future practice.

The Outdoors as a Co-Therapist

The experience of using an outdoor setting as a co-therapist within in-patient treatment is consistent to the research presented in chapter two (Berger & McLeod, 2006; Dattilo & McKenner, 2011; Ewert et al., 2001; Howden, 2012; Peel & Richards). Ewert et al. (2001) detailed the use of alternative outdoor therapies as an opportunity to embody the natural environment. This idea was reflected in the findings of this study as participants shared the enjoyment they got from being able to hear and see the nature around them. Joseph described being able to see, listen, and hear the outdoors around him was stimulating and gave him a sense of relaxation.

There was some ambiguity as to why participants chose to engage in the workshop within an outdoor setting due to the mixed feelings of facilitating in an outdoor program within this context. While all of the participants were able to recognize and understand the role of the outdoors in this type of programming, some of the participants also noted the challenges that came with it.

On one hand, Joseph described using the outdoors as an opportunity to "be away from the hospital," and "be away from his alcoholism." Yet, on the other hand, some of the participants described not being "outdoors people," which hindered them from refreshment and relaxation in an outdoor setting. The findings of this research continue to extend these understandings in the literature by showcasing the effectiveness of using the outdoors as a cleansing space for individuals currently living within an in-patient care setting. This further fits well within a TR paradigm as it provides a space for experiential activities to be a means for therapeutic change (Autry, 2001).

Personal Learning and Growth

Ewert et al. (2001) further outlined the use of experiential activity as being a process of personal learning and growth. The workshop was intentionally designed to provide participants the opportunity to engage in a series of complex and challenging activities to open up the door for potential self-discovery (Howden, 2012). Through the process of engaging in the experiential activities, de-briefing, and processing, participants shared raw lived experiences that provided them to connect and relate on a deeper level. For example, many of the participants shared that the conversations happening in the moment, provided them the space to understand the therapeutic benefits outside of the workshop. Liam said, "I was surprised to see that some of the activities that appeared to be simplistic in nature really got people talking." Upon further reflection, these lived experiences were discussed as a way to understand how the experience as a whole connects into individual's experiences of early recovery. This idea of transferring knowledge and understanding into the daily lives of participants was at the core of the intention behind the workshop (Dattilo & McKenner, 2011).

The findings of this study extend our knowledge and understanding in the field as it provides an understanding of the role nature plays within therapeutic practices. This study further justifies the use of nature-based therapy within an in-patient setting (Jordan, 2015). By breaking

down the confinement of the "four-walls," we can begin to use the outdoors as a space for individuals to "take a break" from traditional therapeutic modalities. Similar to that described in the literature, the lived experiences of individuals engaging in outdoor experiential psychotherapy workshop within an in-patient setting, provided an opportunity for individuals to re-connect with nature, find personal meaning, strength, and hope within recovery (Berger & McLeod, 2006). Through this, we can use the outdoors as a way to open up new ways of thinking and healing within nature (Buzzell & Chalquist, 2009).

The Role of Fun in Care

The intention behind many of the activities in the workshop was to provide participants the opportunity not only to learn about themselves but also to "let go," be "silly," and "have fun." Ava shared, "yeah it was fun and goofy, I don't remember doing something fun and goofy like that sober." Although not all of the participants felt like they were able to channel these feelings, all of them were able to recognize those feelings. Within in-patient settings, TR can adopt relationship-focused activities as a way to support the experience of "fun" and "freedom" for individuals.

There is very little research in the field that specifically targets this understanding of the role of "fun" in recovery of a PTSD-SUD diagnosis. This may be because much of the current literature focuses on the "medicalized" understandings of treatment. Within the literature there is strong evidence outlining positive outcomes that can come from TR practices such as enjoyment for individuals (Austin et al., 2015; Shank & Coyle, 2002). However, this does not show how aspects of relationship-focused activities can provide a sense of "fun" within an in-patient care setting.

The good, the bad, and the ugly of the experience of the workshop all ties into new understandings and knowledge for participants that connects to their lives outside of the workshop. The workshop was presented as "silly" in nature, however, it provided participants the opportunity

to explore the outdoors and learn more about themselves in the process. The findings of this research continues this conversation by extending the current knowledge in the field through the rich and powerful narratives of the participants living in recovery. This study is unique as it draws on understandings of TR, OET, and psychotherapy to inform the use of complementary therapeutic practices. By adopting these understandings in practice, we can open up new ways of seeing and incorporating therapeutic practices within an in-patient setting. This provides strong evidence for the use of relational practices within this setting, as a way of informing positive change within an in-patient setting for individuals living in recovery.

Providing a Platform for the Stories of Early Recovery

In addition to gaining insight regarding the role of providing alternative modalities to care within an in-patient setting, the intention behind this workshop was to provide a platform for the voices of recovery to be heard. Participants discussed the role of group interventions and processing techniques and the process of de-briefing as being a valuable aspect of the workshop. Participants further described this process as providing an opportunity to process and connect their stories of recovery. This was intentionally designed to provide a space for the 'voice in the cracks' to be heard.

The Role of Group Interventions and Processing Techniques

The findings of this study are similar to that of current understandings of the use of group interventions in TR (Shank & Coyle, 2001), and group process techniques in psychotherapy practices (Yalom & Leszcz, 2005; Yalom, 2005). Group interventions are often used in TR settings as a way to facilitate individual change and growth (Carter & Morse, 2011). Through group interventions, individuals have the opportunity to bond with other group members to feel safe, valued, and accepted (Yalom & Leszcz, 2005). The workshop presented in this research worked to actively provide a space for individuals to develop new skills and examine

psychological issues in an emotionally and socially supportive environment (Shank & Coyle, 2002). The findings of this study add a rich narrative to this literature by showcasing how group interventions can be used through the process of sharing, listening, relating, and connecting individual lived experiences of the workshop. Through the role of de-briefing, participants had the opportunity to understand the deeper meaning of the workshop as it applies to their recovery outside of the workshop, and voice their lived experiences.

The Role of De-briefing in Care

Throughout the workshop, participants had the opportunity to de-brief after every activity to share how they were feeling on a moment-to-moment basis. The process of de-briefing provided findings that were consistent with that of group processing techniques within psychotherapy and psychoeducational groups (Yalom & Leszcz, 2005), as well as group interventions within TR (Carter & Morse, 2011; Shank & Coyle, 2002). This type of reflection process is vital for experiential activity as it provides individuals with an understanding of the ways in which their actions and interactions within the workshop transferred into other aspects of their life (Howden, 2012). Through the process of giving meaning to an experience, the participants were able to safely interact and co-construct old and new experiences (Jordan, 2015). This demonstrates the different ways participants were able to express their lived experiences and stories within a changing environment.

The good, the bad, and the ugly of the workshop, provided participants the opportunity to share, listen, relate, and connect their stories. The literature presented in chapter two frames the relational and sensorimotor experiences offered by this study. Relationally speaking, participants not only connected with nature around them, but also the other participants. Some participants found that they were able to relate what others were saying to their own personal experience. For example, Odin shared a powerful realization when he said, "I find that when people are talking

about their experiences the first thing I try to do is relate to their experience, kind of like walking in their shoes." Other times, participants distanced themselves from others if they felt like they could not personally relate. This was evident when Liam discussed that he found it easier to relate and connect to individuals who share a similar background as him as they, "get it." Having the opportunity to unpack the relational experience of the workshop directly connects to the group processing techniques outlined by Yalom (2005). For example, participants had the opportunity to experience a sense of universality to know they are not alone in their feelings. Odin said, "just knowing I am not alone with what is going on here… it allows me to connect." This sense of universality provided the chance to relate and connect participant's experiences on a deeper level. Although at times the participants may not have been on the same page, having the opportunity to share, listen, relate, and connect their experiences was discussed as being a healthy aspect.

Trust and communication. Participants further shared that they struggled with feeling vulnerable with others, which presented a challenge in moments throughout the day. Although this may not have been true for all participants, this sense of trust and commonality was identified as being the ground work for communicating and building relationships with others. For example, Brianna shared, "I don't communicate unless I trust and I rarely trust so I rarely communicate." Participants had the opportunity to share how they were feeling and "get it off their mind," providing them the "peace of mind" to listen, connect, and relate to what the other participants were sharing. Brianna said, "the debriefing was nice because then I got to unload any feelings I had in between and not build up any resentments or frustrations." Amidst the difficult and sometimes challenging aspects of the workshop, participants were able to come together to share their different experiences in a healthy manner. This finding is consistent with the research

presented by Shank and Coyle (2002) as participants were able to process and reflect on their unique experiences of the workshop and generalize these understandings from present activity to life beyond.

This research provides a space for the voices of recovery to be heard through the narratives presented. The narratives work to extend past these pages to showcase a need to stop, and listen to what individuals are saying about their own recoveries and provide a space for universality. This specific study differs from current literature as it provides a space for the voices, stories, and experiences of recovery to be at the forefront of the research. Providing a platform for the 'voice in the cracks' to be heard, we can actively work within the field to ensure we are providing the individuals we work with positive and meaningful therapeutic practices within an in-patient care setting.

The 'Voice in the Cracks'

The history of therapeutic and psychotherapy practices has often "institutionalized people" to the point that they are rendered voices in society (Lord & Hutchison, 2007). As a result, this has had a profound effect on individual's sense of power within this setting (Lord & Hutchison, 2007). Through the process of sharing, listening, relating, and connecting their experience, participants had the opportunity to have an active voice in their own recovery. Although each individuals story is different, each participant shared the learnings and understandings they took from the workshop and applied it to their past addiction and trauma behaviours. These personal learnings not only applied it to participants lives within the in-patient care setting specifically, but also their lives outside of the workshop in general. The workshop worked to actively break down the boundaries that currently exist within the medicalized view of an in-patient setting to recognize the importance of hearing the voices, stories, and experiences of individuals living in recovery. Through the experience of sharing their own personal

experiences and stories, the workshop provided a platform for individuals living in recovery to voice their stories in a way that derives meaning from the experience.

As identified in chapter two, much of the literature surrounding an in-patient care setting perpetuates the discourses surrounding "disability" by oppressing, stigmatizing, and labelling the individuals we work with (Mobily et al., 2014). By providing a platform for individuals to share their own experiences of the workshop we can begin to hear more stories of shared humanity within an inpatient setting (Johnson & Parry, 2015). Through the use of narrative, we can understand how the stories told by participants are closely tied to cultural discourses, ideology, and expectation within the larger culture (Chase, 2005; Reissman, 2007). Within this research, this idea was presented in the "bubble" of in-patient care, in the sense that the participants conceptual experiences of the workshop were influenced by both interpersonal (*in-patient care, societal stigma, societal marginalization),* and intrapersonal (i.e. *mental health diagnosis "label," past and childhood experiences, individuality, morals and values)* influences acting upon them (See Figure 3.).

This study is unique to current literature as it captures the lived experiences of individuals living in early recovery of a PTSD-SUD diagnosis while engaging in outdoor experiential psychotherapy within an in-patient setting. The purpose of doing so was to keep individuals voices at the forefront of the research as an integral aspect of change within this setting. It is stories such as those presented in this research that can be used to break down the meta-narratives of the culture around us to include the voices that are often rendered silent in society (Chase, 2005), and provide a platform for the 'voice in the cracks' to be heard.

Implications for Practice and Research

In wrapping up this section, it is important to understand the knowledge translation that occurs as we move the ideas presented in this research to practice. The implications this research presents are important for both future practice within an in-patient setting as well as future research in the field. It is important to not only discuss the findings of this research in relation to existing literature, but also understand how these findings can be translated into action.

Implications for Practice

The purpose of this study is not to say that traditional modalities of care are ineffective, but that the use of complementary therapeutic practices, can instill a sense of hope and change for individuals within an in-patient setting. The present study contributes to the general body of knowledge and practice related to in-patient care settings by adding a rich understanding of participants lived experiences of engaging in outdoor experiential psychotherapy practices. Through this, the narratives presented in this study showcase the need to critique the idea of "normalization" and challenge the stigma and marginalization that currently surrounds a mental health diagnosis (Cleary et al., 2004).

When considering the findings of this study, the benefit of understanding the role commentary therapeutic practices can have within an in-patient setting is evident in the experiences and stories. Much of the current research surrounding this area focuses on viewing "disability" from a medicalized standpoint (Diedrich, 2007; Linton, 1998; Mobily et al., 2014). Through an understanding of the good, the bad, and the ugly that can come from this type of practice, we can begin to explore the benefit it can have for individuals living in recovery. The findings of this study showcases the ways we can implement relationship-centered practice into care through the use of outdoor experiential psychotherapy practices. This study is unique in the sense that it draws on understandings from TR, outdoor therapy, and psychotherapy as a vehicle for facilitation.

Through research such as this we can begin to challenge the assumption that there are "best practices" when working with individuals living with a PTSD-SUD diagnosis, and begin to show the complex human contexts and systems that surround in-patient care (Arai et al., 2015). Similar to the findings of this study, this is not going to be a smooth process as it asks us to critically examine what we have come to believe is "normal" or "best." As a field we need to critically reflect on how we are currently providing care within an in-patient setting. By unpacking the currently medical understandings surrounding in-patient care, this research showcases a need to open the door to new understandings and knowledge. This study can specifically be used as an example of how integrated complementary forms of therapeutic practices can be beneficial and produce positive outcomes, as compared to traditional therapy activities alone (Bennet, Cardone & Jarcyzk, 1998). This demonstrates one small sample of a very large population of individuals living with a mental health diagnosis. Therefore, we need to ensure we continue to add rich narratives of the individuals we work with into daily in-patient care practices.

Implications for Research

The narrative threads presented in this thesis illuminate several areas for future research and highlight the need for understanding the ways we can view "therapy" differently within an in-patient setting. In a time of great social stigma and marginalization of a mental health diagnosis, providing a platform for individuals living in recovery to share their own personal stories may provide an outlet for positive social change within in-patient settings. It is further important to share counter-narratives, similar to that presented in this thesis, to provide a space for individuals to voice their own lived experience of recovery (Diedrich, 2007). In order to illuminate the voices, stories, and experiences of individuals living in recovery to be heard, we need to see more qualitative and creative methods to research in the current literature. The

findings of this research provide a space for further implications and recommendations for future research. These implications will be further explored in this section.

First, adopting therapeutic practices that pull on nature-based and psychotherapy within an in-patient care setting needs to be further explored to understand how this type of practice can be embedded in current daily practice. This research provides an example of one workshop that was used to understand participant's experiences. In order to further understand how this type of practice can be implemented into every day practices within an in-patient care setting, we need to explore more research such as this. Specifically, more research surrounding the implementation of this type of practice into every day practice is important to understand the positive outcomes that can come of it for individuals living in recovery. Within this area, future practice can focus on the use of adopting the outdoors as a co-therapist and providing a space for individuals to engage in experiential activities that foster a new sense of learning. This in turn allows us to further understand how these types of therapeutic practices can be transferred into the lives of individuals in recovery outside of an in-patient care setting.

Second, this area of research would benefit from hearing more of the voices, stories, and experiences of individual living in recovery. Research is recommended to further explore not only how this type of complementary therapeutic practice can be integrated into daily practice but also how we can provide a platform for the 'voice in the cracks' to be heard. By questioning the medical model, we can open up the door to understanding where social model approaches can fit within this setting. This provides us a space to understand what individuals living in recovery within an in-patient care setting have to say for themselves. By taking the time to stop, and listen to the stories of individuals in recovery, we can be sure we are providing individuals with meaningful therapeutic practices. This also further begs the question of how these

understandings can also assist other individuals living in recovery through the sense of universality. By providing a space for individuals to share their stories and experiences of recovery, this in turn may help someone else down the road know that they are not alone in their journeys. Further research with this specific idea of universality is important to understand how individuals living in recovery understand and relate to other individual's stories of recovery.

Third, these ideas further beg the question of how "power" is understood and distributed within in-patient care settings. By assuming we know what "best-practices" are for the people we work with without taking the time to understand what they have to say for themselves, we are only reproducing the negative consequences of the medical system. As a practitioner in the field we often work with our clients to make new and healthy behaviour changes. Yet ironically, within an in-patient setting, we take on a role of "power" by assuming we know what is best. The findings of this presented research acknowledge the power that could come from sharing the voices, stories, and experiences of individuals living in recovery to the literature. Further research into the role of "power" within these types of settings is beneficial to understand how power is distributed within in-patient settings, and how this in turn affects individual's experiences of in-patient care and recovery.

Researcher's Note

As a researcher, this whole experience taught me three things. One, the complexity of working with individuals living with a dual PTSD-SUD diagnosis. I struggled at times throughout the day thinking that the day wasn't going as "planned." Yet, I came to the realization that often within in-patient care settings, things don't go "as planned." Therefore, as practitioners we need to be aware of this and work through these struggles and "storms" on a moment-to-moment basis as it is in these moments that we have the opportunity to make meaningful therapeutic change. Two. The need for complementary therapeutic practices, to be incorporated

in in-patient settings. Again, this research is not to say that traditional modalities of "therapy" are not effective, it is to say that when we take a chance to open up the door to different ways of seeing therapeutic practices within an in-patient setting, we may provide a platform for individuals living in recovery to share their stories. Finally, that we, as a field, need to make time to hear the voices of individuals living in recovery to hear what they have to say. When we don't take the time to listen to what people are saying about their recovery, we are only just re-iterating past understandings that we deem as "best practices." The issue with this is who is to say we know what "best practices" are? Who is to say we are the expert of another person's experience or story? The research presented here actively works to break down some of the walls that exist in in-patient settings care and provides a platform for voices of individuals living in recovery to be heard. In doing so, it is not all going to be smooth. There may be bumps in the road. There may be dark clouds, heavy rain, and even thunder and lightning at times. Yet, acknowledging this, we must actively look forward to make positive changes within our in-patient care settings that help us understand how we can weather the next perfect storm together.

Directions for Dissemination

The target audience for this specific study will be the healthcare workers in the field, policy and program makers within mental health care systems, the general audience and academics of this specific field, and lastly and most importantly, the community of individuals living in recovery of SUDs and PTSD. Therefore, the dissemination of this research will be targeted for three main areas. First, this research will be disseminated to Homewood Health Centre professionals and policy makers. Second, this research will be disseminated to the academic world of TR to showcase the use of narrative inquiry in this field and importance of exploring complementary and alternative therapeutic practices within an in-patient setting. Finally, it is my hope that the more creative representation and accessibility of this research, in

the form of a book, will be published and used as a recovery tool for individuals living with PTSD and SUDs as they embark on their journeys of recovery. It is my hope that this book will explore stories of sorrow, struggles and joy of living in recovery of a PTSD-SUD diagnosis and discover the 'voice in the cracks' that is so often lost in today's society. By choosing to represent my data in this format, it will be more accessible to individuals living in recovery of a PTSD-SUD diagnosis. Although the outcomes of this research are applicable within an academic setting in terms of informing best practices within the field of TR, more importantly, this book can be used as a tool for recovery for individuals living with a PTSD-SUD diagnosis as they begin their journeys of healing and recovery.

Non-conclusion

Individuals in society living with a PTSD-SUD diagnosis have grown to represent the greatest population of individuals seeking and accessing mental health services (Muskett, 2014). As a health care setting we need to be sure we are providing the best possible care for individuals living with such a diagnosis. Although conversations have begun to emerge regarding how we can create dialogue around the ways that "disability" is socially constructed (Mobily et al., 2014), the findings of this research work to add a rich level of narrative to this conversation by having the individuals living in recovery voice their own stories. It is important to note that the findings from this study may not be generalizable to the greater population of individuals living with a PTSD-SUD diagnosis. However, it is these rich narratives that work to begin to break down the boundaries of in-patient care to address how we can create positive social change. The purpose of this research was to not only understand the role outdoor experiential psychotherapy within an in-patient care setting, but also to provide a platform for individuals living in recovery to share their stories. The intention behind this research is not to say that traditional modalities of

care within in-patient care settings are not effective. Instead, it is to showcase that when we begin to break down the boundaries of in-patient care, we may open up to door to new ways of thinking of and seeing "therapy" within this type of setting. Therefore, to address the guiding research question, the current study has showcased how we can pull on TR, nature-based therapies, and psychotherapy as vehicles to facilitation of complementary therapeutic practices within an in-patient setting. Through the good, the bad, and the ugly of the stories presented in this research, the use of therapeutic practices can influence individual's experiences of early recovery as it provides a platform for individuals to share, listen, relate, and connect their stories. Therefore, my hope is that readers can look beyond the ideas of "best practices" and "therapy" to understand the larger meaning that is created by opening up the door to new ways of seeing care within this setting. Although this leaves readers with a "conclusion" to the guiding research questions, I do not want readers to view this "conclusion" as an ending point.

It is not appropriate to leave you with a "conclusion," instead, I leave you with a non-conclusion of where we can go from here. This thesis is one stand-alone example of how we can begin to create more critical conversations and dialogue with individuals living in recovery. However, the conversation cannot end here as, "each one of us is born different… but behind everyone is our stories." (Joseph)

References

Aldwin, C.M. (1994). *Stress, Coping and Development: An Integrative Perspective.* New York, NY: The Gulliford Press.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed). Arlington, VA: American Psychiatric Association.

Alcoff, L. (1991). The problem of speaking for others. *Cultural critique*, (20), 5-32.

Arai, S.M., Berbary, L.A., & Dupuis, S. L. (2015). Dialogues for re-imagined praxis: using theory in practice to transform structural, ideological, and discursive "realities" within/in communities. *Leisure/Loisir, 39* (2), 299-321.

Arai, S. M., Griffin, J., Miatello, A., & Greig, C. L. (2008). Leisure and recreation involvement in the context of healing from trauma. *Therapeutic Recreation Journal*, *42*(1), 37.

Austin, D. (2001) Therapeutic recreation process. In D. Austin and M. Crawford (Eds.) *Therapeutic recreation: Ab introduction* (3rd ed., pp. 45-56). Needham Heights, MA: Ally & Bacon.

Austin, D. (2013) *Therapeutic recreation processes and techniques: Evidence- based recreational therapy* (7th ed.). Champaign, IL: Sagamore.

Austin, D.R. (2011) *Lessons learned: An open letter to recreational therapy students and practitioners.* Urbana, IL: Sagamore.

Autry, C. E. (2001). Adventure therapy with girls at-risk: Responses to outdoor experiential activities. *Therapeutic Recreation Journal*, *35*(4), 289.

Beard, C. & Wilson, J.P. (2006) Experiential learning: A best practice handbook for educators and trainers (2nd ed.) Philadelphia, PA; Kogan Page.

Bennett, L. W., Cardone, S., & Jarczyk, J. (1998). Effects of a therapeutic camping program on addiction recovery: The Algonquin Haymarket relapse prevention program. *Journal of Substance Abuse Treatment*, *15*(5), 469-474.

Berbary, L. A., & Johnson, C. W. (2016). En/Activist Drag: Kings Reflect on Queerness, Queens, and Questionable Masculinities. *Leisure Sciences*, 1-14.

Berbary, L.A. & Boles, J.C.* (2014). Eight reflection points: Re-visiting Scaffolding For Improvisational Humanist Qualitative Inquiry, Leisure Sciences, 36 (5), 401-419.

Berger, R. (2006). Beyond words: Nature-therapy in action. *JOURNAL OF CRITICAL PSYCHOLOGY COUNSELLING AND PSYCHOTHERAPY*, *6*(4), 195.

Berger, R. (2008). Going on a journey: a case study of nature therapy with children with a learning difficulty. *Emotional and Behavioural Difficulties*, *13*(4), 315-326.

Berger, R., & McLeod, J. (2006). Incorporating nature into therapy: A framework for practice. *Journal of Systemic Therapies*, *25*(2), 80-94.

Berman, M., and D. Brown. (2000). The power of metaphor: Story-telling and guided tours for teachers, trainers and therapists. Carmarthen, UK: Crown House.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Bremner, J.D., Southwick, S.M., Darnell, A., & Charney, D.S. (1996). Chronic. *PTSD in Vietnam combat veterans: Course of illness and substance abuse*. American Journal of Psychiatry, 153:369–375.

Brown, L. A., & Strega, S. (2005). *Research as resistance: Critical, indigenous and anti-oppressive approaches*. Canadian Scholars' Press.

Brown, P. J., Recupero, P. R., & Stout, R. (1995). PTSD substance abuse comorbidity and treatment utilization. *Addictive behaviors*, *20*(2), 251-254

Bruyere, B.L. (2002). *Appropriate Benefits for Outdoor Programs Targeting Juvinile Male Offenders.* Journal of Experiential Education, 25: 207-213.

Bryman, A., Teevan, J., & Bell, E. (2009). Social Science Research Methods 2nd Canadian Edition.x

Burns, G. W. (1998). *Nature-guided therapy: Brief integrative strategies for health and well-being*. Psychology Press.

Buzzell, L., & Chalquist, C. (2009). *Ecotherapy: Healing with nature in mind.* San Francisco, CA Sierra Club Books.

Caldwell, L.L. (2005). Leisure and Health: Why is leisure therapeutic? *British Journal of Guidance and Counselling, 33* (1), 7-26).

Canadian Therapeutic Recreation Association (CTRA). Retrieved from https://canadian-tr.org/.

Centre for Canadian Addiction and Medicine Services (CAMH). Retrieved from http://www.camh.ca/

Chase, S.E. (2005). Narrative Inquiry: Multiple lenses, Approaches, Voices. Sage Handbook & Qualitative Research (3rd ed.). (p. 651-679). Thousand Oaks, CA: Sage.

Clandinin, D. J., & Huber, J. (2002). Narrative inquiry: Toward understanding life's artistry. *Curriculum Inquiry*, *32*(2), 161-169.

Clandinin, D. J., & Connelly, F. M. (2000). Narrative inquiry: Experience and story in qualitative research.

Clay, R. (2001). Green is good for you. *Monitor on Psychology,* 32, 40-42.

Cleary, M., Horsfall, J. & Escott, P. (2014) Marginalization and Associated Concepts and Processes in Relation to Mental Health/Illness, Issues in Mental Health Nursing, 35:3, 224-226, DOI: 10.3109/01612840.2014.883792

Connelly, F. M., & Clandinin, D. J. (1990). Stories of experience and narrative inquiry. *Educational researcher*, *19*(5), 2-14.

Conrod, P. J., & Stewart, S. H. (2005). A critical look at dualfocused cognitive behavioural treatment for comorbid substance abuse and psychiatric disorders: Strengths, limitations and future directions. Journal of Cognitive Psychotherapy, 19, 265–289.

Cooney, G., Dwan, K., & Mead, G. (2014). Exercise for depression. *Jama*, *311*(23), 2432-2433.

Corrigan, P. (2004). How stigma interferes with mental health care. *American psychologist*, *59*(7), 614.

Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski,K. U., Campion, J., Mathisen, J., ... & Kubiak, M. A. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology*, *28*(1), 91-102.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.

Dansky, B.S., Roitzsch, J.C., Brady, K.T., & Saladin, M.E. (1997). *Posttraumatic stress disorder and substance abuse: Use of research in a clinical setting*. Journal of Trauma and Stress, 10:141–148.

Dattilo, J. (2000). *Facilitation Techniques in Therapeutic Recreation*. Stage College, PA: Venture Publishing Inc.

Davis, L.J. (2013). Introduction: Normality, power and culture. In L.J Davis (Ed.), *the disability studies reader (*4th ed., pp. 1-14). New York, NY: Routledge.

Davis-Berman, J., & Berman, D. S. (1994). *Wilderness Therapy: Foundations, Theory and Research*. Kendall/Hunt Publishing Company, 4050 Westmark Drive, Dubuque, IA 52002..

Davis, K. M., & Atkins, S. S. (2004). Creating and teaching a course in ecotherapy: We went to the woods. *The Journal of Humanistic Counseling*, *43*(2), 211-218.

DeLucia-Waack, J. L., Kalodner, C. R., & Riva, M. (Eds.). (2013). *Handbook of group counseling and psychotherapy*. Sage Publications.

deMedeiros, D. (2014) Narrative gerontology in research and practice. New York, NY: Springer Publishing Company.

DeSantis, L., & Ugarriza, D. N. (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*, *22*(3), 351-372.

Diedrich, L. (2007). Cultures of dis/ability: From being stigmatized to doing disability. In *Women's health in Canada: Critical perspectives on theory and policy* (pp. 244-271). Toronto, ON: University of Toronto Press.

Drench, M. E., Noonan, A. C., Sharby, N., & Ventura, S. H. (2007). *Psychosocial aspects of health care*. Upper Saddle River, NJ: Pearson Prentice Hall.

Dustin, D., Bricker, N., Arave, J., Wall, W., & West, G. (2011). The promise of river running as a therapeutic medium for veterans coping with post-traumatic stress disorder. *Therapeutic Recreation Journal*, *45*(4), 326.

Epstein, J.N., Saunders, B.E., Kilpatrick, D.G., & Resnick, H.S. (1998). *PTSD as a mediator between childhood rape and alcohol use in adult women*. Child Abuse and Neglect, 22:223–234.

Eckstein, F., & Rüth, U. (2015). Adventure-based experiential therapy with inpatients in child and adolescent psychiatry: an approach to practicability and evaluation. *Journal of Adventure Education & Outdoor Learning*, *15*(1), 53-63.

Elliott, B. (2011). Arts-based and narrative inquiry in liminal experience reveal platforming as basic social psychological process. *The Arts in Psychotherapy*, *38*(2), 96-103.

Esterberg, K. G. (2002). Action Research. *Qualitative Methods in Social Research*, 135-150.

Ewert, A. W., McCormick, B. P., & Voight, A. E. (2001). Outdoor experiential therapies: Implications for TR practice. *Therapeutic Recreation Journal*, *35*(2), 107.

Finney, J. W., Hahn, A. C., & Moos, R. H. (1996). The effectiveness of inpatient and outpatient treatment for alcohol abuse: the need to focus on mediators and moderators of setting effects. *Addiction*, *91*(12), 1773-1796.

Ford, J. D., & Russo, E. (2006). Trauma-focused, present-centered, emotional self-regulation approach to integrated treatment for posttraumatic stress and addiction: trauma adaptive recovery group education and therapy (TARGET). *American journal of psychotherapy*, *60*(4).

Gass, M. (1993). *Adventure Therapy: Therapeutic Applications of Adventure Programming.* Dubuqe: IO: Kendall/Hunt Publishing Company.

Gass, M.A. (1999) Transfer of Learning in Adventure Programming. . In Miles, J.C. & Priest, S. (Eds.) *Adventure Programming.* State College, PA: Venture Publishing Inc.

Giaconia, R. M., Reinherz, H. Z., Paradis, A. D., & Stashwick, C. K. (2003). Comorbidity of substance use disorders and posttraumatic stress disorder in adolescents.

Gibbs, G. R. (2007). Analysing qualitative data. In U. Flick (Ed.)., *the Sage qualitative research kit.* Thousand Oaks, CA: Sage

Giesen-Bloo, J., Van Dyck, R., Spinhoven, P., Van Tilburg, W., Dirksen, C., Van Asselt, T., ... & Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of general psychiatry*, *63*(6), 649-658.

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity.* New York: Simon & Schuster.

Griffin, J. (2005). Recreation therapy for adult survivors of childhood abuse: Challenges to professional perspectives and the evolution of a leisure education group. *Therapeutic Recreation Journal*, *39*(3), 207.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development*, *29*(2), 75-91.

Hahn, K. (1957). *Outward Bound*. New York: World Books.

Haug, F. (1987). *Female sexualization: A work of collective memory* (E. Carter, Trans.). London:

Verso Publishing.

Haug, F. (1998). *Memory work—Guidelines for research.* Unpublished manuscript.

Hawkins, B. L., Cory, A. L., & Crowe, B. M. (2011). Effects of participation in a paralympic military sports camp on injured service members: Implications for theraputic recreation. *Therapeutic Recreation Journal*, *45*(4), 309.

Hays, D. G., & Singh, A. A. (2011). *Qualitative inquiry in clinical and educational settings*. Guilford Press.

Hiebert-Murphy, D., & Woytkiw, L. (2000). A model for working with women dealing with child sexual abuse and addictions: The Laurel Centre, Winnipeg, Manitoba, Canada. *Journal of Substance Abuse Treatment*, *18*(4), 387-394.

Hien, D. A., Cohen, L. R., Miele, G. M., Litt, L. C., & Capstick, C. (2004). Promising treatments for women with comorbid PTSD and substance use disorders. *American journal of Psychiatry*, *161*(8), 1426-1432.

Homewood Health Centre. (n.d.). Retrieved June 09, 2017, from http://www.homewoodhealth.com/health-centre

Hopko, D. R., Lejuez, C. W., Lepage, J. P., Hopko, S. D., & McNeil, D. W. (2003). A brief behavioral activation treatment for depression: A randomized pilot trial within an inpatient psychiatric hospital. *Behavior modification*, *27*(4), 458-469.

Howden, E. (2012). Outdoor experiential education: Learning through the body. *New directions for adult and continuing education*, *2012*(134), 43-51.

Hyer, L., Boyd, S., Scur eld, R, Smith, D. & Burke, J. (1996). Effects of outward bound experience as an adjunct to inpatient PTSD treatment of war veterans. *Journal of Clinical Psychology Vol. 52* (3), 263-278

Jackson, A.Y. & Mazzei, L.A (2005). *Voice in Qualitative Inquiry: Challenging conventional, interpretive and critical conceptions in qualitative research*. London: Routledge.

Jacobsen, L. K., Southwick, S. M., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: a review of the literature. *American Journal of Psychiatry*.

Janikowski, T.P., & Glover, N.M. (1994). Incest and substance abuse: Implications for treatment professionals. *Journal of Substance Abuse Treatment*, 11, 177–183.

Johnson, C., & Parry, D. (2015). *Fostering Social Justice through Qualitative Inquiry.* Walnut Creek, California: Left Coast Press Inc.

Jordan, M. (2009). Back to nature. *Therapy Today, 20*(3), 26-28

Jordan, M. (2014). *Nature and therapy: Understanding counselling and psychotherapy in outdoor spaces*. Routledge.

Kestenbaum, V. (2005). Professions, ethics, and unity. In C. Sylvester (Ed.), Philosophy of therapeutic recreation: Ideas and issues (Vol. III, pp. 41–48). Ashburn, VA: National Recreation and Park Association

Khantzian, E. J., & Albanese, M. J. (2008). *Understanding addiction as self medication: Finding hope behind the pain*. Rowman & Littlefield Publishers.

Kleiber, D.A., Hutchison, S.L., & Williams, R. (2002). Leisure as a resource in transcending negative life events: Self-protection, self-restoration, and personal transformation. *Leisure Sciences, 24,* 219- 235).

Kofoed, L., Friedman, M. J., & Peck, R. (1993). Alcoholism and drug abuse in patients with PTSD. *Psychiatric Quarterly*, *64*(2), 151-171.

Kreek, M. J. (2011). Extreme marginalization: addiction and other mental health disorders, stigma, and imprisonment. *Annals of the New York Academy of Sciences*, *1231*(1), 65-72.

Kyriakopoulos, A. (2010). Adventure based counselling, individual counselling and object relations: A critical evaluation of a qualitative study. *European Journal of Psychotherapy and Counselling*, *12*(4), 311-322.

Kyriakopoulos, A. (2011). How individuals with self-reported anxiety and depression experienced a combination of individual counselling with an adventurous outdoor experience: A qualitative evaluation. *Counselling and Psychotherapy Research*, *11*(2), 120-128.

Lahey, M. P. (1987). The ethics of intervention in therapeutic recreation. In C. Sylvester, Hemingway, J. L., Howe-Murphy, R., Mobily, K., & Shank, P. A. (Eds.), Philosophy of therapeutic recreation: Ideas and issues (Vol. I, pp. 17–26). Alexandria, VA: National Recreation and Park Association.

Lawson, S., Delamere, F. M., & Hutchinson, S. L. (2008). A personal narrative of involvement in post-traumatic brain injury rehabilitation: what can we learn for therapeutic recreation practice?. *Therapeutic recreation journal*, *42*(4), 236.

Layne, C. M., Pynoos, R. S., Saltzman, W. R., Arslanagić, B., Black, M., Savjak, N., ... & Djapo, N. (2001). Trauma/grief-focused group psychotherapy: School-based postwar intervention with traumatized Bosnian adolescents. *Group Dynamics: Theory, Research, and Practice*, *5*(4), 277.

Lazarus, R.S. (1996). *Psychological Stress and the Coping Process.* New York, NY: McGraw-Hill Book Company.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology*, *53*(3), 314.

Lewis, S. T., & Johnson, C. W. (2011). "But it's not that easy": negotiating (trans) gender expressions in leisure spaces. *Leisure/Loisir*, *35*(2), 115-132.

Light, T.P. (2015). Moving Forward, Looking Back: Historical Inquiry for Social Justice. In Johnson, C., & Parry, D. *Fostering Social Justice through Qualitative Inquiry* (p. 191-216). Walnut Creek, California: Left Coast Press Inc.

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic inquiry*, *289*, 331.

Linton, S. (1998). Chapter one. Reclamation and Chapter two. Reassigning meaning. In *Claiming disability: Knowledge and identity* (pp.1-33). New York, NY: New York University

Lord, J. & Hutchison, P. (2007). Chapter two. Clienthood and compliance: The failure of traditional approaches. In *Pathways to Inclusion: Building a new story with people and communities* (pp. 19-40). Concord, ON: Captus Press.

Lucker, J.L., & Nadler, R.S. (1995). Processing Adventure Experiences: It's the Story that Counts. *Therapeutic Recreation Journal,* 175-183.

McCarville, R. E., & MacKay, K. (Eds.). (2007). *Leisure for Canadians*. Venture Pub.

McCormack, C. (2004). Storying stories: a narrative approach to in-depth interview conversations. *International journal of social research methodology*, *7*(3), 219-236.

McLaughlin, D., & Tierney, W. G. (1993). *Naming Silenced Lives: Personal Narratives and Processes of Educational Change*. Routledge, 29 West 35th Street, New York, NY 10001-2299 (paperback: ISBN-0-415-90517-6, $16.95; hardcover: ISBN-0-415-90516-8).

Miller, D. (2002). Addictions and trauma recovery: An integrated approach. *Psychiatric quarterly*, *73*(2), 157-170.

Mobily, K.E., Walter, K., & Finley, S. (2015). Deconstruction of TR/RT: Does TR/RT contribute to the negative construction of disability? Part 1. *World Leisure Journal*, *57*(1), 46-56.

Mowatt, R. A., & Bennett, J. (2011). War narratives: Veteran stories, PTSD effects, and therapeutic fly-fishing. *Therapeutic recreation journal*, *45*(4), 286.

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International journal of mental health nursing*, *23*(1), 51-59.

Najavits, L. M., Weiss, R. D., & Liese, B. S. (1996). Group cognitive-behavioral therapy for women with PTSD and substance use disorder. *Journal of Substance Abuse Treatment*, *13*(1), 13-22.

Ogden, P., & Fisher, J. (2015). *Sensorimotor psychotherapy: Interventions for trauma and attachment*. WW Norton & Company.

Ostertag, S. F., & Ortiz, D. G. (2013). The battle over meaning: Digitally mediated processes of cultural trauma and repair in the wake of hurricane Katrina. *American Journal of Cultural Sociology*, *1*(2), 186-220.

Ouimette, P. C., Finney, J. W., & Moos, R. H. (1997). Twelve-step and cognitive-behavioral treatment for substance abuse: A comparison of treatment effectiveness. *Journal of consulting and clinical psychology*, *65*(2), 230.

Ouimette, P. C., Finney, J. W., & Moos, R. H. (1998). *Two year posttreatment functioning and coping of patients with substance abuse and posttraumatic stress disorders*. Manuscript submitted for publication.

Ouimette, P. E., & Brown, P. J. (2003). *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders*. American Psychological Association.

Ouimette, P., Read, J. P., Wade, M., & Tirone, V. (2010). Modeling associations between posttraumatic stress symptoms and substance use. *Addictive behaviors*, *35*(1), 64-67.

Overholser, J. C. (2005). Group psychotherapy and existential concerns: An interview with Irvin Yalom. *Journal of Contemporary Psychotherapy*, *35*(2), 185-197.

Pace, C.A. & Samet, H.S. (2016). In the Clinic: Substance Use Disorders. *American College of Physicians*

Peel, & Richards (2005). Outdoor Cure. Therapy Today, 16(10), 4–8.

Priest, S., & Gass, M.A. (2005). Effective Leadership in Adventure Programming. Leeds: Human Kinetics.

Reid, A.G. (2012) Substance-use disorders. *Medicine,* 40(12), 640-643.

Reynolds, M., Mezey, G., Chapman, M., Wheeler, M., Drummond, C., & Baldacchino, A. (2005). Co-morbid post-traumatic stress disorder in a substance misusing clinical population. *Drug and alcohol dependence*, *77*(3), 251-258.

Riessman, C. K. (2007). *Narrative methods for the human sciences*. Los Angeles, CA: Sage.

Riessman, C. K. (2005). Narrative analysis. University of Huddersfield.

Santostefano, S. (2013). *Child therapy in the great outdoors: A relational view* (Vol. 29). Routledge.

Schiraldi, G.R. (2000). *The Post-Traumatic Stress Disorder Sourcebook- A guide to healing, recovery, and growth.* Los Angeles, CA: Lowell House

Schwandt, T. A., & Schwandt, T. A. (2001). *Dictionary of qualitative inquiry*(Vol. 31, pp. 439-448). Thousand Oaks, CA: Sage Publications.

Scott, E. H., & Ross, C. J. (2006). Integrating the creative arts into trauma and addiction treatment: Eight Essential Processes. *Journal of Chemical Dependency Treatment*, *8*(2), 207-226.

Shank, J., & Coyle, C. (2002). *Therapeutic recreation in health promotion and rehabilitation*. Venture Pub.

Shaw, C. R. (2013). *The jack-roller: A delinquent boy's own story*. University of Chicago Press.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), 63-75.

Shogan, D. (1998). The social construction of disability: The impact of statistics and technology. *Adapted Physical Activity Quarterly*, *15*, 269-277.

Simon, W., Lambert, M. J., Busath, G., Vazquez, A., Berkeljon, A., Hyer, K., ... & Berrett, M. (2013). Effects of providing patient progress feedback and clinical support tools to psychotherapists in an inpatient eating disorders treatment program: A randomized controlled study. *Psychotherapy research*, *23*(3), 287-300.

Skwarok, J. N. (2013). *Paddling towards resilience: benefits of canoeing for vulnerable first nations children* (Doctoral dissertation, ROYAL ROADS UNIVERSITY)

Sparkes, A. C. (2005). Narrative analysis: exploring the whats and hows of personal stories. *Qualitative research in health care*, *1*, 191-209.

Squire, C. (2008). Experience-centered and culturally-oriented approaches to narrative. In M. Andrews, C. Squire, & M. Tamboukou (Eds.), Doing narrative research (pp. 41–63). London, England: Sage.

Sutherland, E. H. (1937). The professional thief. *Journal of Criminal Law and Criminology (1931-1951)*, 161-163.

Sutherland, S., & Stroot, S. A. (2009). Brad's story: Exploration of an inclusive adventure education experience. *Therapeutic Recreation Journal, 43*(3), 27-39.

Sylvester, C. (1987). Therapeutic recreation and the end of leisure. *Philosophy of therapeutic recreation: Ideas and issues*, *1*, 76-89.

Sylvester, C. (1999). The western idea of work and leisure: Traditions, transformations, and the future. In E.L. Jackson & T.L. Burton (Eds.), *Leisure studies: Prospects for the twenty-first century* (pp. 17-33). State College, PA: Venture Publishing, Inc.

Sylvester, C. (2005a). Careers, callings, and the professionalization of therapeutic recreation. In C. Sylvester (Ed.), Philosophy of therapeutic recreation: Ideas and issues (Vol. III, pp. 49–58). Ashburn, VA: National Recreation and Park Association

Sylvester, C. (2015b). With leisure and recreation for all: Preserving and promoting a worthy pledge. World Leisure Journal, 57(1), 76–81. doi:10.1080/16078055.2014.1001169

Tedlock, B. (2000). Ethnography and ethnographic representation. *Handbook of qualitative research*, *2*(1).

Thomas, W. I., Znaniecki, F., & Strübing, J. (1984). *The polish peasant in Europe and America* (p. 311). Urbana: University of Illinois Press.

Thomas, C. (2004). How is disability understood? An examination of sociological approaches. Disability and Society, 19 (6) 569-583.

Van Ameringen, M., Mancini, C., Patterson, B., & Boyle, M. H. (2008). Post-Traumatic Stress Disorder in Canada. *CNS Neuroscience & Therapeutics*, *14*(3), 171-181.

Van Den Tillaart, S., Kurtz, D., & Cash, P. (2009). Powerlessness, marginalized identity, and silencing of health concerns: Voiced realities of women living with a mental health diagnosis. *International journal of mental health nursing*, *18*(3), 153-163.

Van der Kolk, b.a. & McFarlane, A.C. (1996). The black hole of trauma. In van der Kolk. B.A., McFarlane, A.C. & Weisaeth, ;. (Eds.) *Traumatic Stress: The effects of overwhelming experience on mind, body, and society.* (3023) New York, NY: The Guliford Press.

Van Puymbroeck, M., & Lundberg, N. (2011). Guest Editors' Comments-Introduction to Veteran Issues: The Role of Therapeutic Recreation. *Therapeutic Recreation Journal*, *45*(4), 265.

Volpicelli, J., Balaraman, G., Hahn, J., Wallace, H., & Bux, D. (1999). The role of uncontrollable trauma in the development of PTSD and alcohol addiction. *Alcohol Research and Health*, *23*(4), 256-262.

Weegmann, M. (2010). Just a story? Narrative approaches to addiction and recovery. *Drugs and Alcohol Today*, *10*(3), 29-36.

Weiner, M. L. (1985). *Cognitive-experiential therapy: an integrative ego psychotherapy*. Bruner Meisel U.

Wiechelt, S. A., & Straussner, S. L. A. (2015). Introduction to the special issue: Examining the relationship between trauma and addiction. *Journal of Social Work Practice in the Addictions*, *15*(1), 1-5.

Wolf, M., & Mehl, K. (2011). Experiential learning in psychotherapy: Ropes course exposures as an adjunct to inpatient treatment. *Clinical psychology & psychotherapy*, *18*(1), 60-74.

Wupperman, P., Marlatt, G. A., Cunningham, A., Bowen, S., Berking, M., Mulvihill-Rivera, N., & Easton, C. (2012). Mindfulness and modification therapy for behavioral dysregulation: Results from a pilot study targeting alcohol use and aggression in women. *Journal of clinical psychology*, *68*(1), 50-66.

Wynn, G. H. (2015). Complementary and alternative medicine approaches in the treatment of PTSD. *Current psychiatry reports*, *17*(8), 62.

Yalom, I. D. (2002). *The gift of therapy*. New York: Harper Collins.

Yalom, I. D., Bond, G., Bloch, S., Zimmerman, E., & Friedman, L. (1977). The impact of a weekend group experience on individual therapy. *Archives of General Psychiatry*, *34,* 399–415.

Yalom, I.D. (2005). The theory and practice of group psychotherapy (5th ed.). New York, NY: Basic Books.

Yalom, I.D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy (5th ed.).* New York, NY: Basic Books.

Yehuda, R. (2002). Post-traumatic stress disorder. *New England Journal of Medicine*, *346*(2), 108-114.

Yehuda, R., & LeDoux, J. (2007). Response variation following trauma: a translational neuroscience approach to understanding PTSD. *Neuron*, *56*(1), 19-32.

Zandberg, L. J., Rosenfield, D., McLean, C. P., Powers, M. B., Asnaani, A., & Foa, E. B. (2015). Concurrent treatment of posttraumatic stress disorder and alcohol dependence: Predictors and moderators of outcome.

Appendix A- Outdoor Experiential Psychotherapy Workshop Schedule Outline

*Meet at clubhouse at *8:00am

Time:	
8:15am	Participants arrive Discussion of research project, ethics and consent (Jaylyn)
9:00am	Ice breaker activities (see below) (Shelagh)
10:30am	10 minute break
10:40am	Experiential activities #1 (see below) (Shelagh)
11:45am	Lunch Break
12:30pm	Experiential activities #2 (see below) (Shelagh)
1:40pm	15 minute break
1:50pm	Final Teamwork activity (see below) (Shelagh)
2:15pm	Audio-recorded focus group (Alyssa and Shelagh)
3:25pm	Final conclusion (Jaylyn)
3:30pm	End of workshop

Description of Activities:

Ice breaker activities:
Introduction and Feeling Cards- Participants will create a circle with a number of "feelings" written down on cue cards spread out in the middle of the circle. Participants will each take a turn going around the circle and introducing themselves and choosing a "feeling card" out of the middle to describe how they are feeling right now in the moment. (Facilitator will discuss the importance of being able to describe you emotion on a moment-to-moment basis and allowing yourself to feel whatever it is you need to feel throughout the activities of the day. Additionally, facilitator will discuss the importance of processing and de-briefing these feelings with the larger group at the end of each activity to create a sense of shared humanity and universality).

Materials needed: Cue cards with a variety of feelings for participants to choose

Chicken goggles- Have participants stand in a circle. Participants put on their "chicken goggles" (place their fingers in a circle around their eyes). First round: participant will pass the "rhythm" around the circle by making a "cluk" noise. If the participant wants to pass it to the left/right they can do so by removing one hand. If they wish to pass it across the circle they do so with both hands. Additional: a "bok bok" means that the pattern changes direction. Have the participants do a few rounds and then place a rule whichever participants "messes up the pattern" must go around the circle and cluk like a chicken while looking every participant in the eyes.

Talking activity- Participants will create two circles, with one circle inside the other. Participants will each be facing another participant in the other circle. One participant in each pairing will have approximately three minutes to talk to their partner. The other partner will simply listen. (Additions: facilitator may give a specific topic to talk about). The other participant will then

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have their turn to talk. (Addition: the circle can move so that participants have a chance to talk to other participants).

Materials needed: No materials needed

Group juggle- The participants will create one large circle. The facilitator will start with a beanbag and pass it to another participant in the group by calling their name. That person will then pass the beanbag to another participant in the group and so on until everyone has the beanbag once and it returns to the facilitator. The facilitator will then practice this pattern once or twice more to ensure everyone knows that pattern well. The participants will continue to pass the beanbag in the pattern. (Addition: facilitator will add more beanbags to the mix). Option: after completion of the pattern, participants can reverse the order.

Materials needed: 6-8 beanbags

Experiential Activities #1:
Willow in the wind- Participants will break off into two groups (depending on size of group). Each group will create a smaller circle. One at a time, participants will step into the middle and do a trust fall. The participants around the circle will work to keep the middle person up as they float around the circle. Participants may choose to close their eyes or keep them open. Note: have participants around the circle stand in a wide stance. Once all participants have had a chance to complete the activity, facilitator may choose to mix up the groups.

Materials needed: No materials needed

Bull ring activity- Participants will all grab onto one or two strings (depending on size of group). All of the strings will be attached to a small ring. The small ring will be on a post on the ground that holds a small ball. As a team, the participants must work together to lift the ball off the post and move it to another post that is in a different area. (Additions: only every other person can speak while the rest are quiet and take instruction and then switch). This activity can be done numerous times with the end post being in more and more difficult positions.

Materials needed: a small ring with a number of strings attached to it, two small stands for the ball, one small ball (squash ball)

Experiential Activities #2:

Blind walk- Participants will pair off. If comfortable, participants will link arms and go for a walk. One participant will wear a blindfold (if comfortable, closing eyes is also an option). The other participant will lead. Participants will then switch places.

Materials needed: blindfold

Human Knot- Participant stand in a circle. Everyone reaches across the group and grabs onto another participant's hand in the circle. Participants do the same thing with the other hand until everyone is holding onto two other participant's hands. The goal of this activity is to "un-knot" the circle without breaking the circle.

Materials needed: none

Eagle, bat and parrot- Participants will get into a group of three. Each participant will take on one role (eagle, bat, or parrot). There will be a mind field of bean bags. The goal of the activity is to lead one team member to a bean bag and bring it back to their team. (Eagle: can see but cannot talk, Parrot: can talk, but cannot see, Bat: is blindfolded taking the direction). The eagle will look out onto the mind field and give direction to the parrot (who cannot see the mind field) by using body language. The parrot will call out the direction to the bat (who is blindfolded) in the field to pick up a beanbag and bring it back to their team. Each participant will have the opportunity to try each position.

Materials needed: 20 bean bags, blindfold

Final Teamwork Activity:

Lava flow activity- Participants will work together to move across a lava flow. Participants must use wood boards to get across the lava. However, if anyone falls off they must return to the beginning and try again.

Materials needed: 3 planks of wood, 3 boxes of wood, two flags

Appendix B- Experiential Psychotherapy Workshop De-briefing

Ice breaker activities:

Introduction and Feeling Cards- no de-briefing

Talking activity
- What were people's experiences of this activity?
- What was it like for you to be the "talker" and having to talk about yourself for 3 minutes?
- What was it like to be the "listener" and not respond to your partner?
- What role did you prefer? Why?
- What role was more challenging for you? Why?
- Did you prefer being given a topic to talk about by the facilitator or being able to talk about whatever you wanted? Why?
- How does this relate to your own personal recovery?

Group juggle
- What were people's experiences of this activity?
- Did you find you were more focused on the person you were catching from or the person you were throwing to? Why do you think this is?
- What was it like for you to have more and more bean bags being brought into the circle? How did you respond?
- How does this relate to your own recovery?

Experiential Activities #1:

Willow in the wind
- What were people's experiences of this activity?
- What was it like for people to go into the middle and trust the other people in the circle would catch you?
- What was it like to be the people on the outside, knowing that the person in the middle was putting their trust in you?
- What role did you prefer? Why?
- How does this relate to your own recovery?

Bull ring activity
- What were people's experiences of this activity?
- What was it like to work as a team to complete the task?
- What did you find was easy about the task?
- What did you find was challenging about the task?
- What was the experience of taking on a "leadership" role like for you?
- What was the experience of listening to the "leaders"?
- What role did you like better? Why?
- If you had to do this activity again, what would you do differently?
- How does this relate to your own recovery?

Experiential Activities #2:

Blind walk

- What were people's experiences of this activity?
- What was the experience like for you to be blindfolded and guided on a walk?
- What was the experience like for you to be the one giving direction?
- Which role did you prefer? Why?
- How does this relate to your own recovery?

Eagle, bat and parrot
- What were people's experiences of this activity?
- What was it like having to work together to complete a common goal?
- What did people like about this activity? Why?
- What did people dislike about this activity? Why?
- What role did people like the best? Why?
- What role did people find the most challenging? Why?
- If you had to do it again, what would you do differently?
- How does this relate to your own recovery?

Final Teamwork Activity:
Lava flow activity
- What were people's experiences of this activity?
- What was it like to work with the larger group to complete the task at hand?
- What did people find worked well in this activity?
- What did people find challenging with this activity?
- If you had to do it again, what would you do differently?
- How does this relate to your own recovery?

Focus Group:
- What were people's experiences of the workshop?
- What was your favourite activity? Why?
- What was your least favourite activity? Why?
- What did people find challenging throughout the day? How did you work through this?
- What were people surprised about throughout the day?
- Was there anything that people felt they learnt about themselves throughout the activities of the day?
- Are there any parallels to the themes being discussed with recovery?
- How will this workshop transfer into your own personal recovery?

Appendix C- Participant Sign-up Sheet

Department of *Recreation and Leisure Studies*
University of Waterloo
***For the recreation therapists use only**

Please put the names of the individuals who wish to volunteer for the workshop below.

Appendix D- Participant Recruitment Poster

Department of *Recreation and Leisure Studies*
University of Waterloo
PARTICIPANTS NEEDED FOR
RESEARCH IN THE USE OF OUTDOOR EXPERIENTIAL PROGRAMMING

We are looking for volunteers to take part in a study of
outdoor experiential workshop for in-patient use within a mental health setting. This is an
exciting opportunity for individuals to engage in outdoor experiential programming within this
setting. This workshop will only be offered once. Participants must be currently attending the
Addictions-trauma stream on the AMS unit at Homewood Health Centre.

As a participant in this study, you will be asked to: participate in an outdoor experiential
psychotherapy workshop facilitated by a recreation therapist followed by a 1-2-hour interview
with the researcher to discuss the experience of the workshop. Your participation and/or
withdrawal from the study will not affect your current and/or future care at Homewood Health
Centre

Your participation would involve *2* sessions. The total time commitment would be
approximately 9 hours (*7* hours for the workshop and 1-2 hours for the interview).

To volunteer for this study, please talk to one of the recreation therapists on the unit to sign up.

For more information about this study,
please contact:
Jaylyn Leighton
Department of Recreation and Leisure studies
at
Email: *jjleight@uwaterloo*

This study has been reviewed by, and received ethics clearance
through a University of Waterloo Research Ethics Committee.

Study Title: Understanding Meaning Derived from Outdoor Experiential Psychotherapy for
                     Individuals Living with Mental Health Issues (Trauma and Substance-use
                     Disorders): A Narrative Exploration

Student Investigator: Jaylyn Leighton, MA Candidate, Dept. of Recreation and Leisure Studies
                     (jjleight@uwaterloo.ca)
Faculty Supervisor: Corey W. Johnson, Dept. of Recreation and Leisure Studies
                     (corey.johnson@uwatelroo.ca)

To help you make an informed decision regarding your participation, this letter will explain what
the study is about, the possible risks and benefits, and your rights as a research participant. If you
do not understand something in the letter, please ask one of the investigators prior to consenting
to the study. You will be provided with a copy of the information and consent form if you choose
to participate in the study

Invitation to participation/What is the study about?

You are invited to participate in a research study about …
- The use of outdoor experiential programming as a complementary therapy for mental
  health recovery (specifically addictions and post-traumatic stress disorder) within an in-
  patient context
- This research is important as it provides reason for the use of alternative and
  complementary therapies for individuals living in recovery of post-traumatic stress
  disorder and addictions as they begin their process of recovery within an in-patient
  setting. Additionally, this study seeks to provide a platform for individuals living in
  recovery to share their experiences, stories and journeys of recovery.
- For student research, for the completion of a master's thesis
- Once all the data are collected and analyzed for this project, I plan on sharing this
  information with the research community through seminars, conferences, presentations,
  and journal articles

1. **Your responsibilities as a participant**

   What does participation involve?
   - Participation in an outdoor experiential workshop that will run at Homewood
     Health Centre for approximately one day (8:30am-4:00pm)
   - You will be asked to participate in the following sequential sessions:
     - Participation in the outdoor experiential workshop (including the
       activities, de-briefings, and an audio-recorded focus group)
     - Participation in a 1-2-hour one-on-one interview with the student
       researcher approximately one week after the workshop
   - Given the group format of this session we will ask you to keep in confidence
     information that identifies or could potentially identify a participant and/or his/her
     comments

How is the data for this research being collected?

- Data for this research is being collected through the audio-recorded focus group and individual interview sessions
- Data will not be directly collected during the participation of the outdoor experiential workshop
- The primary researcher will be participating in the workshop, however she will not be collecting any observation data
- The purpose of the researcher being involved in the participation in the workshop is to understand the experience of the workshop from her own point of view
- The researcher will not speak to the participant's experiences of the workshop
- The researcher will only speak to the data collected from the audio-recorded focus group and individual interview sessions for the findings of this research project

Who may participate in the study?

- The study will involve up to ten participants
- In order to participate you must be currently attending the Addictions-trauma recovery program within the Addictions Medicine Services unit at Homewood Health Centre in Guelph, ON
- Participants must be at least 18 years of age
- In addition to individuals participating within the workshop, two recreation therapists will be assisting in the facilitation of workshop

What is the role of the recreation therapists during the workshop?

- Two recreation therapists will be involved in the planning and facilitation of the outdoor experiential workshop
- The recreation therapists will assist in both the facilitation of the activities, de-briefing of activities as well as the audio-recorded focus group
- The recreation therapists **will not** be involved in the individual interview following the workshop. Therefore, all conversation discussed in the interview will remain confidential between the participants and the researcher.
- The recreation therapists will not be interviewed for the sake of the research project
- The role of the recreation therapists is to assist in the planning and facilitation of the workshop. They will not have any part of the research project. Therefore, all findings of the study will not impact your care plan at Homewood Health Centre.

What does the interview session involve?

- As a participant, you will be asked to sit down with the researcher for a 1-2-hour interview approximately one week after the workshop
- Interviews will occur at Homewood Health Centre in the office space provided in the recreation department.
- Participants will be asked questions that directly relate to their experience of engaging in the outdoor experiential workshop. Participants will be asked to

share how their experience of the workshop influenced their experience of early recovery
- The purpose of the interview will be for the researcher to gain an understanding of participant's experience of the outdoor experiential workshop and how this type of programming may or may not be beneficial within and in-patient setting

2. Your rights as a participant

Is participation in the study voluntary?
- Your participation in this study is voluntary
- You may decide to leave the study at any time by either notifying a recreation therapist on the unit or the student researcher
- Your participation and/or withdrawal from the study will not affect your current and/or future care at Homewood Health Centre
- Your consent to participate in the research process is ongoing and you may choose to withdrawal my consent at any time throughout the research process.
- For the interview, you may decline to answer any question(s) you prefer not to answer by notifying the student researcher
- It is not possible to remove your data from the study once collected because data is anonymous and all identifying information is removed from the data immediately

Will I receive anything for participating in the study?
- You will not receive any payment or remuneration for your participation in the study.

What are the possible benefits of the study?
- Participation in the study may benefit you in the following ways: benefit of engaging in therapy in an outdoor setting, benefit of engaging with other participants and recreation therapists on the unit, opportunity to try new things, opportunity to have fun
- The outcomes of this study will work to provide an understanding of the use of outdoor experiential programming within in-patient mental health settings as a complementary therapy to traditional therapies.
- The academic community will benefit in the following ways: showcasing new ways to do therapy within a recreational therapy setting, providing opportunity for stories and experiences of in-patient care to be heard in order to inform current and future practice
- The findings of this study will be received by academics in the field, practitioners in the field and policy makers within mental health recovery settings

What are the risks associated with the study?
- Although the workshop will be practiced in a controlled setting with professional facilitation and assistance, there is always risk of emotional and psychological distress due to the intensity of the topics at hand. To mitigate this situation, the

professional recreation therapists will be on site to further discuss any concerns or issues that may arise.
- The physical risk of the workshop will not exceed any risks of daily activities

Will my identity be known?
- The research team and the other participants in the focus group will be aware of your identity and participation in the workshop, therefore, anonymity cannot be promised.
- After completion of the workshop, your participation in this study, and the data collected will be confidential. The data collected will be de-identified. Reporting the findings of this study will be completed without names or identifying information.

Will my information be kept confidential?
- The information you share will be kept confidential by assigning pseudonyms and codes to each participant. All information collected from participants will be grouped together to gather main themes that come from the data.
- Your personal information will be stripped off the data after pseudonyms are assigned and the data will be kept in a password protected computer.
- To further secure and protect identities of participants, a process of encryption will occur in which all participants are assigned a code-name to de-identify any and all personal information
- All physical paper copies with personal identifiers (i.e. consent form) will be kept in a secure file folder for two years and then confidentially shredded.
- Only the research team will have access to the study data.
- Research data will be retained for a minimum of 2 years, at which time it will be confidentially shredded and destroyed.
- Although all participants are asked to keep all information confidential, there is not guarantee that they will do so.
- Confidentiality will be maintained unless disclosure of information is required by law. For example, in instances where the intent to harm self or others is disclosed to the

Will I be audio-recorded or videotaped?
- There will be **absolutely no** video tapes or pictures taken during the facilitation of the workshop or interview.
- The focus group will be audio recorded at the end of the workshop session for research purposes.
- The individual interviews with the researcher will be audio-recorded for research purposes.
- The purpose of the audio-recording is to make an accurate representation of what is being said
- Consent to the participation of the research process assumes that participant gives permission to be audio-recorded during the focus group and individual interviews.

3. **Questions, comments or concerns**

Has the study received ethics clearance?
- This study has been reviewed and received by the Research Ethics Board (REB) at the Homewood Research Institute (HRI). If you have any questions for the committee please contact Steve Abdool at SAbdool@homewoodhealth.com
- This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22687) If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or oreceo@uwaterloo.ca

Who should I contact if I have questions regarding my participation in the study?
- If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Jaylyn Leighton through email at jjleight@uwaterloo.ca or the faculty supervisor for this project (Corey W. Johnson) at corey.johnson@uwaterloo.ca

What if the study procedure(s)/topic causes me distress/concern?
- If you have any further concerns or issues, or would like additional support to assist you, please contact one of the recreation therapists involved on the unit

By providing your consent, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Study Title: Understanding Meaning Derived from Outdoor Experiential Psychotherapy for Individuals Living with Mental Health Issues (Trauma and Substance-use Disorders): A Narrative Exploration

Student Investigator: Jaylyn Leighton, MA Candidate, Dept. of Recreation and Leisure Studies
Faculty Supervisor: Corey W. Johnson, Dept. of Recreation and Leisure Studies
                    (corey.johnson@uwatelroo.ca)

I have read the information presented in the information letter about a study conducted by **Jaylyn Leighton,** Department of Recreation and Leisure Studies at the University of Waterloo. I have had the opportunity to ask questions related to the study and have received satisfactory answers to my questions and any additional details. I was informed that participation in the study is voluntary and that I can withdraw this consent by informing the researcher.

Please read the following statements:

● I have read the information presented in the information letter about a study being conducted by Jaylyn Leighton of Recreation and Leisure Studies at the University of Waterloo, the Recreation Therapists at Homewood Health.

● I have had the opportunity to ask Jaylyn any questions related to this study, to receive satisfactory answers to my questions, and any additional details I wanted. I am aware that I may withdraw from the study without penalty at any time by advising the researchers of this decision.

● I understand audio-recording of the debriefings will take place. I understand that the purpose of the audio-recording is to ensure an accurate representation of the data. I am also aware that my information will be kept confidential and that any personal identifiers will be de-identified in any reports or presentations. I understand that answers I provide may be used word for word; however, a made up name (pseudonym) will be used in place of my real name. I understand that confidentiality will be maintained unless disclosure of information is required by law. For example, in instances where the intent to harm self or others is disclosed to the researcher.

● I was informed that I may withdraw my consent at any time without penalty. I also understand that my consent is ongoing throughout the research process. I understand that I am able to withdrawal my consent at any time before the research data is submitted for publication. I understand that once the research project is concluded and the paper is submitted or published, I will not be able to withdraw my data.

● I understand this study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22687). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or oreceo@uwaterloo.ca. For all other questions contact **Jaylyn Leighton** by

email at **jjleight@uwaterloo.ca** or Corey W. Johnson (faculty supervisor) at
corey.johnson@uwaterloo.ca

- **I understand all of the information that has been provided to me about this research study, and I agree, of my own free will, to participate in this study.**
  ☐ YES   ☐ NO

By signing this consent form, you are not waiving your legal rights or releasing the investigators or involved institution(s) from their legal and professional responsibilities.

Participant Name (*please print*): _____

Participant Signature: _____

Witness Name (*please print*): _____

Witness Signature: _____

Date: _____

To be completed by researcher: I have fully explained the procedures of this study to the participant.

Researchers Signature: _____   Date:
_____

To be completed if you choose to withdraw from the study (Verbal or Written):
_____wishes to withdraw from participation in the *Understanding Meaning Derived from Outdoor Experiential Psychotherapy for Individuals Living with Mental Health Issues (Trauma and Substance-use Disorders): A Narrative Exploration* study.
Please indicate below your wishes regarding your data and further participation in the workshop:

☐   I wish that specific observations of me not be taken and recorded, but acknowledge that the researcher will continue to make general observations of the Outdoor Classroom group. I will allow data previously collected to be used in this study.

☐   I wish that specific observations of me not be taken and recorded, but acknowledge that the researcher will continue to make general observations of the Outdoor Classroom. I will not allow data previously collected to be used in this study.

Signature of the Participant: _____   Date:
_____

Researcher Name: _____ Researcher Signature: _____
_____

Date: _____

Date: _____

Appendix G- Feedback Letter

University of Waterloo

Friday February 16, 2018

I would like to thank you for your participation in this study entitled "Understanding meaning derived from outdoor experiential psychotherapy for individuals living with mental health issues (trauma and substance-used disorders): A Narrative Exploration. As a reminder, the purpose of this study is to explore the meaning created and use of outdoor experiential programming within an in-patient setting.

The data collected during the participation in focus group following the outdoor experiential workshop and individual interviews will contribute to inform best practices within a therapeutic setting as well as provide a platform for stories and experiences of recovery to be heard.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#22687). If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at 1-519-888-4567 ext. 36005 or ore-ceo@uwaterloo.ca.

Please remember that any data pertaining to you as an individual participant will be kept confidential. Once all the data are collected and analyzed for this project, I plan on sharing this information with the research community through seminars, conferences, presentations, and journal articles. If you are interested in receiving more information regarding the results of this study, or would like a summary of the results, please provide your email address, and when the study is completed, anticipated by [insert date], I will send you the information. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email as noted below.

Jaylyn Leighton, Student Investigator

jjleight@uwaterloo.ca

Corey Johnson, Faculty Supervisor

Corey.johnson@uwaterloo.ca

Department of Recreation and Leisure Studies

University of Waterloo

Interview protocol

LEAD ONE: Explore how the use of outdoor experiential psychotherapy are influencing individuals' experiences of early recovery

1. Tell me what motivated you to volunteer for the workshop in the first place?
   a. What was it like for you to sign up for a workshop, now knowing what it was all about?
   b. How did you come to the decision to volunteer for the workshop?
2. Can you tell me a bit about the role you felt the outdoor environment played in your experience of the workshop?
   a. Did you enjoy participating in the outdoor environment? Why or why not?
   b. How would this workshop have looked differently in an indoor setting?
3. Tell me about the experience of engaging in the workshop alongside the recreation therapists?
   a. Did you find this hindered your participation in the workshop? Did you find it enhanced your participation in the workshop? Why or why not?
   b. What did you like about having the recreation therapists participating alongside you?
   c. What did you dislike about having the recreation therapists participate alongside you?
   d. In what ways, if any, did it alter your relationship as you went back to the unit?
4. Tell me what it was like for you to connect with other people throughout the workshop?
   a. How did you find you were able to connect with others?
   b. Did you find any commonalities with the other participants?
   c. Did you find any differences with the other participants?
   d. Did you learn anything about yourself in terms of connecting with others from the workshop?
   e. What was it like for you to have an opportunity to share your story and experiences of the outdoor workshop?
   f. Tell me about your experience of hearing other participants experiences of the workshop?
5. Tell me about the experience of de-briefing the activities?
   a. How, if at all, did you find the experience of sharing your own experience of the workshop and activities played into the meaning created throughout the workshop?
   b. Tell me how you experienced the sense of story-sharing in the workshop?
   c. In what ways, if any, were the debriefings helpful to you?
   d. In what ways, if any, did you find that you were able to connect meaning to the activities of the workshop to your own personal recovery?
6. Tell me how the experience of participating in the experiential activities was for you?
   a. Was there an activity you found you struggled in? how did you work through that?
   b. Was there an activity you found easy to complete? Why do you think that was?
   c. What was your favourite activity? Why?
   d. Which was your least favourite activity? Why?
   e. Were there moments throughout the day that you felt like you were being challenged? How did you work through that?

f. Was there a time during the workshop that you felt at peace or like you were having fun? What was that feeling like for you?
g. Can you tell me something you felt you discovered about yourself throughout the workshop?
h. In what ways, if any, did this experience connect to your recovery?
i. In what ways, if any, do you feel you will transfer what you learnt during the workshop to your own personal recovery?
j. Can you tell me how this experience helps you in your transition to life outside of Homewood? When you return to your own reality?

Is there anything else I have not asked you that you think is important for me to know about your experience of the workshop?

Appendix I- Draft Script for Recreation therapists at Community Meeting

As part of a research project at the University of Waterloo we are offering a one-time-only outdoor experiential workshop here at Homewood. The workshop will run on **Friday February 16th** from **8:00am-4:00pm** at Homewood Health Centre. Outdoor experiential programming is a fun form of complementary therapy that utilizes an outdoor environment to facilitate experiential activities that work create a deeper understanding of recovery. As a participant in this research study you will be asked to participate in two sessions. First, participation in a day-long workshop of experiential activities outside facilitated by one of the recreation therapists on the unit. In addition, you will also be asked to join in a focus-group discussion at the end of the workshop that will be facilitated by the recreation therapist. The primary researcher of the project will be participating in the workshop as well. However, she will not be involved in the facilitation of the workshop. Second, you will be asked to participate in a one-hour one-on-one interview with the primary researcher a week following the workshop. The recreation therapists will not be a part of this interview. The purpose of this research project is to understand the lived experiences of individuals living in recovery as they engage in outdoor experiential programming. If you would like to know more about the research project, we have information letters for potential participants in the department. If you are interested in signing-up for the workshop and research project, please talk to one of the recreation therapists. Space is limited, so we will only be able to accommodate 6-8 participants. It is important to note that this workshop is NOT a part of your care and treatment here at Homewood. Participation in this workshop is strictly on a voluntary basis and will not affect your treatment or care here at Homewood.

Appendix J- Procedural Memo

The following is a list that outlines the steps taken during both analysis and representation of the transcript:

1) I finished the transcription of the audio-recorded focus group the day after the day of the workshop to ensure I was properly recording which participant said what
2) I finished the transcription of the remaining six individual interviews two weeks after the workshop date
3) I started by printing 2 copies of each interview transcript and the focus group transcript (one for the individual story representation and the other for the narrative thematic analysis)
4) Line by line coding (summarizing line by line with one word)
5) Complied all codes into one document and printed it
6) Cut all of the codes and placed them on a desk
7) Began organizing the codes into categories that spoke to each code
8) In total I recognized 21 different categories including (alcoholic behaviours, past behaviours, childhood behaviours, working through racing thoughts, feelings of being outside, senses of being outside, therapy indoors, stories, connecting with others, "Not being different- fitting in", group setting, positive emotions, having fun, "getting out of my comfort zone", "learning new things", "trying something different", task-focused activities, negative emotions, "being anchored in recovery", "transferring into recovery").
9) I then organized these categories into four main themes: (1) working through past negative addiction and trauma behaviours alcoholic behaviours, past behaviours, childhood behaviours, working through racing thought); (2) The role of the outdoors: letting go of structure and routine (feelings of being outside, senses of being outside, therapy indoors); (3) Connecting with others through stories (stories, connecting with others, "Not being different- fitting in", group setting); and (4) The experience of the workshop (The perfect storm: the good, the bad, and the ugly of in-patient care) (positive emotions, having fun, "getting out of my comfort zone", "learning new things", "trying something different", task-focused activities, negative emotions, "being anchored in recovery", "transferring into recovery").
10) I colour coded each theme (1) blue, (2) green, (3) pink, and (4) yellow
11) I then re-read the transcripts and highlighted the meaningful words and experiences that spoke to each main theme
12) Next, I worked to conceptualize the ideas and created a Venn Diagram to help illustrate how I was conceptualizing the main meaningful ideas that came from the data
13) After conceptualizing my ideas, I began the process of writing the individual narrative stories to represent each one of my six participants
14) I used the transcripts that had not yet been highlighted and started by cutting out all of the words from the participants
15) I then organized the first participants (Ava) cut outs in a way that created her "story" and I glued this on large pieces of paper to create a "story board" (I did this for the remaining five participants (Odin, Brianna, Liam, Heather and Joseph) in this order so that I was working individually on one "storyboard" before moving to the next so that it was fresh in my mind).

16) After completing the individual participant narrative stories, I moved back onto the narrative thematic analysis aspect

17) I began by cutting out all of the highlighted pieces on the transcript and organized it into my four themes

18) Next, I organized each of the cuttings within the themes to reflect the categories I want to further explore in my findings and discussion

19) I created a "storyboard" for each theme as a way to help me as I wrote the narrative findings aspect of the findings

20) I then went back to look at the "narrative thread" analysis aspect and began to cut the transcripts and organize the cuttings into the four main themes I identified based on my analysis (I kept all the remainder clippings from the transcript that I was not using).

21) Once I had cut all the transcripts and had all the cuttings organized into the four main themes, I began with the "role of the outdoors" theme and laid out all of the transcript cuttings and began to re-organize the cuttings in a way that reflected the different unique categories. Once I had it organized in this way I glued in onto a larger piece of paper so that it made sense to me and I was able to follow that sequence as I wrote up that theme.

22) I continued to do this for the two other themes (working through past behaviours and connecting with others through stories)

23) When I got to my final theme (the experience of the workshop) I came to the understanding that the experience of the workshop was at the core of the understanding of the other three themes