

Understanding Trauma-Related Distress Among Wilderness Therapy Field Staff

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Abstract

There is a dearth of research in the field of outdoor behavioral healthcare on the direct care staff at wilderness therapy programs, known as field staff. Some research has identified direct care staff as particularly susceptible to burnout and high levels of stress due to personal, organizational, and social factors. Recent research on burnout in fields such as social work has indicated that what was thought to be burnout may actually be the accumulation of stress over time, or some sort of post-traumatic distress, namely a response to specific incidents and pervasive cognitive and emotional shifts due to working with individuals with a trauma history. This mixed methods study used demographic and incident surveys, as well as the Trauma Attachment and Belief Scale, the Impact of Events Scale-Revised, and follow-up interviews to explore the prevalence of trauma-related distress in wilderness therapy field staff and their perceptions of support, coping, and processing the experience. Recommendations for the field based on the findings indicate a need for increased training on self-care practices, de-stigmatizing the use of mental health professionals for direct care staff, including educating staff about insurance benefits for mental health care, and assessing for signs of instructor stress such as through staff debriefs and increased social support.

Keywords: training, vicarious trauma, burnout, wilderness therapy

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Wilderness therapy (WT) field staff have a crucial role in the care and delivery of services for clients of Outdoor Behavioral Healthcare (OBH). Field staff travel with clients, spending 24 hours a day, for shifts ranging from 4 to 16 days in the field. They are responsible for keeping clients safe, running groups, and helping clients with their clinical goals and skill acquisition (Kolaski & Taylor, 2019). Despite their important role in wilderness therapy outcomes and programming, research on field staff is currently lacking (Kirk & O'Connell, 2012). While some research has focused on the general experience of being a field staff (Field et al., 2016; Karoff et al., 2019), most of the research to date has focused on negative aspects of the role, such as the challenges, stressors, high turnover rate and burnout (Kirk & O'Connell, 2012; Kolaski & Taylor, 2019; Marchand, 2008; Marchand & Russell, 2013; Marchand et al, 2009; Maslach & Leiter, 2008).

These studies have found evidence that direct care staff, both field staff and those in residential treatment programs, experience high rates of stress and turnover, something that has been attributed to burnout (Kirk & O'Connell, 2012; Marchand et al., 2009). Research is beginning to suggest that burnout, as the term is currently used, may actually incorporate a few different distinct processes, which include secondary trauma, and vicarious traumatization (Jenkins & Baird, 2002; Kanno & Giddings, 2017). These processes may contribute to employee distress and eventual job termination (Reghr et al., 2004). In addition, since field staff are linked to positive client outcomes (Kolaski & Taylor, 2019), a failure to support them may go so far as to encourage negligence and negatively impact clients' treatment (Heron & Chakrabati, 2002). Thus, it is imperative to gain a better understanding of if and how distress shows up in wilderness therapy field staff and what can be done to mediate this distress. This study will seek to explore the contributions of vicarious and secondary trauma to field staff distress and factors that may contribute to mediating this state.

Experiences of Direct Care Staff

While there is limited research on wilderness therapy field staff,

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research on direct care staff in wilderness therapy programs, outdoor education, and Residential Treatment Centers (RTCs) can deepen our understanding of the experiences of staff in these professions. Marchand (2008) identified that field staff in wilderness therapy programs reported that their schedules presented a challenge, both due to the amount of time they spent with clients with clinically complex behaviors, as well as their long stretches of work shifts with variable time off. Marchand (2008) also found that field staff reported high levels of anxiety and physical or emotional challenges as significant difficulties related to their work.

These reports are significant for this study because they suggest burnout or some sort of trauma-related distress. In addition, insufficient pay, pressure to perform, and compromises that were made for work, such as in personal relationships, were reported to be significant contributors to instructor stress (Marchand et al., 2009; Maslach & Leiter, 2008). Goodness of fit between employee and the job, as well as expectations about the role were also linked to job satisfaction for wilderness therapy field staff (Marchand et al., 2009; Marchand & Russell, 2013). Lastly, senior field staff reported being unsatisfied with promotion, contingent rewards, operating conditions, and communication within the organization (Marchand et al., 2009).

While the focus of much research has been on the stressors and challenges of being direct care staff, findings indicate that field staff experience personal benefits from their jobs as well (Bunce, 1998). In a study of Australian outdoor education practitioners, positives of the work included flexibility and variety, autonomy and responsibility, community and support at work, training opportunities, and work location (Thomas, 2001). In the area of training, 93% of RTC direct care staff reported they could benefit from additional training (Lakin et al., 2008). The authors suggest that direct care staff could specifically benefit from training in cognitive restructuring, or separating person and behavior, and relaxation techniques. Stapleton et al. (2016) suggest that training staff on task-oriented versus emotion-based coping mechanisms could be beneficial as well. Finally, a need for promoting self-care among employees by providing training on components of self-care, such as mindfulness and sleep hygiene, has been advocated for OBH programs and for individuals working with clients who have experienced trauma (Kolaski & Taylor,

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2019; Valent, 2002).

Understanding Trauma-Related Distress

The role and expectations of wilderness therapy field staff clearly have embedded challenges and stressors that may affect an employee's satisfaction, turnover, and job performance. In addition, exposure to clients' stories of trauma or clients acting out behaviors as a result of trauma, commonly encountered by field staff, can effect the mental health of staff and lead to issues with retention and performance as well (Figley, 1995b). These experiences can contribute to three related, but distinct phenomena: burnout, secondary trauma, and vicarious traumatization (VT).

According to Jenkins and Baird (2002) there is much conceptual overlap between these ideas as they all result from "exposure to emotionally engaging clients via interpersonally demanding jobs and represent debilitation that can obstruct providers' services" (p. 425). Burnout is a more general phenomenon that can occur in any social service setting, while VT and secondary trauma are specifically related to work with trauma populations (Newell & MacNeil, 2010). No research currently exists on the levels of either VT or secondary trauma in wilderness therapy field staff, a gap this study aims to fill.

Burnout

Research on burnout suggests that it is composed of three dimensions: exhaustion, cynicism or depersonalization, and inefficacy (Maslach & Leiter, 2008). Maslach and Leiter (2008) found that organizational factors such as workload and union support had the greatest significant impact on burnout. Overload, or a workload that was perceived to be above and beyond what a person might be capable of, contributed significantly to employee feelings of exhaustion. Employee data also showed that role ambiguity and role conflict contributed to depersonalization. Co-worker support seemed to provide a mediating factor to burnout and was related to accomplishment and efficacy. Person-job match, which Leiter and Maslach (2004) define as congruence between individual dimensions and job dimensions on six categories (workload, control, reward, community, fairness and values) was also a significant factor in predicting burnout.

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Secondary Trauma and Vicarious Traumatization

Secondary traumatic stress (STS) can be conceptualized as an experience almost identical to Post Traumatic Stress Disorder (PTSD) with the only difference being that the person who develops PTSD directly experienced the event, while the person developing STS has been exposed to the event indirectly or vicariously (Figley & Kleber, 1995). Originally this idea was drawn from the experiences of family members of sexual assault survivors and combat veterans and was subsequently expanded to include the experiences of professionals ranging from police officers to nurses and therapists (Figley, 1995b).

Vicarious trauma has been conceptualized by Williams et al. (2012) as a shift in one's internal experience and psychological well-being, and it was originally defined by Pearlman and Saakvitne (1995) as the permanent "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (p. 31). Pearlman and Mac Ian (1995) explain that this experience may be cumulative across time and can permeate the inner world of the person experiencing it. McCann and Pearlman (1990) describe the potential effects of vicarious trauma as nightmares, fearful thoughts, intrusive images, and suspicion of others' motives. These are all symptoms that may be present in STS as well, though they ascribe the root of these issues to be exposure to aspects of client's stories involving victimization that are inconsistent with the therapist's cognitive schemas. They highlight several areas whereby alterations to core beliefs may lead to distress and vicarious traumatization, including trust, safety, and power and control.

As Jenkins and Baird (2002) point out, these constructs are a bit conceptually muddy, although their research suggests that they are interrelated and may present distinct aspects. Key differentiations made by Jenkins and Baird (2002) between STS and VT include: the focus on symptoms in STS vs. theory in VT, the focus on observable reactions in STS vs. on covert thinking changes in VT, the focus on a wider population of professionals and individuals in STS vs. the focus on trauma therapists and mental health workers in VT, and the focus on as little as one exposure in STS vs. the focus on cumulative effects of long-term exposure in VT. Jenkins and Baird (2002) also point out that these concepts are

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distinctive from the concept of burnout in their focus on interactions with individuals who have experienced traumatic events. For the purposes of this paper, the experiences of stress, related to working with clients with a trauma history, will be referred to as trauma-related distress.

Current Study

Wilderness therapy field staff may be at risk for developing distress related to either secondary traumatic stress or vicarious traumatization, due to the unique role they play in working with clients. In fact, some of the stress that has previously been attributed to burnout may actually be more accurately defined as some sort of post-traumatic distress. One study found that nearly half of adolescents in wilderness therapy and residential treatment programs reported recent traumatic events (Bettmann et al., 2011). As such, it is likely that wilderness therapy field staff will be exposed to their stories of trauma. In addition, wilderness therapy field staff may also be exposed to situations where their safety or client safety is threatened, such as aggression, self-harm, or running away (Gass et al., 2012). Bettmann et al. (2011) found in their study defining characteristics of clients in residential treatment that the population is “highly oppositional and acting out” (p. 205). Thus, it is reasonable to assume that field staff may be exposed to events that could lead to STS, or possibly even PTSD, although no research has explored the prevalence of these experiences in field staff.

This study aims to fill this gap by exploring the prevalence of distress related to vicarious trauma and secondary trauma among wilderness therapy field staff, as measured by the number of potentially traumatic experiences field staff experience during their shifts, and the cognitive, interpersonal, and intrapersonal shifts that may suggest the presence of trauma. This research also explores the perceptions of WT field staff about their work experiences qualitatively, something that is currently lacking in the literature (Kirk & O’Connell, 2012).

Methods

The study population consisted of wilderness therapy field staff drawn from six different programs in four different states in the United States. Four programs are members of both the Outdoor Behavioral Healthcare Council (OBHC) and the National Association of Therapeutic

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Schools and Programs (NATSAP). One program is a member of NATSAP only, and the final program is not a member of either organization. Programs and individuals were identified through attendance at the Wilderness Therapy Symposium in August 2016 and August 2018, postings to industry Facebook pages such as the Therapeutic Adventure Professional Group and the Wilderness Genealogy Project.

Due to the exploratory nature of this study and the focus on coping in the field, only staff who had worked a shift in the past month were included in the sample size. In total, 250 surveys, with prepaid return envelopes were sent out. Thirty survey packets were returned, resulting in a return rate of just over 10%. Of the 30 packets returned, all were fully completed and 21 participants who completed packets indicated they would be willing to participate in a follow-up interview. Interviews took place over the phone between December 2016 to February 2017 and again from December 2018 to March 2019. Of the 21 participants who agreed to be contacted for interviews, 9 participants followed through with scheduling and completing interviews when contacted.

Data Collection Tools

Surveys

As a part of the survey packet, participants were asked to complete a brief demographic survey as well as a survey on the number, type, and frequency of possibly stressful events they estimate having experienced in the course of the past six months of their job.

Trauma Attachment and Belief Scale (TABS)

The TABS scale was developed as a measure to assess the cognitive, interpersonal, and intrapersonal shifts that may suggest the presence of trauma and has been used to assess vicarious trauma (Pearlman, 2003). The assessment consists of 84 statements that participants are asked to score based on their beliefs about themselves and others on a Likert type scale of 1 to 5 with 1 being strong disagreement and 5 strong agreement. The assessment can produce scores on 10 subscales: self-safety (need to feel secure and reasonably invulnerable to harm), other-safety (need to feel that cherished others are reasonably protected from harm), self-trust (need to have confidence in one's own

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perceptions and judgments), other-trust (need to depend or rely on others), self-esteem (need to feel valuable and worthy of respect), other-esteem (need to value and respect others), self-intimacy (need to feel connected to own experience), other-intimacy (need to feel connected to others), self-control (need to manage one's feelings and behaviors), and other control (need to manage interpersonal situations).

The assessment also includes a total score that provides an index of the participant's overall level of disruption in areas that are important to maintaining healthy relationships. The higher the total score, the greater the assumed disturbance to belief structures with a mean standardized non-clinical sample total score being 187.2. Pearlman (2003) provides an argument for the face validity of the assessment as well as the assessment previously known as the Traumatic Stress Institute Belief Scale Revision L (TSI-BSL), which has demonstrated construct validity in research by Jenkins and Baird (2002). For the TSI-BSL, Jenkins and Baird (2002) report a Cronbach's alpha of .95 for the total score and Pearlman (2003) suggests the internal consistency for the TABS may be .95 for the total score and the test-retest reliability to be .75 for the total score. Jenkins and Baird (2002) report that the Cronbach's alpha for the subscales of the TSI-BSL range from .62 to .83. This study used the TABS to assess disturbances in beliefs and schemas that may be related to working with individuals who have experienced trauma.

Impact of Events Scale-Revised (IES-R)

The Impact of Events Scale-Revised is a 22- item scale designed to assess the symptoms on three subscales of Avoidance, Intrusion, and Hyperarousal related to the direct experience of traumatic events (Weiss, 2007; Weiss & Marmar, 1997). The IES-R was designed to account for criticisms to the original Impact of Events Scale and build upon its widespread use by including a domain for hyperarousal symptoms. Weiss and Marmar (1997) report a high internal consistency with estimates of the coefficient alphas as follows: Intrusion ranging from .87 to .92, Avoidance ranging from .84 to .85, and Hyperarousal ranging from .79 to .90. Creamer et al. (2003) demonstrated the construct validity of the IES-R using a sample of Vietnam veterans and comparison scores with the PTSD Checklist (Weathers et al., 1993). Though the IES-R is not designed to

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make a diagnosis of PTSD, cutoff scores for a possible clinical diagnosis have been reported in the literature with Creamer et al. (2003) offering a conservative clinical cutoff as a total score of 33. Other markers for interpreting scores include suggestions by Asukai et al. (2002) that a cutoff of a total score of 24 or more may signal PTSD as a clinical concern and research by Kawamura et al. (2001) suggesting that scores of 37 or more may be suggestive of trauma that is significant enough to suppress immune function up to 10 years after the event.

In this study, the IES-R was used to assess behavioral responses and symptoms of potentially traumatizing events experienced while working with clients in wilderness therapy. Bride et al. (2007) are careful to point out that while this measure may be used to assess secondary trauma or hearing stories of traumatic experiences, it is designed to assess the direct experiences of trauma. Unlike trauma therapists working in an office, wilderness therapy field staff may be more likely to directly experience intensive acting out behaviors and hear of traumatic stories, so the researchers chose this scale to measure responses to strike a balance in this area. The participants were instructed to complete the survey based on the most stressful experience they had while working as a wilderness therapy field staff.

Interviews

Due to the exploratory nature of this study, the researchers chose a semi-structured interview process to explore what wilderness therapy field staff experience as stressful in their work and how they attempt to process and cope with these experiences in and out of the field. As Miles et al. (2014) point out, this loose design is appropriate for research that seeks to explore understudied or socially complex phenomena. All interviews were conducted over the phone and recorded for transcription.

Participants

The total sample size included in the study was 30 participants. Table 1 reports demographics for the participants, with a fairly even split of males and females and most had a college or graduate degree. In addition, over half of the participants filled out the survey before their shift, with the rest split as during and after their shifts. The average number of field days reported by participants was about 271.1 days ($sd =$

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380.2) with a range from 22 to 2150 field days reported. Only six participants had less than 90 field days (See Table 1).

Table 1

Demographics of Study Participants (N = 30)

Demographics of Participants	% (N)
Gender	
Female	56.7 (17)
Male	43.3 (13)
Education	
High School	3.3 (1)
Some College	3 (10.0)
College Degree	63.3 (19)
Some Graduate	6.7 (2)
Graduate Degree	16.7 (5)
Shift Length	
4 days	3.3 (1)
8 days	80.0 (24)
16 days	16.7 (5)
Time when completed survey	
Before Shift	56.7 (17)
During Shift	20.0 (6)
After Shift	16.7 (5)
Number of Field Days	M = 271.1, SD = 380.2
Less than 90 days	20.0 (6)
90-180 days	30.0 (9)
181-360 days	30.0 (9)
360 +	20.0 (6)

Independent sample t-tests found no significant difference between those participants with less than 90 days in the field and those with more

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in terms of the number of incidents they experienced, as well as no significant differences across both the TABS total score and its subscales, and the IES-Revised total score and its subscales. In addition, ANOVA analyses reported no significant differences in the total number of incidents, TABS total and its subscales, as well as the IES-Revised total and its subscales based on level of education (high school/some college, college, some graduate school, graduate degree).

Finally, one-way ANOVAs were calculated to better determine if the time when field staff took the survey (before, during, or after shift) was related to mean differences in the number of incidents reported, the TABs total and subscales, or the IES-R total and subscales. The overall ANOVA models found no significant differences, nor were pairwise significant differences found in the post-hoc analyses. Hence, there were no significant relationships between the number of field days and education with reported levels of incidents or scales of distress.

Results

Dosage of Incidents

This study explored how often and what type of potentially stressful incidents wilderness therapy field staff experienced over the past six months (See Table 2). In addition to those listed on the survey, there was also an option for participants to write in “other stressful events.” Responses included: “Witnessing another staff get kicked in the face,” “Running out of water with a group of girls in the summer,” “Client suicide attempt,” “Client completing suicide after leaving the program,” “Client having flashback,” “Following a large client out of camp,” “Being on safety with a student for 2 weeks,” “Working with a co-staff not comfortable with,” “Client refusal to participate,” and “Client broke ankle.” Each of these events was reported as happening only once in the past six months.

Overall, whether field staff experienced a specific incident type in the past six months, and how frequently, varied greatly depending on the incident type. For each potentially stressful event surveyed, at least 10% of the participants reported having experienced that event at least once in the past six months. The number of potentially stressful events an

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individual experienced in the past six months ranged from 4 to 294, with a mean of 43.03. Of note, one participant reported 294 incidents, yet the next highest incident number was 148 events, indicating this individual may be an outlier. The median number of incidents was 29.50 events over the past six months which is a better estimate of the average number of incidents experienced by staff in the study.

The most frequently experienced stressful events reported were client reports of suicidal ideation and clients sharing a history of mental or emotional abuse with 86.67% of study participants having reported experiencing one of these events over the preceding six months with a mean frequency of 6.07 and 4.27 times respectively over that period. In addition, 76.7% of field staff reported that clients shared about a history of physical abuse at least once in the last six months, and 69.1% reported that clients shared about a history of sexual abuse at least once in the past six months. These numbers correspond to previous findings that clients of wilderness therapy often report recent traumatic events (Bettmann et al., 2011), and that wilderness therapy field staff are often hearing stories of this past trauma.

Additionally, a number of field staff who reported experiencing events related to personal and client safety, although once again, this varied greatly in the frequency of these events. 83.3% of participants reported experiencing verbal threats directed at another client at least once in the past six months, although only 56.7% experienced verbal threats directed at themselves at least once in the past six months. In addition, 60% of field staff reported experiencing physical threats directed at another client at least once in the past six months, but only 33.3% of field staff experienced physical threats directed at themselves at least once in the past six months.

The least frequent type of incident reported was client self-harm requiring evaluation by a medical professional outside of the field with a mean of 0.23 experiences over the past six months and 13.33% of participants having experienced this once in the past six months. Overall, this data indicates that wilderness therapy field staff are exposed to traumatizing events, though which types of events and with what frequency vary greatly.

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Table 2

Number and Type of Potentially Stressful Incidents Experienced by Staff over 6 months (N = 30)

Type of Incident		Did not Experience (Reported 0 Incidences)	Experienced 1-2 times in last 6 months	Experienced 3-5 times in last 6 months	Experienced 5-9 times in last 6 months	Experienced 10+ times in the last six months
	M (SD)	% (N)	% (N)	% (N)	% (N)	% (N)
Verbal threats directed at you	9.07 (25.4) Range 0-100	43.3 (13)	23.4 (7)	16.7 (5)	3.3 (1)	13.3 (4)
Verbal threats directed at another client	7.1 (18.3) Range 0 - 100	16.7 (5)	33.3 (10)	30.0 (9)	6.7 (2)	13.3 (4)
Client report of suicidal ideation	6.07 (7.4) Range 0 - 32	13.3 (4)	33.3 (10)	13.3 (4)	16.7 (5)	23.4 (7)
Client sharing history of mental or emotional abuse	4.27 (3.8) Range 0 - 15	13.3 (4)	30.0 (9)	23.4 (7)	20.0 (6)	13.3 (4)
Client walking out of camp	2.93 (7.3) Range 0 - 40	30.0 (9)	43.4 (13)	16.7 (5)	10.0 (3)	3.3 (1)

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Client sharing history of sexual abuse	2.9 (4.1) Range 0 - 16	30.0 (9)	40.0 (12)	13.3 (4)	6.7 (2)	10.0 (3)
Client sharing history of physical abuse	2.5 (3.1) Range 0 - 15	23.3 (7)	40.0 (12)	26.7 (8)	6.7 (2)	3.3 (1)
Physical threats directed at another client	2.47 (5.3) Range 0 - 25	40.0 (12)	43.3 (13)	6.7 (2)	0	10.0 (3)
Physical threats directed at you	1.50 (4.6) Range 0 - 25	66.7 (20)	23.4 (7)	3.3 (1)	3.3 (1)	3.3 (1)
Participated in therapeutic hold	1.30 (2.1) Range 0 - 15	60.0 (18)	30.0 (9)	3.3 (1)	3.3 (1)	3.3 (1)
Witnessed therapeutic hold	1.23 (3.0) Range 0 - 10	56.7 (17)	23.4 (7)	16.7 (5)	0	3.3 (1)
Client self-harm not requiring medical attention	0.90 (1.1) Range 0 - 4	43.3 (13)	43.7 (14)	10.0 (3)	0	0
Client walking out of camp and being out of instructor sight for more than 15 minutes	0.57 (1.7) Range 0-9	76.7 (23)	20.0 (6)	0	3.3 (1)	0

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Client self-harm requiring evaluation by a professional outside of field or program staff	0.23 (0.6) Range 0 - 2	86.7 (26)	13.3 (3)	0	0	0
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Trauma Attachment and Belief Scale (TABS)

The TABS total score provides an index of the participant’s overall level of disruption in areas that are important to maintaining healthy relationships (Pearlman, 2003). The mean total score for participants was 176.20, with a standard deviation of 34.01, and a range from 111 to 251 (See Table 3). Five of the participants had a total score that fell within the high range and two participants fell within the very high range when compared to a nonclinical standardized group as reported by Pearlman (2003). As such, 23% of the participants scored above average for a nonclinical standardized group. A correlation was conducted to assess if the TABS total score, or its subscales, was related to the number of potentially stressful incidents a participant reported. There were no significant correlations found except for the subscale of “other safety” ($r = .368$, $df = 28$, $p = .045$), which reflects “the need to feel that cherished others are reasonably protected from harm inflicted by oneself or others” (Pearlman, 2003).

In regard to the subscales, all ten subscales had a mean score in the average or low range (See Table 3). The proportion of individuals scoring in the high or very high range for each subscale were as follows: “other-intimacy” (36.7%), “self-control” (30%), “self-intimacy” (26.7%), “self-esteem” (26.6%), “other-control” (20%), “self-trust” (16.7%), “other-safety” (10%), “self-safety” (6.7%), “other-trust” (3.3%) and “other-esteem” (3.3%).

Overall, based on the TABS total scores, while 23% of participants scored in a range indicating there may be disruptions in areas important to maintaining healthy relationships, the majority of participants do not indicate disruptions. In addition, the majority of participants do not have disruptions in functioning at the level of the ten subscales either.

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Table 3

TABS Scores and Subscales including Clinical Ranges of Symptoms

TABS Total & Subscales		Very Low	Low	Average	High Average	Very High	Extremely High
<i>M (SD)</i>		<i>% (n)</i>	<i>% (n)</i>	<i>% (n)</i>	<i>% (n)</i>	<i>% (n)</i>	<i>% (n)</i>
Total	176.2 (34.0) ^a	10.0 (3)	26.7 (8)	40.0 (12)	16.7 (5)	6.7 (2)	
	Range 111 - 251						
Self-Safety	24.6 (7.1) ^a	43.3 (13)	3.3 (1)	43.3 (13)	6.7 (2)	-	3.3 (1)
	Range 13 - 47						
Other-Safety	15.0 (4.4) ^a	23.3 (7)	10.0 (3)	53.3 (16)	6.7 (2)	3.3 (1)	3.3 (1)
	Range 8 - 28						
Self-Trust	16.5 (4.0) ^a	16.7 (5)	3.3 (1)	60.0 (18)	6.7 (2)	10.0 (3)	3.3 (1)
	Range 8 - 26						
Other-Trust	16.2 (3.8) ^b	43.3 (13)	30.0 (9)	23.3 (7)	-	3.3 (1)	-
	Range 8 - 27						
Self-Esteem	16.6 (4.6) ^a	10.0 (3)	23.3 (7)	40.0 (12)	13.3 (4)	13.3 (4)	-
	Range 9 - 26						

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Other-Esteem	15.6 (3.2) ^b Range 9 -25	23.3 (7)	23.3 (7)	50.0 (15)	-	3.3 (1)	-
Self-Intimacy	16.9 (4.3) ^a Range 8 -24	16.7 (5)	13.3 (4)	43.3 (13)	10.0 (3)	16.7 (5)	-
Other-Intimacy	19.1 (6.0) ^a Range 9 -32	6.7 (2)	13.3 (4)	40.0 (12)	16.7 (5)	20.0 (6)	3.3 (1)
Self-Control	21.7 (5.0) ^a Range 13 -33	6.7 (2)	13.3 (4)	50.0 (15)	10.0 (3)	20.0 (6)	-
Other-Control	14.9 (4.4) ^b Range 7 - 23	30.0 (9)	16.7 (5)	33.3 (10)	13.3 (4)	6.7 (2)	-

Impact of Events Scale-Revised (IES-R)

The results of the IES-R corroborate the findings of the TABS in that while the majority of individuals do not seem to be greatly affected by their direct experience of traumatic events from work, there are a number of individuals whose well-being has been disturbed (See Table 4). While 73.3% of participants scored a range indicating no distress, 26.6% of the participants scored above the cutoff designated by Aukai et al. (2002) as an indicator of possible clinical levels of distress. Beyond that, two (6.7%) of the participants scored above the level designated by Creamer et al. (2003) as a cutoff for the possible diagnosis of PTSD. Additionally, two (6.7%) of the participants scored above the level that research by Kawamura et al. (2001) indicates as a possible marker for decreased immune function for up to 10 years after the event due to stress. Overall, these numbers represent that while many field staff are not experiencing

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high levels of distress, for a few, there have been significant disruptions.

Table 4

IES-R Score Distribution

	<i>M(SD)</i>	<i>Median</i>	<i>Range</i>
Impact of Events Scale Total	14.3 (14.5)	8.0	0 -55
Intrusive Subscale	6.6 (6.4)	5.0	0 - 18
Avoidance Subscale	4.7 (5.2)	2.5	0 - 22
Hypervigilant Subscale	3.0 (3.9)	2.0	0 -15

IES-R Total Score Cut-off Ranges	%	<i>n</i>
0 -23 (No distress)	73.3	22
24-32 (clinical level of distress)	13.3	4
33-38 (possible PTSD diagnosis)	6.7	2
39 or greater (PTSD & decreased immune function)	6.7	2

Interviews

The interviews investigated instructors' sources of stress, and methods for coping and processing, including both individual tactics and organizational support, and opportunities to access mental health support more formally.

Sources of Stress

When asked about the most stressful part of their job, 7 out of the 9 participants interviewed described some version of dealing with safety and critical incidents either from clients acting out or some sort of illness or injury and not feeling supported in this. Described by one participant as follows:

I think it’s fair to call them intense moments when clients are

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pushing boundaries in unsafe ways either physically or verbally/emotionally and this ultimate thought point of keeping my cool while keeping everyone safe, seeing clearly what's going on, issuing you know effective action on my part to help you know calm things down and simultaneously give people feedback and keep things safe.

In describing the stress of dealing with critical events, these participants described the intersection of not only having an ill, injured, or acting out client, but also having to manage an uncontrollable environment, such as cold, blizzard conditions, or heat, managing many moving parts simultaneously, or being far away from any kind of medical support. Two participants went so far as to describe a feeling of anxiety about being ultimately responsible for the death of a client, with one participant stating, “And then it just, then if anything happens then it would be like I was the last person with some parent’s kid and I know that conversation would happen with me because I was there and that’s like, super stressful.”

Participants also described a lack of control of client behaviors and the anxiety this can create because of the types of behaviors clients may engage in. One participant described the difficulty of dealing with these behaviors when they were turned towards staff stating, “being consistently abused by multiple students for an extended period of time of, like, name-calling and degrading in that way.” Field staff described knowing of other field staff who spent multiple nights crying themselves to sleep while on shift and feeling like they were going to pull their hair out. One participant explained, “I told [program executive director] had that been my first shift ever, never having worked wilderness or residential treatment before, I would’ve quit on the spot because it was that emotionally draining.”

In addition to student behaviors, critical incidents, and safety, participants discussed a few other sources of stress. One participant described the lack of information or inaccurate information that can be passed on to field staff about clients and how that affects staff’s ability to work effectively with their clients. Similarly, another participant discussed the stress induced by being prepared to go into the field with one group, and then at the last minute being told that one’s assignment had changed. This same participant discussed how the stress of behaviors from the field

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could extend to student behaviors when they were discharged, such as losing a previous student to suicide. This participant discussed how difficult this experience can be, particularly because of the time spent and closeness of the relationships that field staff make with their students, even in one shift.

Finally, some participants discussed stressors that specifically relate to the career of wilderness therapy instructing. One participant identified the low pay that wilderness field staff receive as a source of stress. Another instructor expressed the lack of awareness, or access to, potential career development tracks for wilderness field staff as a source of stress. Lastly, one participant discussed the difficulty of maintaining relationships with individuals outside of the field due to the realities of “having to regularly disappear for two weeks at a time.”

Staffing and Training

One idea that emerged in almost every interview was the need for more staff to adequately manage situations through training and professional development of staff. Participants discussed the need for new field staff to be properly trained to minimize the stress put on head field staff caused by a lack knowledge about the program model or the basics of safety. One participant described this problem as follows:

I just think that they weren't trained enough or weren't qualified for the position fully, so I think that was a huge extra stress on head field staff, especially those of us who you know had been there for already like a year and then we see all these new field staff coming in and it's like we just know that's not okay, so it's like just adding stress to what our jobs already revolve around.

For some participants, the lack of adequate staff and lack of support they experience is viewed as a symptom of companies trying to grow too quickly or as the company priority being profits or image over actually doing what they say. The stress of being a head field staff while training new or undertrained field staff also seems to be related to not being able to take a moment away from the group or time to be alone to take care of oneself. This pressure of feeling responsible for others 24/7, even during sleep, without true breaks increased field staff stress.

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One participant described being the only field staff member in a group with a medical certification and thus being required to be with the group at all times. Other participants described this stress not necessarily as related to the numbers of staff, but as a combination of staffing and group volatility and possible mismatches between staff and groups. One field staff explained how this directly impairs their ability to support participants in their growth saying, “I think when I’m experiencing actual stress, then I can’t really facilitate eustress for these kids. I think that’s a big factor. I think it would be a bigger factor for students if I as an instructor wasn’t stressed out in a negative way.” Further on in the interview the same field staff states, “You know my real job is safety and if I can’t manage my own safety when a kid is like spitting at you and trying to throw punches at you, how am I supposed to manage everybody else’s and try to facilitate a positive experience?” This inability at times to create a positive experience was further elaborated by one participant who expressed their stress as sometimes resulting from not seeing student gains during a shift.

The individuals interviewed also discussed other staff as a great source of support in the field. Multiple participants mentioned the importance of being able to check-in with other field staff at the end of a day and decompress. A couple participants also touched on the importance of finding humor or levity in serious moments.

Participants suggested a few different solutions to these issues. Multiple participants suggested having an extra staff on rotation to be ready and willing to go into the field and support volatile groups. Participants also suggested having more staff in the field when newer field staff are being trained to better support head field staff and the learning process for new field staff.

Other suggestions included more upfront training on professionalism and boundaries in a therapeutic setting, especially with regards to working with individuals who have experienced trauma and abuse and moving requirements for certifications such as the Wilderness First Responder to earlier in the field staff development process. Training also connects to two other categories that emerged, namely culture and awareness of benefits and attitudes about seeking support from a mental health professional.

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Culture Surrounding Mental Health Support

A few different participants talked about the culture around ending a shift or processing stressful events in the field. One interviewee explained, “You know, I’m not trying to judge it, but umm you know very much at the end of the week staff and management alike are kind of like, ‘Alright, let’s get this meeting done with so we can all go home.’” Most participants discussed the availability of support either from other staff, field supervisors, or program therapists, but a hesitance to use it or confusion about how or when to approach this kind of support because there have not been times set aside for it. One participant also described the difficulty of opening up about what you are struggling with or what clients have brought up for you for fear of what others might think of you. This theme of reluctance for seeking support extended to seeking mental health support from a professional outside the organization as well.

About half of the participants discussed a hesitation towards seeking professional support, despite simultaneously stating that they imagine they would have had benefits had they chosen to do so. For example, one participant explained, “I think for a long time I was kind of like opposed to it. Like I can tough it out. Like I don’t need to go see a therapist. I’m helping kids that need to go see a therapist, I don’t need to go see a therapist myself. Looking back, like kind of reflecting on that, like heck yeah, I could’ve used one.” Other participants expressed never having considered it and still others expressed a lack of financial resources to do so or confusion and ambivalence about attempting to find a therapist to work with. Only two participants expressed not really seeing a need for this kind of support, one whose answer was couched within a discussion about not necessarily being able to afford individual sessions and not really knowing what therapy might have to offer, and the other having tried therapy in the past and finding it to not be helpful. On the other hand, three participants said they had utilized the support of a therapist during their time instructing and found it helpful.

Interestingly, only two field staff were aware of having health insurance that would support them seeking support from a mental health professional, despite all but one participant reporting that they did have insurance. A few participants reported that their company does offer to pay for four sessions of individual therapy per year, or post critical

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incident, but reported not having utilized this support for reasons previously described. In this area, participants suggest that it might be necessary to create a different culture around discussing stressful events. In particular, they suggested structured time for debriefing with management and some sort of regularly scheduled debrief with program therapists.

Program Therapists

When questioned about the support they receive from program therapists most participants replied that this could vary widely from therapist to therapist, but generally seemed to view therapists as a source of support. About half of participants discussed the support they received from therapists as clear guidance and strategies on working with clients in the field, with one participant stating that therapists sometimes helped run student groups.

In addition, 7 of the 9 participants described the support of program therapists simply making time for field staff as helpful, whether this was to discuss student behaviors, incidents, their emotions, or aspects of life completely unrelated to work. A couple of field staff explained the importance of simply asking how they were doing. In addition, a few participants specifically delineated understanding that the program therapists were fundamentally there for the students, and that field staff should not be relying on them for their own therapy, but rather as a general support network of people who understand the difficulty of the work they do. For example, one participant explained:

Even just asking. Even if they know they can't do anything, you know, it's just like the thought that counts and I think that goes huge like it goes a really long way with field staff, like just to have it even considered like, 'Hey I am considering your feelings right now and even though I know I can't do anything I know this is a stressful job for you right now.'

The idea of wanting to feel valued and appreciated as a person came up in almost every interview. Two participants explained that this extended to program therapists and management listening to the field staff's clinical opinions. In addition to support from program therapists, participants also described other ways they attempt to cope with their stress from

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instructing.

Coping with Stress

About half of the participants described the importance of relationships in coping with the stress they experience from work. One individual discussed feeling blessed to have a good partner, good family, and good friends to support them. Another described venting to their roommate and how good it felt to have people compliment them based on descriptions of their job. In fact, 8 of the 9 participants discussed the importance of talking to others to process their experiences, whether this be other staff, friends, family, or professional mental health supports.

In addition, two participants discussed the importance of focusing on the positives of their work, as well as other participants discussed what kept them in their jobs. One participant explained that they stay in the job by focusing on the growth and the small moments they get to be a part of with the following description:

...so that's what I do on my off shift is just like kind of think about the things that I got to see, and I got to witness, and how it made me feel and I got to share that special moment with X amount of people. Even down to something as small as a kid cooking dinner for a bunch of people, and everyone's like, "This is so good!"

Another participant explained the importance of creativity in how they approach the kids and trying to recreate investment both for themselves and clients by doing something different from the cookie cutter routine.

All of the participants described what might be considered play or various aspects of wellness in their descriptions of coping and processing stress. Most touched on spending some of their free time enjoying outdoor activities and exercising, such as hiking, rock climbing, snow sports, or running. One participant touched on the importance of eating well, and another touched on the importance of sleep. Four of the participants also touched on formal mindfulness-based practices such as meditation and yoga. Three of the participants discussed writing or journaling. And three participants discussed finding coping in reading, two in fantasy novels and one in a meditation book. Finally, two field staff discussed the importance of taking time to be alone to cope with their stress, and one field staff

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discussed the importance of separating their work from their time off. The importance of time off was mentioned by two other field staff as well.

Discussion

Limitations

One limitation of this study is its small sample size. While this study holds value in offering a starting point for the discussion of the issue of trauma-related distress in wilderness therapy field staff, it is in no way generalizable to the field at large, due to a small sample size and the fact that the sample was drawn from only six programs. The field is both unified and highly diverse, meaning there may be large variations from program to program. Additionally, the low response rate hampers generalizability because it may indicate response bias. For instance, field staff who are not experiencing distress from their work may have less incentive to complete the surveys, or field staff who are feeling overwhelmed by the stress of work may choose not to fill out surveys.

The data on frequency of incidents experienced must also be interpreted with caution because it is based on self-reports and not corroborated with incident reports or other program data. The wide range in reports of some incidents may be due to the nature of self-report data and a tendency to either over or under-exaggerate some experiences, or it could be due to certain field staff working more with certain client groups. This study did not analyze these types of management and scheduling characteristics, so the range lacks a clear explanation.

Additionally, the lead researcher had a previous working relationship with five participants who both filled out surveys and chose to do a follow-up interview. This may have influenced their answers in some way or the interpretation of their answers. In order to attempt to control this, other members of the research team reviewed all transcripts and coded for themes to ensure a degree of interrater reliability.

Finally, several members of the research team have practice experience in wilderness therapy, which may both enhance and confound the research. Fox et al. (2007) explain, “Being a practitioner researcher is not the same as being an academic researcher. The practitioner approaches and embeds research within practice in ways that an academic researcher cannot” (p. 1). As Fox et al. (2007) explain this type of knowledge and

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situation may allow the researcher to make shortcuts that reach beyond irrelevant data and can also introduce bias especially in research design and interpretation. Fox et al. (2007) highlight the importance of reflexivity and collaboration to navigate and mitigate these concerns. In an effort to minimize any bias arising from the practitioner researcher role, the lead researcher utilized reflective techniques such as journaling and seeking alternative explanations for data between five readings of interview transcripts and drafts of the final research document, all methods recommended by Fox et al. (2007) to minimize bias in this type of research.

Implications for Practice

With these limitations in mind, there are important findings that should be considered from this study. First, while the types of events and their frequency vary greatly, field staff are exposed to a multitude of potentially traumatizing events, such as hearing stories of clients' trauma history and experiencing safety related incidents. Second, the interviews conducted in this study make it clear that staff do experience stress from their job, although the sources differ greatly. Though each participant expressed an investment in clients and a desire to help them grow, many described how the stress of their job and a lack of support led to jaded views, disenchantment, negative beliefs about WT, damage to their own mental health, and poor support for the clients.

Yet, despite these potentially traumatizing events and job-related stress, in the investigation of whether participants may be experiencing some form of post-traumatic stress from their work, data from the TABS and IES-R indicate that about three-fourths of participants are not experiencing any clinical levels of distress, nor disruptions in areas important to maintaining healthy relationships. On the other hand, about one-fourth of participants did score in the range indicating possible clinical levels of distress and possible disruptions in areas important to maintaining healthy relationships with themselves and others. The current research did not investigate individual level characteristics that may account for these differing experiences, such as a history of mental illness, and a trauma history. As such, it is important for future research to consider these individual level constructs to better parse out who may experience distress from the work of a field staff. Similarly, given that

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three quarters of the field staff did not report clinical levels of distress, research should explore what factors, such as self-care, training, mental wellness or other coping mechanisms, may protect field staff from experiencing concerning levels of distress.

Regardless of these individual level characteristics, organizations can play a role in supporting all field staff given the high intensity of their jobs. While many field staff engage in self-care practices, they often expressed hesitancy at seeking out support within their organization or from mental health professionals in order to process their stress, even in organizations who already have supports in place, such as health insurance, incident debriefing or even therapy. Program supervisors and therapists may need to create more formalized systems for evaluation of stress and supporting field staff in order to ensure the resources they do have are being utilized, a practice that is consistent with recommendations made elsewhere (Kanno & Giddings, 2017). This may be especially important because field staff reported personal wellness as particularly important in dealing with stress, a finding that is consistent with work by Williams et al. (2012).

Other practices that may be particularly important are reorganizing some of the training protocols for staff and rethinking when staff may be asked to get certain certifications such as Wilderness First Responder training. Additionally, adding more staff, and more experienced staff will help to alleviate stress. Field staff also seem to draw heavily on their relationships with other staff members, so programs may seek to increase these relationships through out of work activities with staff or having more time when staff can discuss their experiences in training and debriefing, a practice advocated for elsewhere as well (Kirk, 2013).

Conclusion

While remembering the limitations to generalizability, this study reveals field staff experience potentially traumatic events in the field, as well as reporting job-related stress with varying frequency and origins. While many field staff reveal no clinical levels of distress from these experiences, some staff do experience trauma-related distress, rather than what has previously been viewed as a more generic form of burnout. These findings merit prioritizing self-care, peer and administrative

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support, and mental healthcare for staff in these settings.

These results suggest a need for further and more extensive study in the realm of trauma-related distress for wilderness therapy field staff. Future research in this area could seek to better assess stress among WT field staff, as well as creating appropriate metrics for programs to better identify field staff who may need extra support. Research could also examine field staff characteristics and how these impact experiences of stress due to their work. Longitudinal studies could also address how field staff distress impacts client outcomes and conduct a cost benefit analysis of field staff turnover. Finally, research should seek to examine the impacts of various initiatives taken by programs to address trauma-related stress and turnover in the field staff role in order to enhance the wellbeing of both staff and participants.

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