

The dissociative mechanism of change in wilderness and adventure therapy; Psychological harm and possible malpractice

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Wilderness and adventure therapy (WT, AT) have employed cognitive or adaptive dissonance and involuntary treatment for decades. Cognitive dissonance occurs when people are faced with situations that do not confirm their expectations. Past WT participants have protested that involuntary, inescapable and harsh conditions harmed them through PTSD and dissociation. In this study, we compare dissonance and dissociation using a critical realist and argumentative research process using publicly available data. We argue that dissociation is a response, recorded both in the design of some WT practices and in participant statements and is often mistaken for dissonance. Deliberate use of forced cognitive dissonance during involuntary treatments align with the conditions that may cause dissociation. Therefore, planning to enforce cognitive dissonance during coercive WT or AT is likely to be harmful and, knowing of this potential, may be regarded as malpractice.

Before Reading

This article presents a comprehensive critique of coercive adventure therapy, concentrating on wilderness therapy. Those involved in the field, including practitioners, academics, and parents, may feel remorse through their role in implementing or supporting these practices. We contend that a misunderstanding of a well-known mechanism of change, having been employed coercively, has unintentionally harmed AT and WT participants. Two authors (WD and GP) have personal experience as adventure therapy providers, also share this sentiment and propose that the most constructive approach is to embrace change and advocate for more compassionate practices. Two authors (SD and JM) are past participants, preferring the term survivors of residential treatment and WT, one an artist and the other a published researcher. The final two authors (CK and LD) are experienced clinicians working exclusively with complex trauma and dissociation, both having also contributed to treatment guidelines. Readers should understand that this team came together to ensure that the material presented is accurate and fair, with the aim that harmful practices be understood and ceased.

Background

“By improving the ability to recognise flawed justifications and understanding how intentions can have moral boundaries a person will have the ability to apply their rational mind to preventing unintentionally creating bad outcomes rather than justifying unethical actions” (Ping, 2019, no pagination)

Critical realism (Houston, 2010) research seeks to uncover the often hidden entities and mechanisms involved in empirical outcomes, and therefore illuminate where moral boundaries have been violated. In this article, critical realism is applied to examine the behavioural changes achieved in wilderness therapy programs. These programs have faced substantial criticism from past participants, who tend to prefer being known as “survivors” (JM and SD), for employing questionable methods in the pursuit of therapeutic changes. Rather than criticising, our aim is to be critical as we explore causal mechanisms that may shed new light on outdoor therapy, and in doing so help practitioners make decisions in the best interest of participants.

Wilderness therapy (WT) broadly refers to therapeutic excursions into areas of natural beauty, varying in remoteness and locality (Fernee et al., 2017). In the USA, WT is often conflated with adventure therapy (e.g. Tucker et al., 2022). However, the USA stands out with a group of WT businesses operating on a specific model, detailed shortly, centred around involuntary behaviour change (Harper et al., 2021). Throughout this article, WT refers exclusively to this USA model, frequently referred to as outdoor behavioral healthcare (OBH). Complaints levelled at these coercive WT programs involve all types of such programs, regardless of accreditations, licensing, certification, memberships, size or ownership. We appreciate attempts from industry centres, such as the Association for Experiential Education, the Outdoor Behavioral Healthcare Center (now renamed the Outdoor Research Collective; ORCs), and the Therapeutic Adventure Professionals Group, to provide accreditation to therapeutic services, though all licensed clinicians are already

members of professional associations with codes of ethics and practice guidelines. In this case, we privilege disciplinary professional standards and human rights above standards created by and for coercive WT and the troubled teen industry in the United States. We acknowledge that WT is a broad field and that there are programs that describe themselves as WT, and others with similar design, that do not use coercion. For example, we note that the Mountain Center and BaMidbar Therapy have both referred to themselves as WT programs and that both are not coercive while yet having been members of collectives that include coercive WT organisations. Our criticism is not levelled at those WT programs or at others which similarly exclude coercion, although we have no authority to say who is doing what.

Adventure therapy (AT) is a more comprehensive term encompassing a wide range of adventuring for therapeutic benefit. Worldwide and across the USA, AT varies in duration, location, activities, and processes, and is generally enthusiastically received, particularly by adolescents. Some theorise that adventure is developmentally appropriate for this age group (Harper, 2017; Pryor et al., 2018). While we acknowledge that AT (and Outdoor Education) is often conducted with various levels or types of coercive practice, this is not systematic in the way it appears to be in WT, and we will use “AT” to encompass all voluntary uses of therapeutic adventure. Further exploration of the divergence between coercive and non-coercive practice is discussed in detail by Pringle (2024).

Our primary purpose is to reconcile the criticisms of coercive WT survivors (Mater, 2022; Moniuszko & Arnowitz, 2024) with the empirical evidence recorded by WT researchers (Gass et al., 2019). That is; to understand how participant complaints are not evident in researchers’ observations. There appear to be hidden factors not evident in the current empirical material that might explain these polarised perspectives. By applying critical realism to the knowledge base regarding coercive WT mechanisms of change, we aim to address this dilemma, which significantly impacts public perceptions of AT globally (see

Pringle, 2024; Moniuszko & Arnowitz; 2024; Okoren, 2022).

Exploring Wilderness Therapy

To provide the necessary context for understanding current perspectives on coercive WT efficacy, a brief historical overview, relevant to the topic, may be helpful for the reader. While no one narrative dominates the therapeutic use of narrative, coercive WT seems to have originated, as a ~~specific~~ mental health intervention for adolescents in the USA in the 1980's. Its roots can be traced to a survival course at Brigham Young University (BYU), the Church of Jesus Christ of Latter-day Saints university in Utah (White, 2011). Graduates and staff from BYU founded or developed several WT programs, such as the Anasazi Foundation, which also had a strong focus on survival skills. In these programs, youth were tasked with creating packs and tents from tarpaulins, generating fire through friction for cooking and warmth, carving wooden spoons, and using tin cans for cooking, eating, and personal hygiene (White, 2017). Additionally, participants engaged in strenuous hikes through remote areas, often exposed to harsh weather conditions. After a series of fatalities, and the recent fatality of a 12-year-old ruled a homicide in February 2024 (Dobud, Maldonado, & Pringle, 2024), and numerous complaints, physical safety was improved, in accordance with government mandates in 2007 (Russell et al., 2008).

A ~~central~~ major concern for this article is that about 65% (Combs, 2015) of the adolescents in these coercive WT programs are involuntarily admitted and prevented from leaving (Dobud, 2021; Harper et al., 2021). While high numbers of involuntary participants are unique to coercive WT compared to AT, there are many other shared common elements and confusion of terminology for practitioners, service users, and researchers stressing the importance to define our terms clearly.

Exploring Mechanisms of Change

Both WT and AT appear to place emphasis on *personal responsibility* (Pryor et al., 2018; Tucker et al., 2016). Personal responsibility is a concept closely tied to choice theory (Glasser, 1999), reality therapy (Glasser, 1990) and cognitive dissonance theory (Festinger, 1957). These terms are common in AT (Gargano & Turcotte, 2019) and WT (Combs et al., 2016). At its core, personal responsibility involves taking ownership of one's position in the world while not apportioning blame, or excuses for inaction, as explained by Glasser (1999) with the statement; "if we are willing to suffer the alternative [such as] punishment or death – no-one can make us do anything we don't want to do" (p. 332). This seems to be extended in coercive WT to include that individuals are expected to be entirely responsible for their attitude and situation, regardless of any oppressive social or systemic conditions over which they have no control.

The uncompromising pursuit of personal responsibility was described by one coercive WT survivor; "The therapist told me that I was mistaken, my father (who [the therapist] had never met) was never abusive. Instead, it was me that had all of the problems" (M. anonymous, 2020). The unbending pursuit of personal responsibility, for situations outside the individual's ability to control, appears frequently in survivor accounts (Rubino, 2024).

Cognitive or adaptive dissonance refers to a situation in which a person encounters information that contradicts their existing beliefs or expectations (Cooper, 2019; Festinger, 1957). Many AT programs use dissonance to target *schemas*, or one's fundamental beliefs about reality (Gargano & Turcotte, 2019). However, dissonant change in involuntary situations often has a weak impact as people may simply reject the relevance of the situation to their worldview or schemas (M. Brown, 2008). The change may only occur based on the involuntary situation the person is held in. Festinger (1957) explained that schema change through forced dissonance requires significant reinforcement if it is to endure.

When WT design centres on involuntary participation, dissonance reinforcement is achieved by increasing perceived stress (Priest, 2023a) and by prolonging the WT duration (White, 2019). Coercive WT in the USA is also often followed by months-long stays in residential treatment centres for further reinforcement, a practice common to America's troubled teen industry (Porter, 2023). Rather than creating new and potentially helpful schemas, in these long stay processes confirmation of preexisting maladaptive schemas may occur. It is being increasingly reported that children from coercive or overly strict families later experience their needs being unmet by caregivers (Bortolon et al., 2017; Chuck & Kingkade, 2024; Moniuszko & Arnowitz, 2024) in these inescapable programs, as explained by one survivor;

I was terrified... I just remember feeling so helpless. It's like you're living in this existence, but you don't have free will, you don't have autonomy, and they make that very clear to you... You have no freedom. You have no choice (Moniuszko & Arnowitz, 2024).

This has progressed to the extent of a Feb 2024 fatality due to a mixture of coercion, improvised restraint equipment, and denial of care (Chuck & Kinkade, 2024), ultimately ruled as homicide (Whitehead & Emert, 2024). Even without this tragedy, forced schema change in the absence of great care and safety is particularly concerning. Dissonance is effective for schema change, yet less so when forced onto people, requiring coercive WT programs to reinforce the weak effect by intentionally increasing stress and prolonging the experience.

Although dissonance is recognised in AT literature as a mechanism of therapeutic change, it is approached with caution (M. Brown, 2008; Gabrielsen et al., 2019). Typically, that caution involves voluntary participation and participants' genuine ability to consent to and reject certain outdoor or therapeutic activities (Dobud & Natynczuk, 2023; Herbert,

1996). Indeed, the use of dissonance in therapy has long been known to have greater impact when people freely choose how they interpret a situation (Festinger, 1957). In AT, the term *challenge by choice* refers to this uncoerced participation (Herbert, 1996) and is rooted in the understanding that coercive dissonance is unethical and ineffective (Dobud & Natynczuk, 2022).

Exploring the Potential for Harm

Extensive criticism has been directed towards WT for the use of involuntary admission (Magnuson et al., 2022) and coercive treatment (Pringle et al., 2023). Involuntary admission can be violent with the young person believing they are being abducted, even possibly to be sex-trafficked (Dobud, 2021; Gass et al, 2022). Although dissonance is proposed as the central mechanism across many forms of AT (Newes & Bendoroff, 2004; Priest, 2023), coercive WT routinely forces dissonance as a primary mechanism of change (Priest & Gass, 2017) requiring several reinforcers such as; (a) surviving isolated natural environments, (b) exacting performance of tasks, (c) promotion through phases/levels, (d) the use of culturally appropriated spirituality, such as drumming and First Nations' ceremonies, and (d) lengthening the program duration to three months (White, 2019). These practices dating back as far as the 1980's (White, 2011) seem to continue today (Mater, 2022; Moniuszko & Arnowitz, 2024; Okoren, 2022).

The reinforcers described above seem particularly coercive, and survivors share experiences about inadequate hygiene, ill-fitting clothing like boots and underwear causing chaff and blisters, restrictive diet, and restrictive practices such as being tied with cords to staff and being wrapped in tarpaulins to prevent escape at night (Chuck & Kingkade, 2024). Additionally, there are frequent breaches of confidentiality when participants are encouraged to criticise each other in the pursuit of direct daily feedback (Dobud, 2021; Mater, 2022; Pringle, 2023; Stull, 2020). One of us (JM) described their experience in a podcast:

we had no basic comforts there and there was this attitude among the staff of ... if you wanted something that wasn't necessary to literally keep you physically alive, then you were a spoiled brat and you were being dramatic. I was someone who was not allowed to carve a spoon ... because I was a self-harm risk. So, they made me just find a stick on the ground and brush off the dirt ... I was just constantly eating dirt ... if you were successful in making a flame, your reward was that the therapist would bring you a bagged salad from the grocery store ... we were so desperate for fresh vegetables that we were working our asses off to try to make these fires. And I just remembered the lettuce tasting so fresh and good, the one or two times that I was able to make a fire. (INSERT REFERENCE, timestamp 10.10)

Descriptions of these practices and experiences are rare in the outcome literature.

However, some WT researchers and programs deserve credit for their efforts to address these concerns in tangible ways (Norton et al., 2022; Wingate Wilderness Therapy, 2023). The reinforcement of dissonance through constant coercion, threat, and diminishment of dignity seems to be justified by labelling survivors as dangerous (Golightley, 2020) and by framing the reinforcement practices as valuable learning situations. One of us (SD) vividly recalls “cult-like shaming [and felt] broken by the pain of exposure and hard labor.” These probable abuses form the backdrop for the focus of this article, and we will not delve deeper into them as our intention is to draw other parallels.

Our Central Concern

The International Society for the Study of Trauma and Dissociation (ISSTD) is the only multidisciplinary international professional society dedicated to complex trauma and its most severe form; dissociation. Their description of complex trauma (CT) bears disturbing similarities with the coercive form of WT as listed in the previous section. In their 2020 fact sheet, CT is described as experiences that are; (1) repeated or ongoing, (2) difficult or impossible to escape from, (3) occur[ing] within a personal relationship (4) begin in childhood, affecting a child’s development, and (5) covered up, kept secret or denied. The

ISSTD's portrayal of harm caused by these adverse childhood experiences suggests that coercive WT's mechanism of change might be less about choices prompted by dissonance and more about overwhelming people into submission.

Members of the ISSTD have studied, and have successfully treated, dissociation for decades. In the ISSTD's fact sheets (2023b) *dissociation* is defined as, when a person, "disconnects awareness from experience, feeling, sensation, and/or the self. Children, even more than adults, may dissociate when they are overwhelmed by fear or pain and cannot escape" (p. 4). Unlike dissonance, which involves making a choice between one's own competing explanations of an experience, dissociation is an escape of the mind when no other escape is possible. While there may be various interpretations and definitions of dissociation, the ISSTD's definition is used for our analysis.

Comparisons between dissonance and dissociation are few because they represent distinct mechanisms of change. Reuban and Parish (2022) found that people with autism, often facing dismissive or hostile situations, may be more susceptible and report high levels of dissociation due to the dissonance between their reality and that of neurotypical people. These hypotheses suggest that dissociation might diminish the dissonant conflict between experiences of self-in-the-world and self-in-WT. That is, the coerced WT experience seems so unlike the normal home environment that dissociation, separating the coercive WT experience as unrelated to normal life, seems inevitable. In early treatments for war-related PTSD and amnesia, this clash of realities would increase dissociation and deepen amnesia, or exacerbate the overt symptoms (P. Brown et al., 1999). Coercive and threatening experiences are effective in training soldiers for war and are not used when returning these soldiers to peacetime families. Using coercion and threat to improve the normal lives of young WT participants may well cause them to dissociate the reality of WT from the reality of home, as seen in war-caused PTSD.

Some of the common practices of coercive WT appear to cause overwhelming threat and to separate the WT reality from previous behaviour. When a coercive WT participants' behaviour becomes socially unacceptable, they may be punished (Porter, 2023), dismissed by “ghosting”, where everyone pretends to neither see or hear them (as recounted by WD), or removed for solo experiences, sometimes called the “Mask of Black” (K. R. Rosen, 2021), until compliance is achieved. While other psychotherapy approaches may operate on some mechanism of cognitive dissonance, adding coercive, and involuntary components to WT programming restrict client choice. We raise concerns that dissonance may not always be the safe mechanism of change as promoted in the WT literature, especially in hoping to reconcile claims of superior outcomes in WT with clients experiencing harm (Harper et al., 2024).

Methods

As we are examining an ethical issue rather than an efficacy issue, and there is plentiful information, we have collected selective material representing the main issue, rather than a systematic review, instead using an “argumentative approach” (Fischer & Gottweis, 2012, p. 2; Murungi & Hirschheim, 2022). We sought items in the scholarly and non-peer reviewed, or grey literature, to explore the main concerns and examined these using a critical realist lens. Dissonance and dissociation are well known and researched and we compare them in the context of the coercive WT application of dissonance and argue that one is often being mistaken for the other.

Much of the WT efficacy evidence employs a positivist approach (Creswell & Poth, 2018) and based on the idea that there is a single reality that might be understood if pinned down by statistics and researchers who avoid bias by direct engagement with participants. Such approaches tend to be quantitative and deductive while other methodologies employ a thick and rich description of phenomena and experiences and tend to be inductive (Creswell & Poth, 2018). The critical realism methodological approach is concerned with mechanisms

of change, and involves *retroduction*, the development of hypotheses to identify mechanisms and the role of agency, time and context in events (Eastwood et al., 2014; Houston, 2010).

Ontologically, the critical realist examines the *empirical* world as observable, an *actual* world of events caused by mechanisms of change that may or may not be observed and a *real* world of structures that cause mechanisms of change to be activated (Haigh et al., 2019). Mechanisms can interact at the real and actual level. Observer(s) might remain unaware of what is happening at the empirical level. By investigating and theorising about the causal mechanisms of events (Eastwood et al., 2014), we might identify entities and influences, and thus move the actual world into the empirical world.

As mentioned earlier, we found no shortage of information. Noting the tendency of institutions and individuals to dispute, attack, and claim victimhood (Freyd, 1997) when the practice detail of coercive WT is described we have used only publicly available information, verified by the experience of our survivor co-authors (SD and JM.) We have not collected or manipulated any original information in the presentation of evidence for this article.

Evidence

In this section, we begin by presenting the (1) *empirical evidence* supporting the perspective that cognitive/adaptive dissonance is the mechanism of change for which WT programs create the required conditions. Next, we examine the evidence regarding the (2) *actual* impact upon the group of participants who refer to themselves as survivors of WT. Lastly, we analyse the evidence for (3) *real* coercive WT practices that activate causal mechanisms which explain the actual reality. The evidence is summarised in Table 1.

[TABLE 1 GOES ABOUT HERE]

Empirical Evidence

The empirical evidence shows that forced cognitive dissonance has been an integral

part of coercive WT programs since the 1980s. In a podcast, Mitchell shared his awareness of parts of self, noting that “the part that wants to use [drugs] goes to sleep during the program” (White & Mitchel, 2019, Timestamp 20.59). This appears indicative of dissociation, which is inherently about parts of self. Mitchell further explained that they analysed the moment of change “and broke it down almost to the day of breakthroughs that happened, it was very systematic” (27.53). He understood that during solo experiences, when participants camped for a day or days totally alone, that “the therapeutic pieces were what happened ... in their relationships, and how the experience was structured and how it's perceived” (28.26). He elaborated further, about disorienting threats that prompted bonding with field guides, and the host interjected in agreement:

(Mitchell) a lot of what happens in wilderness therapy is you're taking urban kids and putting them in a very threatening environment. (White) [a] disorienting threat.
 (Mitchell) It's disorienting, and they feel threatened, and that's part of the magic, is because of that threat they bond with the instructors and the people who are there (White) 'cause they're scared when they're threatened they turn, yeah. (Mitchell) There is nowhere else. It's part of the isolation'. (31.23)

Mitchell also described further coercion through realistic, simulated, emergency scenarios where young participants believed that accident victims might actually die if they did not adequately perform rescue tasks. In another phase later, the survivors experienced culturally appropriated fire ceremonies, drumming and chanting to reinforce these deliberately cultivated parts of self. This approach was not unusual and was soon validated by researchers.

Gass (1993) described cognitive dissonance as a foundation for AT, stating that “change always disrupts an equilibrium” (p. 145). Consequently, participants adopt new behaviours that make more sense than old and unhealthy behaviours. However, this choice is prescribed and forced and the “person or factors producing change cannot rest and they (or it)

must continue to be implemented . . . to assure that change is . . . maintained”, and that “change is rarely purely voluntary” (p. 145). Priest and Gass (1997) later emphasised that adventure professionals structure risk in a manner that causes participants to “perceive it as being enormously high, while in actuality it is much lower than perceived” (p. 17). These authors asserted the necessity of coercion and forced dissonance.

Priest and Gass have maintained this view for decades, stating in their adventure leadership textbook that; “What you must implement as a leader are adaptive dissonance situations” (Priest & Gass, 2005, p. 151). Other researchers like Newes and Bandoroff (2004) appeared to support this view:

experiential learning theory is based on the belief that learning is enhanced when individuals are placed outside of their comfort zones and into a state of dissonance. Learning is then assumed to occur through the necessary changes required to achieve personal equilibrium [(i.e., modern dissonance theory), Festinger, 1957] (p.2).

Newes and Bandoroff also reinforced that “high levels of emotional risk are encouraged [because] perceived risk is thought to create tension and disequilibrium within the individual, ultimately leading the client to a position of choice (i.e., dissonance theory)” and that, “it is the perceived physical risk that is a cornerstone of AT” (pp. 16-17). These claims of empirical reality spanning 1993, 1997, 2004, 2005 and 2019 maintain that threat causes desirable behavioural and attitudinal choices.

Cognitive dissonance remains in use to explain mechanisms of change in AT and coercive WT. The literature shows the theory being used to explain therapeutic change in AT up to within a few months prior to this manuscripts review (Flom, 2022; Gabrielsen et al., 2019; Gargano & Turcotte, 2019; Nicholls, 2024; Priest, 2023a, 2023b; Pringle, 2023; Pryor et al., 2023). The empirical evidence seems clear, that cognitive dissonance is a theory of change that has a decades-long use in AT and promoted by Gass (1993), Priest and Gass

(1997) and Newes and Bendoroff (2004) to justify heavily coercive practice as, “that process of stepping through the stress into the treatment that is absolutely necessary to sometimes save their lives” (White & Sawyer, 2022, timestamp: 00.25.11).

Actual Evidence

A reality television series about coercive WT ran annually from 2005-2007. Brat Camp showcased Redcliff Ascent, Aspen Achievement Academy and Turnabout Ranch which was a stationary version of WT. Although a sensationalised television series, which inappropriately used narration and subtitles that belittled WT participants, we draw attention to the actual footage of practitioner’s treatment and response to the distress of young participants. In the first episode of the first series (<https://www.youtube.com/watch?v=Aebo0O6OEyM>) a Redcliff Ascent director is seen laughing while explaining that when young people claim to hear voices the staff dismiss it as “amusing” and “we don’t buy it” (16.30). Young participants were unable to even brush their teeth without permission providing evidence of the level of coercive control. All personal items, including jewellery, were removed, very basic equipment was issued, and they were blindfolded during the journey to the campsite “to prevent runaways” (31.20). By timestamp 35.45, the first significant behavioural change was announced as a success, although sudden changes could also be a dissociative response (ISSTD, 2016).

Practitioners described bizarre participant behaviour which they dismissed as “excellent act[ing]” (42.15) and shortly after, that participant urinated next to the therapist during his introductory meeting. By episode two (<https://www.youtube.com/watch?v=0IChA22Zz84>), this behaviour disappeared, possibly confirming Mitchell’s (2019) belief that parts of the self “go to sleep” during WT. In episode three (<https://www.youtube.com/watch?v=VNZ9yJbAFRo>), another young participant describes past sudden and uncontrollable violence with periods of amnesia, the latter of

which are frequent dissociative symptoms. These admissions were responded to with staff insistence on personal responsibility, behavioural choice, and cognitive control (14.30 & 20.05). Participants were punished for physically helping peers (32.30), reinforcing the message that each person was alone in the world, and personally responsible for everything in their world.

In 2014, seven years after the Brat Camp series ended, Mater, a former WT survivor turned researcher, shared their experience of dissociation during their coercive WT program at age 13. Mater's oral history research included a photograph of them staring into space. Their research included accounts from survivors who attended the same residential treatment facility after most of them completed a variety of WT programs. In other accounts, a WT survivor recounted that, "I was stripped of my identity and quickly learned how to dissociate through it, which I honestly think helped preserve some of my stability" (Andrews, 2022, Question 16). This aligns with Dobud's (2020) qualitative research, where a WT survivor stated, "They literally stripped me of my individuality" (p. 174). Furthermore, survivor accounts recall specific ritualised practices that suggest dissociative programming:

They made us do this 'death to self ritual' where they blind folded us and took us to an empty field where there was a dug out grave. They made us lay in it one at a time. We had to write our own eulogies and then they would read them to us while we were in the grave. Next, they would come and stand over us saying weird things, pretending to be our parents and relatives (anonymous G., 2020).

Survivors often mention dissociation, sometimes through the use of ritual and cult-like practices, further supporting early WT design principles described earlier by White and Mitchell (2019).

Amnesia is often described by coercive WT survivors, and is a common dissociative response (Kate, 2018). Coercive WT survivor Rensin (2016) could not recall periods of their WT experience, including the last day when they were discharged, despite having

photographs of the process. Paris Hilton (Dean, 2020) also forgot about her coercive WT experiences for over 20 years, only recalling them when filming her biography. A friend of Hilton's, also a survivor, noted that survivors often "wake up" (Dean, 2020, Timestamp 1.22.38) 15 to 20 years after their WT experience, a pattern repeated in other survivor interviews (Stull, 2020). Kenneth Rosen (2021), another survivor author, described a decade of "hazy memory following his last program" (p. 203). One of us (JM), "only survived by dissociating. Nothing ever felt right again. It seems clear to me that dissociation and repatterning is the goal of these programs." Surprisingly, the dissociative impact of coercive WT's dissonance practices seem well-known among survivors, yet WT research scientists appear to have overlooked this possibility.

Pringle (2024) explains that supporters and providers of coercive WT have often blamed bad press for the criticisms listed here as Actual Evidence:

Advocates of OBHC and WT often deny these claims as exaggerated (Blue Ridge Therapeutic Wilderness, 2022; Reedy, 2022), attack the credibility of the accuser (Evoke Therapy Programs, 2023; Wingate Wilderness Therapy, 2023) and argue that these problems are no longer occurring or limited to a few dissatisfied participants (Aspiro Adventure Therapy, 2023). (p. 8)

To the contrary, criticism of coercive WT is voluminous and wide-ranging beyond social media, as evidenced by two mainstream media articles by Fanlo (2022) and Okoren (2022) with each drawing international attention to coercive WT. An Open Letter (Dobud et al., (2024) critical of coercive WT has been signed by over 200 people including several human rights lawyers, complex trauma experts, and outdoor therapies academics. In academia, Harper (2023) reflected on the history of WT criticism, Pringle (2023) compared coercive WT with complex trauma and human rights principles, and Jeffery et al., (2023) called on the AT field to; "Develop ways of opening conversations about the hard things, and

about topics that might be controversial or sensitive.” These three papers were all derived from the 2022 International Adventure Therapy Conference where criticism of coercive WT was widely discussed. Indeed, an extra out-of-session discussion was added to the conference for all delegates to consider coercion in AT. Golightley’s (2023) doctoral thesis details coercive WT practice and links them to the *Troubled Teen Industry* of residential treatment centers with comparable practices. Substantial and ongoing criticism of coercive WT practices is far more than mere bad press or complaints by disgruntled past participants.

Real Evidence

Festinger (1957) and Herbert (1996) were quite clear that forced dissonance had limited impact, with Herbert highlighting the ethical concerns of violating AT’s “challenge by choice” principle (p. 5). Festinger explored forced dissonance in detail, dedicating 39 pages to this in his foundational book, noting that defences may prevent, “the new cognition from ever being fully established” (p. 137). He proposed that people might reduce dissonance, such as identifying with others’ beliefs, converting them to one’s view or dismissing the other as incomparable. These strategies pose challenges for coercive WT programs.

Festinger (1957) specified that reward and punishment influence dissonance, and he concludes, that such dissonance is harmful, “if reward was promised for compliance, or if punishment was threatened for noncompliance, at least some persons would exhibit forced compliance and, hence, suffer dissonance” (pp. 89-90). We note that he did not use the word “dissociate” in his book, perhaps as the word became more common after diagnostic re-naming in the 1994 version of the DSM. We surmise that by “suffer dissonance” he meant harmful dissonance, which we name as dissociation. Being a behavioural health approach, coercive WT seems wedded to reward and punishment, such as gaining token equipment when attaining levels/phases/stages or punished by being denied a hot meal when unable to

light a fire by friction, often described as a natural consequence.

Generally involving isolation from the outside world for long periods, coercive WT programs demand high levels of perceived threat and reduced social support options. As explained on White's (2019) podcast, the staff are the only support figures available when the young participants' sense of self collapses due to high levels of emotional risk and threat. This likelihood partially explains why the coercive WT general conditions of isolation, control, and threat are important to the mechanism of change.

The general coercive WT conditions correspond to the features of complex trauma, as previously described, and share similarities with conditions that cause dissociation.

Dissociation is a coping mechanism when children are “overwhelmed by fear and...cannot escape” (ISSTD, 2023, p. 4). Coercive WT involves overwhelming young people in an inescapable program to create forced cognitive dissonance. The ISSTD (2023) further explains that “children may use dissociation to disconnect from and block out what is happening to them, what they are feeling, what they are thinking, who is causing the harm or pain, and what they are sensing in order to cope” (p. 4). This resembles survivor testimony and correlates with the foundational coercive WT design (Gass, 1993; White, 2019).

Dissociation and dissonance, although different mechanisms, appear linked when dissonance is forced, as it is in coercive WT programs.

Gass's (1993) book included a chapter by Webb describing dissociation as a defence mechanism triggered by “fear and anxiety that may accompany adventure activities” (p. 98). Yet in the same book, Nadler (1993) asserted that “disequilibrium [leading to dissonance] must be present for change to occur in adventure experiences” (p. 59). Nadler then described dissonance in the same way that Kate et al. (2023) described causes of dissociation, and repeated here:

Dissociation is likely when the individual has a chronic sense of feeling unsafe, which may be due to unpredictable parental behaviour, feeling powerless, having no control over one's life, experiencing unfairness, living in an environment of secrecy, and being isolated from the outside world, often in an attempt to hide the dysfunction that exists behind the closed doors. (p. 10)

Nadler illustrated the process of changing their “sense of self to lessen emotional discomfort” (p. 62) and described breakthrough as un-safe and discomfoting, as shown in Figure 1 (p. 58). Nadler's illustration of the process of changing one's sense of self to alleviate emotional discomfort closely resembles the description of dissociation causation by Kate et al. (2023).

[FIGURE 1 GOES ABOUT HERE]

Nadler (1993) emphasised that the breakthrough experiences, illustrated in Figure 1, require practitioners to deliberately increase levels of anxiety, frustration, disequilibrium, the perception of risk, and significant effort to induce dissonance. It is important to note that Nadler's requirements for dissonance creation stand in stark contrast to the recommended phased treatment for CT, in which safety and stability is phase 1 and is essential throughout treatment (Kezelman & Stavropoulos, 2012).

Notably, Nadler's dissonance conditions, reiterated by Priest and Gass (1997, 2017), Priest (2023), and Newes and Bendoroff (2004) might illustrate a long commitment to forcing a dissonance mechanism of change upon involuntary participants, resembling the mechanisms for dissociation. These include a lengthy inescapable situation controlled by caregivers, that feels significantly unsafe and unpredictable while isolated from the wider world thereby shrouding the experience in secrecy and ritual (ISSTD, 2016, 2020; Kate et al., 2023).

Critical Analysis

Cognitive or adaptive dissonance is a well-known mechanism for schema or

behavioural change, and is not inherently harmful. Glasser (1990) and Festinger (1957) never intended that coercion be used to achieve dissonance. While both authors described forced compliance and dissonance, they mainly emphasised the limited strength of involuntary change, necessitating extraordinary reinforcement processes if the change were to be maintained. When dissonance is forced and reinforced in ways that may also cause or trigger dissociation, the coercive WT dissonance mechanism becomes problematic, unsafe, and unethical. Coercive WT often seems to rely heavily on involuntary and coercive practices, employing overwhelming threat to achieve cognitive dissonance as the primary means for creating enduring change in young people with diverse concerns. As shown, this assertion is boldly made in AT textbooks and it seems to be an unquestioned core for coercive WT programs.

Newes and Bandoroff (2004) cited support for dissonance from Herbert (1996), yet they omitted that Herbert specifically excluded coercion from the ethical application of dissonance. More recently, proponents of forced dissonance in coercive WT have referred to arguments from the transtheoretical approach, justifying coercion as “tough love” and the least-worst but acceptable process (Hardy, 2022, p. 63). The transtheoretical model (Prochaska, 2020), developed for treating addiction, proposes that some coercion may be needed to move from pre-contemplation, to contemplation and then readiness to change, due to the powerful hold that addiction has on impulse control. “Tough love” (Gutierrez & Czerny, 2018, p. 206) coercion is justified to avoid further harm. However, this model was never intended for use in WT settings, and imposing it as a justification for forced dissonance seems misplaced. The WT citations justifying coercion exclude the cautions of original dissonance authors.

Proponents of coercive WT frequently claim that the young person would otherwise die or be sent to prison and that WT is the only other practical option (White, 2021). The

National Association for Therapeutic Schools and Programs (NATSAP) recently solicited for support with a suggested form letter that included the statement that; “This program saved my child’s life” (NATSAP, 2022). This emotive claim lacks support in basic USA statistics (Stull, 2020). The belief that coercive cognitive dissonance is an unfortunate yet essential mechanism in coercive WT seems contrived.

The risks associated with pursuing cognitive or adaptive dissonance lie in the potential for the change to be assumed as dissonance, while actually being dissociative. This potential seems to have been overlooked by researchers. Outdoor therapy researchers are encouraged to not only collect efficacy data, but to collect data on adverse effects, as recommended by Rosa et al. (2023). This should include data related to physical safety, human rights, and possible dissociation caused by the program. Research should focus first and foremost on privileging participant voice and improving outdoor therapy outcomes and experiences.

We propose that the real entity that produces the dissociative mechanism of change (harm) is the design of coercive WT; the deliberately threatening and coercive situation. Without participant voices, which are uncommon in WT research, there has been no advocacy for risk assessments of possible harm due to treatment. The term dissociative mechanism of change/harm was developed by (GP) and was first mentioned in his doctoral research in his 2023 thesis. We are concerned about the risks to the life-course and sense of self from these involuntary situations that employ a forced dissonance/dissociative mechanism of change (harm).

K.R. Rosen (2021) documents a “parade of those who died after the programs” (p. 203) being unable to live happy and meaningful lives. Admittedly, some survivors may have been vulnerable to dissociation prior to WT due to adverse childhood experiences (ACE’s), and their responses to these adversities may have led to their enrolment. Yet, some claim

problems due to the program itself, particularly the coercive transport to and inescapable nature of WT (Andrews, 2022). If responses to ACE's did result in admission to coercive WT then further adversity as part of the program design seems unlikely to be helpful. Moreover, some find that the coercive WT enforced schemas do not align with the outside world (Porter, 2023). These experiences have been recounted repeatedly on social media by survivors, including the two of us with lived experience as coercive WT survivors (SD and JM). The only counter to this avalanche of testimony is longitudinal research of the weak efficacy for coercive WT (Tucker et al., 2022), although such research is admittedly difficult to conduct. For example, one project had less than 10% complete data sets at 18 months (Combs et al., 2016). There remains insufficient evidence to support claims that coercive WT is the life-saving solution as often claimed. Survivor testimony of the harms they experienced might be more accurate.

The degree of harm directly resulting from coercive WT programs cannot be dismissed as “exceptional” (Reedy, 2022) or as “myths” (Whitworth, 2023). Many survivors describe ongoing PTSD (Dobud, 2020; Gibbons, 2023) along with years of anxiety, sleep, relationship and substance abuse issues (Andrews, 2022; Dean, 2020; Mater, 2022). Survivors' accounts, in the grey literature, are evocative and hardly require scholarly interpretation. One of us, a survivor-artist (SD), explains that:

wilderness therapy wrecks lives and causes endlessly recurring trauma that makes both daily life and formerly loved activities and environments sources of permanent torment...it fixes nothing...it breaks one's ability to think of oneself as free...it breaks one's ability to believe their soul is inviolate...it is a rape of the human mind (INSERT AUTHOR NAME, 2023).

In Figure 2, they (SD), previously an enthusiastic biology student, illustrates how their coercive WT-based trauma has now made them unable to connect with the natural environment. It seems spurious to protest that the complaints of survivors are not evidenced.

We might simply count the number of complaints and measure the depths of despair if we require quantitative indications.

[FIGURE 2 GOES HERE]

Regarding risks to the sense of self, the mechanism of change raises significant concerns. Cognitive choice, the mechanism of dissonance, may be beyond the person's capacity due to cognitive deterioration during chronic and acute stress (Kozłowska et al., 2015). Genuine choice requires opportunities for dissent; otherwise the choice is forced (Herbert, 1996; World Health Organisation, 2021). Survivors have mentioned dissociating to conform. This can lead to a dissociated *betrayal blindness*, in which the survivor willingly acquiesces to expectation to preserve their dependent relationship with the organisation (Danylchuk, 2022). This mechanism can be hard to distinguish from cognitive dissonance (Freyd & Birrell, 2013; Smith & Freyd, 2017). Betrayal blindness involves dissociating from acknowledging the coercive threat, can appear to be willing commitment to the program, and has lasting psychological and health impacts (Smith & Freyd, 2017).

Approximately 45% of the WT cohort may consist of young people with CT (Bettman et al., 2014) who may be already prone to dissociative coping (ISSTD, 2023b; Kate et al., 2023). The use of coercion in WT programs may (re)trigger dissociative responses to threat merely from disempowering experiences (Katz, 2022; Pringle et al., 2023). The all-encompassing and inescapable nature of coercion, along with the magnitude of threat, would significantly influence whether a dissociative response will be triggered. Given the clearly stated aim of coercive WT to increase the young person's perception of threat, coupled with betrayal blindness to coercion and dismissive caregiving, dissociation is highly likely to occur instead of dissonance.

Disturbing similarities exist between coercive WT practices and the behaviours of cults (Mater, 2022). While coercive WT “advertise themselves as ideal facilities with pure

intentions and proper techniques, [its history appears] rooted in cults and a focus on behavioural change instead of genuine growth” (Mater, 2022, n.p.). Chatfield (2018) compared residential treatment centres to totalistic institutions like cults, which share uncomfortably similar features with survivor descriptions of coercive WT, resonating the experiences of the two survivors co-authoring this article (SD and JM). Chatfield identifies three major features; control of the survivors' bodily functions, a complete lack of privacy and an inability to predict what would happen next. Survivors recall being able to eat, talk and sleep only when permitted, toileting under constant watch, not showering for weeks, and a disorienting denial of “future information,” such as where they were hiking or when the therapist would visit (see Moniuszko & Anowitz, 2024, for detail). The pervasive physical control, coupled with cognitive and emotional coercion within coercive WT programs significantly contributes to the overlap of dissonance and dissociation.

Stein and Russell (2016) proposed that cults foster disorganised attachment which seems reminiscent of the earlier comments by White and Mitchell (2019) regarding bonding with field guides at the moment of psychological collapse. Other cult researchers point to the demand for compliance, uncritical thinking, denial of volition, and denial of the self (Salande & Perkins, 2011) that we previously identified as coercive WT general conditions in the pursuit of dissonance. The aftermath of cult experiences, described by S. Rosen (2017) is like WT survivor accounts of derealisation, amnesia and fugue with co-existing cult and non-cult selves, and “shame and guilt about pleasure, self-promotion and self-expression” (p. 20). The impacts of cults are disturbingly similar to the accounts of older WT survivors, as K. R. Rosen described (2021).

Having demonstrated that the pursuit of cognitive/adaptive dissonance through enduring isolation, organisational coercion and perceived threat is likely to cause a young person to dissociate while appearing to comply, we must now reflect on the ethical

responsibility of practitioners. Ethical dilemmas emerge for WT practitioners in the areas of dignity, autonomy, beneficence and nonmaleficence, as presented in Table 2. The primary ethical requirement is to do no harm, and treatment for dissociation is based upon the “centrality of safety and stabilization” (Kezelman & Stavropoulos, 2020, p. 118) and yet coercive WT deliberately creates situations in which perceived risk and threat are “enormously high” (Priest & Gass, 2005, p. 18). This means that coercive WT, being the opposite of healing for dissociation and complex trauma, should be expected to actually cause both trauma and dissociation.

[TABLE 2 GOES ABOUT HERE]

How have AT and WT health practitioners adopted and continued to use coercive, oppressive, overly risky and sometimes even aggressive practices, despite ethical principles and advances in human rights-based approaches to health provision (World Health Organisation [WHO], 2021)? These calls include to abolish involuntary treatment (WHO & United Nations [UN], Office of the High Commissioner on Human Rights, 2023). Partly, the answer lies in the failure of the USA to ratify either the UN *Convention on the Rights of the Child* (1989) or the *Convention on the Rights of People with Disabilities* (2006). There is no legal requirement for WT programs in the USA to conform to the human rights standards accepted by most of the rest of the world. Yet disciplinary ethics statements seem irreconcilable with practices that deny or diminish human rights.

Dissonance appears less frequently in AT literature than it did some 20 years ago and now trauma-informed and human rights-based approaches provide other and kinder perspectives into mechanisms of change. Although sometimes it is assumed that we (the authors) desire the abolition of all WT programs, it is only the harmful practices that we wish to be abolished, and we expect that WT might flourish again as a consequence if that is done. As we gain more understanding about the impact of complex trauma and dissociation,

resulting from betrayals of trust in relationships and denial of dignity, we recognise the harm caused by enduring experiences of threat. Sadly, these experiences, in the hands of those entrusted by the public to provide ethical therapeutic care, have a high probability of causing dissociative responses (Kate et al., 2023; Smith & Freyd, 2017).

Nearly 15 years ago, M. Brown (2008) expressed concern that adventure education and therapy practices had stagnated. Recently, there has been a resurgence of critical reflection of once considered inviolate AT practices (Brookes, 2022; Gabrielsen et al., 2019; Harper & Fernee, 2022; Pringle et al., 2021). It is time for WT to heed Browns advice:

In relative isolation we tend to draw on some foundational texts that have not been critically examined, are repeatedly referenced, and through which the field continues to perpetuate taken-for-granted assumptions as defining principles of . . . theory and practice (2008, p. 10).

Having critically examined the coercive WT reliance on cognitive or adaptive dissonance to force psychological change, we believe there is overwhelming evidence that what is thought to be a condition of dissonance is often, in reality, a condition of dissociation. Therefore, the coercive WT treatment is routinely iatrogenic, meaning the treatment is harmful. All of this articles authors stress the importance of doing no harm. Based on this principle, we call for the immediate and unilateral prohibition of forced use of dissonance. Knowing that harm from forced dissonance is probable, we propose that any continued use of the now correctly identified dissociative mechanism of change (harm) should be considered as malpractice.

Limitations

Coercive AT and WT, using the dissociative mechanism of harm, fail all participants. We find these approaches unethical in most treatment guidelines, and of ethics statements for professional helping associations as shown in Table 2 and coercive practice should be used

with no one. Future research might seek to identify the specific practitioners, and programs involved or the populations most impacted.

Conclusion

Cognitive dissonance remains a legitimate mechanism of change, although its effective application faces challenges in involuntary programs. The problems with the cognitive choice required for this mechanism is threefold; (1) it is unlikely to be within the persons capacity as cognition deteriorates with chronic and acute stress, (2) it requires actual opportunities to dissent to avoid forcing the choice, (3) it could lead to dissociated reaction without any observable indication that this has become the mechanism instead of cognitive dissonance. Therefore, practitioners in involuntary programs will not know whether they have harmed or healed. The likelihood of harmful impact should be expected to increase in proportion to the amount of coercion applied. To continue with coercive practice, knowing that the dissociative mechanism of change (harm) is likely and not knowing what is actually happening, would seem to be an ethical violation of disciplinary licensure. Additionally, it appears likely to be viewed as malpractice by observers outside the coercive WT segment of AT practice.

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Notes on Contributors; AUTHORS 1-6 BIO

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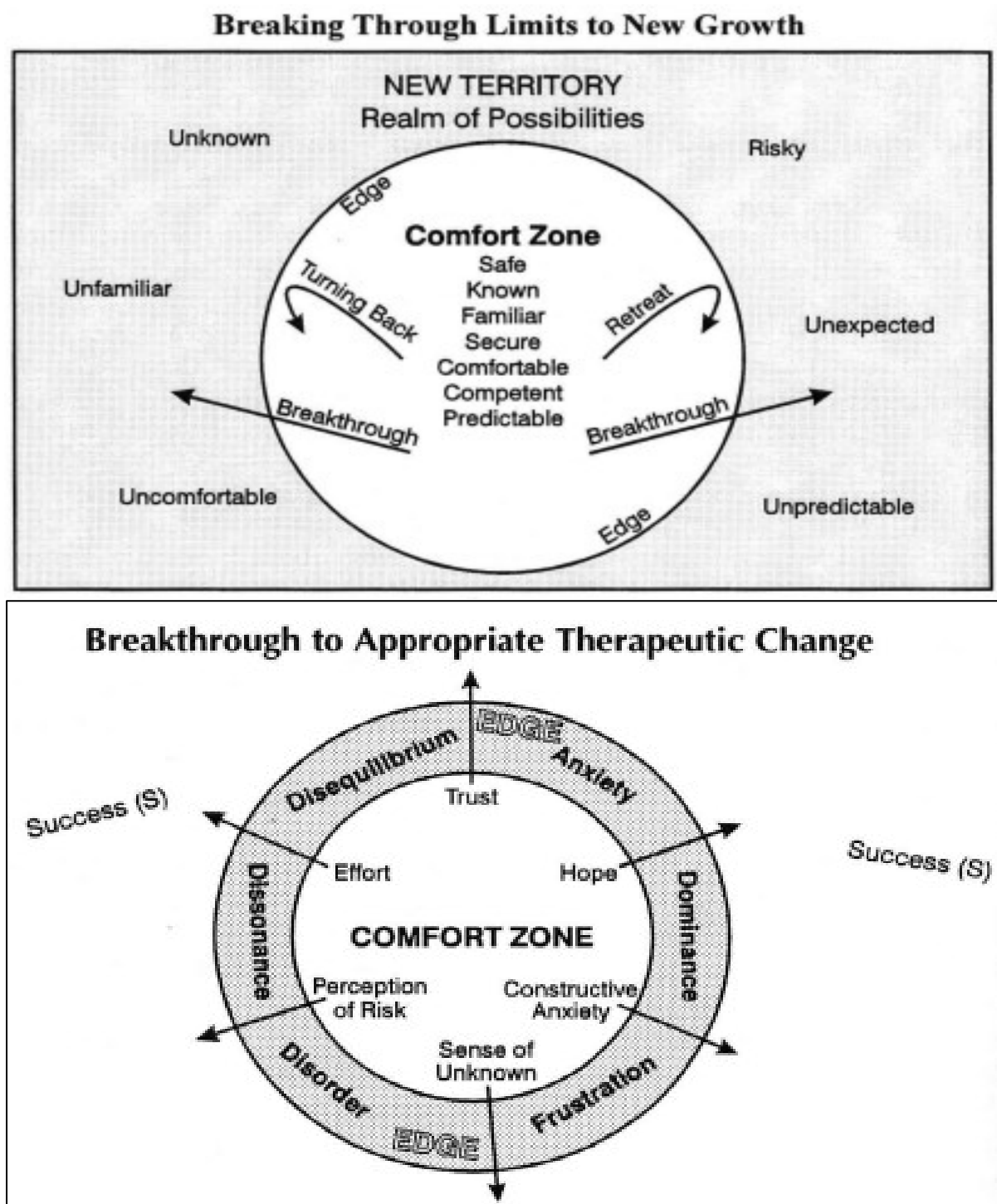
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Figure 1

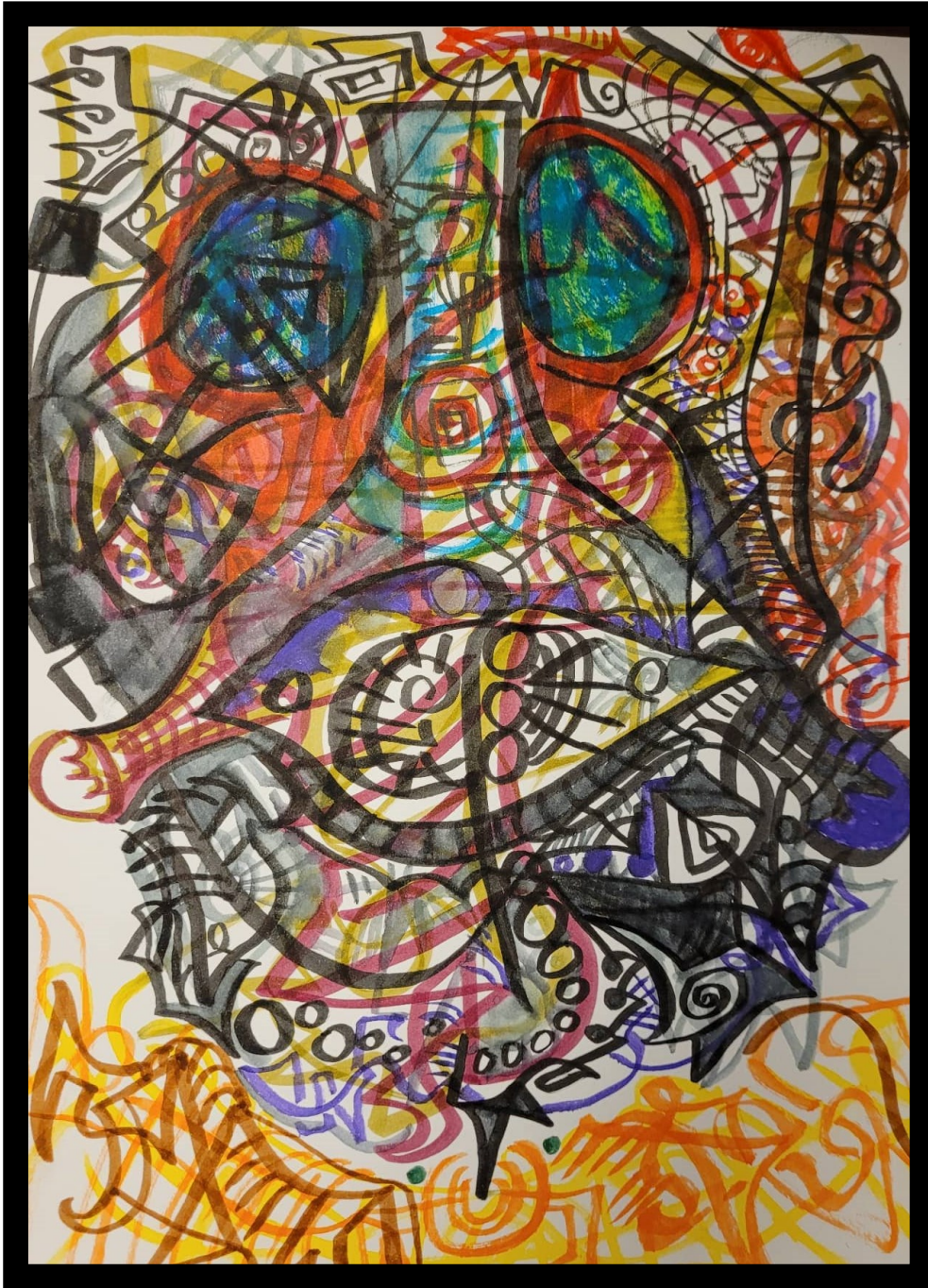
Nadler's (1993) Diagrams of Breakthrough Conditions



Note. Nadler (1993, p. 58, p. 64). What Nadler illustrates as the realm of possibilities includes many of the uncertainties that Kate et al. (2023) list as causal conditions for dissociation.

Figure 2

Dissociated from the Woods by Bastards



Note: This drawing by *INSERT AUTHOR NAME*, represents the experience of dissociation caused by a wilderness program being looked back upon several years later. It incorporates the dissociation of the abusive event as well as the pain and progressive psychological collapse that it caused over the following year. A major theme is fear motivating the imitation of inhumanity and the impenetrability of the figure to the world around them.

Table 1

Critical Realist Evidence Domain Summaries

Author, Year	Title	Context	Source	Summary
Empirical Domain				
Gass (1993)	Adventure therapy: Therapeutic applications of adventure programming	Research	Edited book	Experiential learning is “predicated” (p. 4) on cognitive dissonance
Newes & Bendoroff (2004)	What is adventure therapy?	Research	Conference paper	Describes increasing perceived stress to achieve forced cognitive dissonance
Priest & Gass (1997, 2005, 2017)	Effective leadership in adventure programming	Textbook	Textbook	Describes centrality of cognitive dissonance by increased stress
White (2019)	L. Jay Mitchell, Co-Founder of SUWS, Founder of Alldredge Academy and Greenbrier Academy (No. 57) In Stories from the Field: Demystifying wilderness therapy.	Podcast	Spotify	L Jay explains causing parts of self to withdraw through use of fear, deepening change through ceremony, repetition and spirituality
Actual Domain				
Andrews 2022	Concentrated interviews with the survivors of the Troubled Teen Industry	Biographical record	Magazine article	WT participants describe ritual, harm and general conditions
Anonymous, Gabi Dean (2021)	Survivor, Pacific Quest Wilderness 2019 This is Paris; The real story of Paris Hilton	Biographical record TV documentary	Web article YouTube	Forced to simulate death and rebirth in a earthen grave Survivor mentions forgetting her WT experience

Dobud (2020)	Experiences of adventure therapy: A narrative inquiry	Research	Thesis	Survivors experienced ongoing PTSD from their WT experience
Dubon (2023)	Dissociated from the woods by bastards	Artwork & biographical record	Twitter	Survivor depicts despair about their dissociation caused by Aspiro WT
Kate (2018)	The prevalence of dissociation and dissociative disorders, and trauma and parent-child dynamics as etiological factors: implications for the validity of the trauma model and fantasy model of dissociation	Research	Thesis	Prevalence of dissociation amongst college students
Isaacs (2005)	Brat camp (UK) Series 1 & 3: Redcliff Ascent WT, Aspen Achievement Academy	TV documentary	YouTube	Shows footage of survivors with dissociative symptoms and showing sudden change
Mater (2022)	The troubled teen industry and its effects: An oral history	Research	Journal	Survivors reported dissociation during WT plus general abuses and neglect
Rensin (2016)	I went into the woods a teenage drug addict and came out sober. Was it worth it?	Autobiography	Magazine article	Describes himself forgetting significant periods of time during WT at Second Nature.
K.R. Rosen (2021)	Troubled: The failed promise of America's behavioral treatment programs	Biography	Book	WT participants often die through suicide and misadventure after their programs

Real Domain

M. Brown 08	Comfort Zone: Model or metaphor?	Research	Journal	'...the field continues to perpetuate taken-for-granted assumptions as defining principles...' (p. 10)
Festinger (1957)	A theory of cognitive dissonance	Research	Book	Forced dissonance is not very effective and requires reinforcement
Herbert (1996)	Use of adventure-based counseling programs for persons with disabilities	Research	Journal article	Dissonance in AT should not be forced

ISSTD (2016)	Dissociation FAQ's.	Fact sheet	Website	Dissociation tends to involve repeated and often ritualised abuse
ISSTD (2020)	Trauma and complex trauma: An overview.	Fact sheet	Website	Complex trauma tends to be repeated, inescapable, involving caregivers, in childhood and denied
ISSTD (2023)	Child and adolescent fact sheet—For caregivers	Fact sheet	Website	Dissociation caused by inescapable situations
Kate et al., (2023)	Parent-child dynamics as predictors of dissociation in adulthood	Research	Journal	'Dissociation is likely when the individual has a chronic sense of feeling unsafe' (p. 10)
Kezelman & Stavropoulos (2012)	Practice guidelines for treatment of complex trauma and trauma informed care and service delivery	Treatment guidelines	Book	Phase 1 of complex trauma treatment is safety and stability
Nadler (1993)	Therapeutic process of change	Research	Edited book	described dissonant breakthrough as un-safe and discomfoting (p. 66)
Priest (2023)	Mechanisms of change for adventure: four pathways through the 'black box' process	Research	Journal article	AT requires dissonance induced by fear
Webb (1993)	The use of a three-day therapeutic wilderness adjunct by the Colorado Outward Bound school with survivors of violence	Research	Edited book	Dissonance provoked by 'fear and anxiety that may accompany adventure activities' is dysfunctional (p. 98)

Note: This table is structured in three domains as used by Haigh et al.(2019) , who concluded that; 'Researchers' views about the nature of knowledge and its construction inevitably influence their research aims, approaches and outcomes' (p. 1). They suggested that research improves when complex and multi-layered entity groupings are examined for relationships and causal mechanisms.

Table 2

USA Therapy Disciplines Ethical Statements Relating to Mechanisms of Change

Professional Association	URL	Applicable Ethical statement	Relevance
American Psychiatric Association	https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf	physicians provide care with ‘with compassion and respect for human dignity and rights’	Ongoing and involuntary dissociation is debilitating, undignified and impinges on a range of rights.
American Psychological Association	https://www.apa.org/ethics/code	‘strive to benefit those with whom they work and take care to do no harm’ ‘respect the dignity and worth of all people, and the rights of individuals to ... self-determination.’	Ongoing dissociative harm is triggered by environments that remind the person of the conditions of original harm. Claims of PTSD, anxiety, dissociation, agoraphobia and physical health complaints have known correlation to dissociative mechanisms of change. Dissociation is induced when there is no choice.
National Association of Social Workers	https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English	‘respect [for] the inherent dignity and worth of the person [and to] promote, restore, maintain, and enhance the well-being’ of those whom Social Workers help	Dissociation is not consciously controlled, is triggered by a wide range of potential stimuli, has unpredictable, ongoing, and debilitating impact that are not in the persons interests. Dissociation interferes in people's ability to attend to study, work and interests and reduces self-determination. A core problem is the significant pressure on relationships, upon which all people rely for well-being.
Clinical Social Work Association	https://www.clinicalsocialworkassociation.org/CSWA-Ethics	‘safeguard the interests and concerns of the client [and] ‘individual self-determination’ and ‘do no harm’ ... not provide treatment interventions ... that may conflict with these values.’	As above.
American Association for	https://www.aamt.org/Legal_Ethic	‘Responsiveness and excellence in service’	Excellence is precluded by the likelihood of harm from dissociative mechanisms and conditions.

Marriage and Family Therapy	s/Code_of_Ethics.aspx		
American Counseling Association	https://www.counseling.org/docs/default-source/ethics/practitioner-39-s-guide-to-ethical-decision-making.pdf	‘bedrock principles of autonomy, justice, beneficence, nonmaleficence, and fidelity...allowing an individual the freedom of choice and action...not inflicting intentional harm, and not engaging in actions that risk harming others’	Forced dissonance, let alone involuntary dissociation, is caused by the removal of choice. Dissociation is a debilitating harm and should be an anticipated risk in coercive and inescapable situations of disempowerment.
American Therapeutic Recreation Association	https://www.atra-online.com/page/Ethics	Principle include: beneficence, non-maleficence, autonomy. ‘provide for ... well-being by maximizing possible benefits and relieving, lessening, or minimizing possible harm... use their knowledge, skills, abilities, and judgment to help persons while respecting their decisions and protecting them from harm... preserve and protect the right of each individual to make his/her own choices’	As above. Forced dissonance does not respect a person’s autonomy or choices. Forced dissonance is likely to cause dissociation should earn protection from harm.
American Occupational Therapy Association	https://research.ota.org/ajot/article/74/Supplement_3/7413410005p1/6691/AOTA-2020-Occupational-Therapy-Code-of-Ethics	‘ <i>Freedom</i> indicates valuing each person’s right to exercise autonomy and demonstrate independence, initiative, and self-direction...value the service recipient’s right and desire to guide interventions... valuing, promoting, and preserving the inherent worth and uniqueness of each person....	As above. Dissociation is produced by the inability to change the intolerable situation. The dissociative mechanism of change inherently dismisses the worth and uniqueness of the person.
American Nurses Association	https://nurse.org/education/nursing-code-of-	Ethical principles include nonmaleficence, beneficence, autonomy.	The potential for dissociative harm from forced dissonance should prompt less risky interventions. Patient consent should prompt routine checking for distress.

	<u>ethics/#:~:text=W</u> <u>hat%20are%20th</u> <u>e%20five%20cod</u> <u>es,justice%2C%2</u> <u>0and%20privacy</u> <u>%2Fconfidentialit</u> <u>y.</u>	Specifically, nurses ‘support the patient in their medical wishes and ensure that the medical team is remembering those wishes. Sometimes, nurses will need to continue to advocate for a patient despite the wishes being verbalized because the medical team might not agree’	Advocacy for the patients wishes should prompt professional dissent. Observable distress and completion of dissociation checklists during forced dissonance should prompt a report of adverse outcomes.
National Board of Certified Counselors	<u>https://www.nbcc</u> <u>.org/assets/ethics/</u> <u>nbcccodeofethics.</u> <u>pdf</u>	Also nurses are responsible for ‘selecting interventions and care that will cause the least amount of harm to achieve a beneficial outcome [while] responsible for reporting treatment options that are causing significant harm to a patient, ‘enhance the social and mental well-being of their clients while supporting the overall physical health of each client...minimize unavoidable or unanticipated harm	Dissociation severely impacts well-being. Institutional betrayal physical health. As dissociation will be mistaken for cognitive dissonance it is an anticipated and avoidable result.
