



Article

“Putting Down and Letting Go”: An Exploration of a Community-Based Trauma-Oriented Retreat Program for Military Personnel, Veterans, and RCMP

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Abstract: (1) Background: Current military members, veterans, and Royal Canadian Mounted Police (RCMP) experience higher rates of posttraumatic stress disorder (PTSD) and moral injury (MI). Trauma-oriented retreats have been offered as a means of addressing these concerns. This article aims to explore the impact of a non-evidence-based trauma-oriented retreat for the above populations experiencing PTSD or MI; (2) Methods: This qualitative study, nested within the larger mixed-methods pre/post longitudinal follow-up study, examined the experiences of 124 military members, veterans, and RCMP who participated in the retreat. Data were collected from semi-structured interviews and first-hand observations of the organization. Analysis was conducted using thematic analysis while being informed by realist evaluation principles; (3) Results: The results showed that important contextual elements were related to participants being ready, having multiple comorbidities and using the program as a first or last resort. Effectual mechanisms included a home-like setting; immersion; credibility of facilitators; experiential learning; an holistic approach; letting go, and reconnecting to self. Outcomes included: re-finding self, symptom management, social connection, and hope for a meaningful life. The gendered analysis suggested less favorable results; (4) Conclusions: Care is warranted as the evidence-base and effectiveness of trauma-oriented retreats yet needs to be established prior to broad use.

Keywords: military; veteran; Royal Canadian Mounted Police; posttraumatic stress disorder; moral injury; trauma-oriented retreat



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1. Introduction

The mental health and well-being of military members, veterans, and public safety personnel (PSP (e.g., firefighters, police, emergency medical services)) is of increasing concern to Canadian and international communities. Isolated or cumulative traumatic experiences during service can have enduring impacts and cause long-term struggles throughout many domains of well-being such as employment activities, self-care, and leisure pursuits. Veterans Affairs Canada’s Life After Service Survey 2019 indicates that veterans with recent releases (i.e., between 2012 and 2015) had a higher rate of difficult adjustment (42%) and reported chronic mental illnesses including depression (26%), anxiety (21%), and posttraumatic stress disorder (PTSD) (24%) at higher prevalence than Canadians of comparable age and sex [1]. Similarly, a 2018 Canadian study showed that approximately 44% of PSP screened positive for at least one mental health disorder [2]. While a predominant focus

of trauma research has examined PTSD, a growing body of literature is highlighting the potential importance of a construct referred to as Moral Injury (MI). Distinct from PTSD, MI occurs when individuals face experiences that cannot be justified within their personal and moral beliefs of right and wrong [3], and can lead to psychological, social, ethical, existential, and spiritual suffering and impairment [4]. Preliminary research is illustrating that MI is associated with more severe PTSD, major depressive disorder, generalized anxiety disorder, and suicidality [5], all of which can interfere with treatment response and lead to poorer outcomes [6].

Considering the above challenges and concerns, there is a growing interest in researching holistic approaches that address the biopsychosocial-spiritual domains of health and well-being associated with trauma-related conditions. Evidence is emerging regarding the potential importance and value of non-talk therapies and integrated mind-body-spirit approaches as complementary methods to traditional PTSD treatment [6]. Mind-body-spirit approaches may include yoga; meditation; exercise; deep breathing; nature therapy; art-based therapy, and animal therapy [7–9]. While these approaches may not directly address the trauma experienced by the individual, they are aimed at addressing the impact that trauma has on the mind, body, and spirit [10]. A meta-analysis by Kim et al. [7] found that mind-body-spirit approaches were potentially effective in addressing symptoms associated with PTSD, stress responses, depression, anxiety, coping, and self-efficacy. Advantages of mind-body-spirit approaches also include that they: (1) target the emotional distress and somatic symptoms; (2) do not require persons to directly engage with their trauma memories; (3) aim to build resilience and connection to self and community [10], and (4) foster a sense of safety with self or a group to heal from the experienced trauma [11–13]. Some researchers have proposed that mind-body-spirit approaches also facilitate improved psychosocial well-being and may enhance coping [13].

One mind-body-spirit approach which has gained significant attention is that of holistic trauma-oriented retreats. Retreats are unique in their ability to provide intensive, immersive interventions over a short period of time, with most retreats ranging between a few days to two weeks [10]. Proposed benefits of retreats include cost-effectiveness, attractiveness to clients, and low dropout rates [14]. O'Hara [15] has suggested that therapeutic elements of trauma-oriented retreats may include: retreat sites that establish safe and nurturing spaces (often in nature); incorporation of metaphor and ritual as means of processing trauma and experiences; acknowledgement of the spiritual domain and moral injuries; sessions that include a variety of healing interventions; rapid building of relationships and community via small group size, and having clinical staff and peer supports trained to address the unique needs of the population in a non-judgmental and compassionate manner. Ward, Wood, and Young [14] have argued that retreats are similar to group therapy in that multiple individuals with similar experiences are brought together, creating a sense of camaraderie, validation, normalization, and reconnection. Retreats have been found to be potentially more effective when peer supporters attend the program, as peers may “engender hope in the clients that they too may conquer their demons” [16].

Intensive retreats have been used with various health conditions, such as multiple sclerosis [17] and cardiovascular risk factors [18]. Limited research exists to determine the efficacy of residential treatment for PTSD within the military and veteran populations [16,19,20]. Thomas et al. [11] found that military veteran participants’ spiritual exploration was “affirmed, renewed, or raised as a result of attending the peer-led resilient leadership program.” Similarly, Monk, Ogolsky, and Bruner [19] found that trauma symptoms were significantly reduced for veterans, and partners reported a decrease in distress after the intervention. Lastly, Kamena and Galvez [16] found that 122 of the emergency responders’ arousal and reactivity, avoidance, intrusive symptoms, negative alterations in cognition and mood, depression, exhaustion, symptoms related to panic attacks, somatic symptoms, and suicidal thoughts, were all significantly decreased post-retreat.

While trauma-oriented retreats are becoming more available, the lack of robust evidence regarding how and why they may be beneficial is highly problematic. Little com-

parison between types of trauma-oriented retreats along with what elements are most efficacious (i.e., if retreats with yoga are more effective than those with animal therapy) resulting in a paucity of evidence. As many of these retreats in Canada are offered by community-based not-for-profit organizations, they often lack the capacity to do the necessary research or program evaluations to determine the effect of the programs.

Purpose Statement: The purpose of this article was to explore the impact of a Canadian non-evidence based trauma-oriented retreat for military members, veterans, and RCMP who were experiencing PTSD or a MI. Specifically, this manuscript will focus on the qualitative data collected to capture participant voices as a means of better understanding when, where, why, how, and for whom this modality may be beneficial, including a gendered analysis exploring differences between men and women. This study was about exploring the effect of the trauma-oriented retreat and should not be interpreted as a program evaluation nor determination of the evidence-based nature of the retreat.

2. Materials and Methods

2.1. Study Design

This qualitative evaluation study is one component of a larger mixed-methods pre/post cross-sectional longitudinal pilot study designed to explore the effect of an intensive trauma-oriented retreat. This qualitative study examines the subjective experiences of participants who attended the program, and explores elements and mechanisms of the retreat that were seen by the participants as being therapeutic.

2.2. Participants, Recruitment, and Informed Consent

In the larger study, 164 participants ($n = 97$ Canadian military veterans, $n = 51$ active-duty military personnel, $n = 16$ Royal Canadian Mounted Police (RCMP)) participated in the retreat and consented to enroll in the research study. Of the 164 participants, 112 were men, 50 were women and 2 did not wish to identify their gender. Eligibility criteria included an ability to understand and speak English (as the program is only delivered in English); being a Canadian regular force military member or military veteran; having a diagnosis of PTSD and/or symptoms of MI that had been determined by a registered medical professional, and having a stated desire and ability to participate in the trauma-oriented retreat. Suicidal ideation was not a contraindication to participation as suicidal ideation frequently accompanies severe PTSD and MI. This study received University Research Ethics Board (Pro00086960) and the Canadian Armed Forces (CAF) Health Services Surgeon General's Endorsement (E2019-02-250-003-0005). Major ethical consideration included participants feeling coerced to participate in the program, issues of confidentiality and anonymity, and safety of participants engaging in aspects of the research—especially the questionnaires and interviews.

Screening and recruitment occurred as follows. Potential participants desiring to attend the program were screened by the program's medical team to determine eligibility and fit, and were scheduled to attend a gender-specific cohort. Prior to the commencement of the program, potential participants engaged with the research team over a private video-conference and were invited to participate in the research study. Voluntary participation was explicitly discussed, and potential participants were informed that choosing not to participate in the research study would in no way impact the care provided by the program, nor would program staff know who had consented to study participation. Potential participants were instructed to take a hard copy of the consent form and questionnaires that, once completed, were sealed in envelopes. Potential participants who did not want to participate in the research were also instructed to put the blank consent forms and questionnaires into sealed envelopes to help maintain anonymity. The same process occurred during the offboarding process at the close of the intervention.

2.3. Data Collection

Qualitative data collection consisted of post-intervention semi-structured interviews, open-text survey questions, and program observations. Interview data were collected via 45–60 min semi-structured interviews with participants, approximately two weeks after program completion. Interviews were conducted by a senior member of the research team and consisted of open-ended questions exploring participants' perspectives regarding the trauma-oriented retreat, including: (1) their overall experiences; (2) impression of components of the retreat; (3) impact on their PTSD and MI symptoms, and quality of life since returning home, and (4) how the program might be improved. These categories of questions were iteratively derived from the participants' interviews themselves. Initial interviews had additional questions related to Veterans Affairs Canada's construct of well-being (containing seven domains). After initial interviews, however, it became clear that the number of questions was interrupting the natural flow of the conversation and that participants were often unclear as to how such well-being questions related to their experience of attending the trauma-oriented retreat. Instead, participants predominantly shared information regarding the above categories when asked about their experiences. As such, subsequent interviews became both more focused and open, based on the modification of the questions. The interviewer began to provide general questions related to these categories and let participants share naturally whatever was most important to them while also providing small prompts when necessary to gather the above data. Interviews were conducted primarily over the telephone or using a secure 256 bit-encryption Health Insurance Portability and Accountability Act (HIPAA) compliant Zoom platform. All interviews were audio-recorded with permission before being transcribed. Some participants requested not to be recorded, resulting in the research team member taking hand notes which were then typed up and used for analysis. A total of 124 participants out of 164 agreed to be interviewed.

Two clinician-scientists also attended the retreat for the purpose of describing and documenting the content and components of the program. Both researchers captured observations in field notes which were included in the post-intervention semi-structured interview data set.

2.4. Data Analysis

Data analysis was conducted in accordance with thematic analysis [20] and influenced by principles of realist evaluation (RE) [21]. Central to RE is an explanatory analysis aimed at determining what interventions work for whom, in what circumstances, and in what respects. An RE is centrally concerned with exploring the complex and dynamic interaction among context, mechanism, and outcome (CMO) which provides the main structure for an RE analysis [21]. The CMO (Figure 1) acknowledges that an intervention frequently consists of multiple components including background contexts, stakeholder motivations and relationships, clientele skills, capacities, volition and limitations, the impact of infrastructure, environmental features, structural or economic pressures, and personal or political agendas, all of which may impact the success or failure of the intervention [22,23]. While a full RE was not conducted, these principles did influence the researchers during the second level of thematic coding where themes were explored in light of a CMO configuration.

The thematic analysis method was chosen because of its compatibility across different qualitative methods. Braun and Clarke [20] described thematic analysis as a method for identifying, analyzing, and reporting patterns (themes) in rich detail which may also allow the researchers to interpret various aspects of the topic. Terry et al. [24] also suggested that thematic analysis allows for social as well as psychological interpretations of data which can be useful for producing qualitative analyses suited to informing policy development. Practically, thematic analysis involves examining the text in detail to identify recurring patterns (open coding) which are refined into 'themes' through inductive and/or deductive analysis. That is, those that arise directly from the data and those which relate to theory and previous findings, respectively.

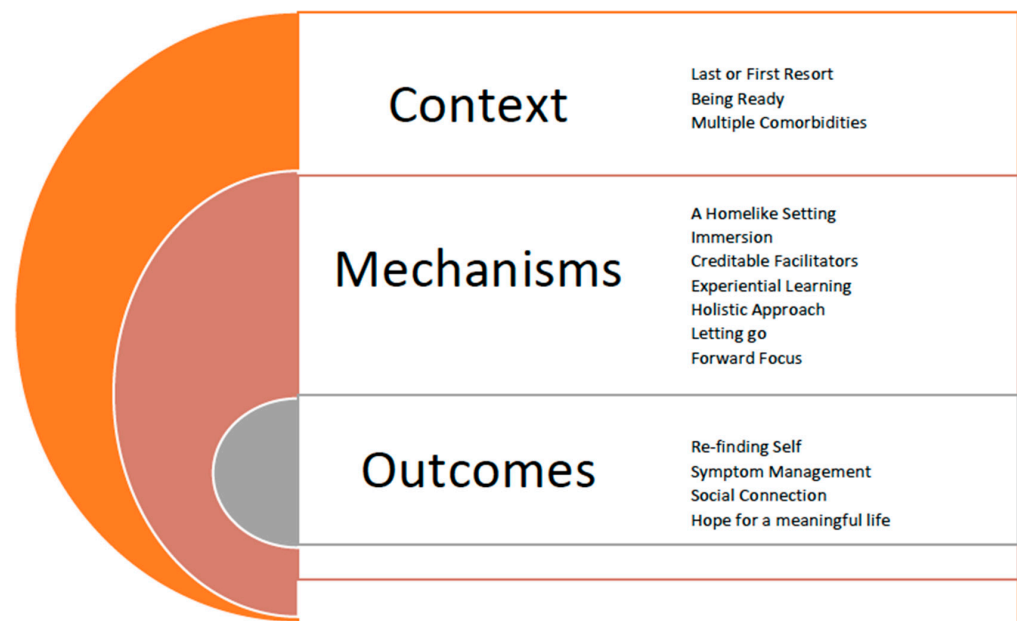


Figure 1. Context–mechanism–outcome configuration.

Data analysis was conducted by four members of the research team who had also completed multiple interviews and were intimately familiar with the post-intervention interview data. Preliminary open codes were based on in vivo codes collected from each participant interview and the interviewer's notes. This coding was done using NVivo and Excel software. The four researchers reviewed the transcripts and independently coded the interviews. Once independently coded, each transcript was reviewed by two of the other reviewers to ensure the validity, reliability, and conformability of the analysis. This also ensured inter-rater reliability and bracketing of researcher bias as differences regarding the first level in vivo coding were resolved through ongoing discussion between all authors [25]. Once in vivo codes were established, they were organized and collapsed into secondary codes which focus on patterns of similarity and difference between both the individual interviews and the genders. This allowed the researchers to build themes that were predominantly and frequently found in the data.

The researchers subsequently organized the preliminary themes based on RE principles and developed a CMO configuration. This process entailed each of the reviewers again independently reviewing the transcripts looking for data related to the context, mechanisms, and outcomes associated with the program. This data extraction was conducted by hand so that the researchers could directly code off the data and take notes about potential connections. These notes became more rich and nuanced through the creation of memos that captured key ideas and iteratively broadened preliminary thoughts. Once the initial CMO data was extracted, the research team began to theorize about ways in which the data (i.e., the second level thematic codes) could be organized into a CMO configuration. Within RE and thematic analysis, it is important to note that focus is on interpretation and theorizing of the data. As such, there is not a focus on quantification of the data as all data which helped to answer the research question were included. The proposed second level codes and RE framework then underwent a second round of collective analysis with particular attention being given to results which helped to answer the research question. This resulted in secondary codes being collapsed into themes and subthemes, and then organized according to the theorized CMO configuration. Our analysis therefore contains both a thematic analysis which derives data directly from participants' experiences (i.e., though the in vivo and secondary-level coding) and the researchers' interpretation and theorization about who, what, when, where, and how participants are moved to engage in trauma-oriented retreats. In accordance with the method, our results highlight data which

was found frequently and also data which was found less frequently but was deemed to be relevant to answering the research question (e.g., the gendered data). The results are therefore organized according to both of these approaches—that is, the data are grounded in participant experiences and our theory. Participant quotes were selected for their ability to illustrate each theme and support the CMO configuration. Field notes and researchers' observations were included in this data set and underwent RE and thematic analysis.

3. Results

3.1. Context

Within RE, context is an important piece of understanding where the intervention may fit, who may attend it, and why. The context matters because it influences the reasoning or motivation of the participants engaging in the intervention. Finally, the context may provide alternative explanations of the observed outcomes which need to be considered during the analysis to avoid over-generalizations about the applicability of the intervention. Within this study, a key feature of the context was discovering who was attending the program and what features supported individual participants' entry into it. Three aspects of context were found to be relevant: last or first resort, being ready, and having multiple comorbidities.

3.1.1. Last or First Resort

The majority of participants who attended the program had significant prior experience with mental health interventions (e.g., individual psychotherapy, pharmacological interventions, peer support, or other complementary treatments). Many of them acknowledged trying the program as a "last resort" in the hopes of either improving upon their current health (e.g., feeling stuck or stalled out in therapy), or because they perceived that previous interventions had not been effective for them. Equally, participants acknowledged that they attended at the request/ultimatum of a close family member (i.e., spouse/partner) to get help or potentially risk losing their family. Less frequently, participants (especially active-duty military) attended as their first mental health intervention. Motivations for attending the program included: (1) having a friend or colleague who had recommended it and (2) the lack of requirement for a medical referral. The latter reason was particularly attractive to active-duty military personnel who were fearful of asking their chains of command for mental health help.

16-24 "I saw it as sorta my last chance because I just retired about a month-and-a-half ago so I saw that as my last chance at a kick at the can so to speak."

30-25 "Everyone sees the bullet wound, and no one sees the mental wound and for me at work, I didn't tell anyone."

3.1.2. Being Ready

Participants reflected on the importance of "being ready" or in the right mindset to attend and benefit from the program. Some participants highlighted that the reality of seeing the program as their last resort left them with no other choice but to "lean in" and try and glean as much from it as possible. Equally, some participants also acknowledged that, after years of trying to manage their trauma and symptoms, they had developed strongly embedded defence and avoidance techniques that were difficult to overcome or modify, especially during the first 48 hours of the program. They noted that if they had not entered the program completely committed to doing whatever the facilitators asked of them, it may have been extremely difficult to engage in some of the alternative and holistic activities at the program. Personal openness and motivation factored heavily into participants' impressions of the program.

62-30 "I think when you go to this program you really have to be in a place where you want and need help and you have to be willing to participate and put the work in. So if you are just going there and kind of I don't wanna say fake it and come out the same kind of person you were. So you have to really put in the work and bear your soul basically."

You get out of it what you put into it and I think the guys in that cohort put everything into it and so I think they are all in a really good place."

155-45 "I felt very raw going there... And what I felt at this point before I went I was like you know what, clearly what I am doing is not fixing the problem or my daily life was being consumed for the most part so clearly I needed to try something out of my comfort zone and be open-minded and try something different."

3.1.3. Multiple Comorbidities

Another important piece of the context was that participants who attended the program frequently self-reported having multiple health comorbidities on the demographic questionnaires. Comorbidities were spread across physical, psychological, social/familial, and spiritual domains. Regarding the psychological domain, most participants showed high levels of acuity and frequently scored well above the cut-off range for multiple mental conditions (e.g., PTSD, major depressive disorder, generalized anxiety disorder). They also scored high on the MI scale. In sum, participants were often acutely unwell and had been for some time upon arrival to the program.

10-23 "I had not had the confidence or the strength because I've been and continually have chronic pain, so it was a challenge to do anything before . . . so I had really stopped doing anything... and going to [the program] put me back on track to kind of challenge myself a little bit more physically."

147-46 "I was using a lot of drugs and drinking as well, so just yeah... so it's hard because you know on the one hand [PLACE] and that treatment gave me what I needed at the time, but on the other, there was this big part of like connection and understanding and like compassion that I didn't quite receive when I was seeking treatment for concurrent trauma and addiction."

3.2. Mechanisms

Within an RE, the term 'mechanism' refers to the underlying social or psychological drivers that may influence participants' choices (reasoning) and their capacity (resources) to put these into practice. Mechanisms frequently describe not only the specific components of the program but why those components may have supported achievement of the desired outcomes. Put another way, it is not the intervention that "works", rather the "subjects are persuaded to accept, install, maintain and act upon it" [26] (p. 344). Mechanisms from an RE, therefore, often highlight some personal motivation and factors for both the participants and the intervention staff which can also either hinder or support program uptake. Useful mechanisms of the program included: a home-like setting; immersion; perceived credibility of the facilitator(s); experiential learning; use of a holistic approach; putting down and letting go, and a forward focus—reconnecting to self.

3.2.1. A Home-like Setting

Participants noted how environment and setting contribute to the program. Attendees described the environment as "home-like" and as a "sanctuary" where participants felt "respected as an individual". In particular, participants conveyed that the homelike nature of the buildings contrasted sharply with institutional settings and feeling "treated as hostages". Caring staff who sought to treat them with dignity contributed to a sense of welcome and home-like atmosphere. Additionally, being in a nature-rich environment away from urban realities was an important feature. Participants found nature to be very soothing and grounding, which helped lessen some of their hypervigilance, and allowed them to be more present and vulnerable to their traumas.

20-24 "So going there, the only thing that I had in my mind was if they open the door in a lab coat and a wheelchair and all that kind of stuff I am not going in. That's bugged me since I was a kid, just being committed and that terrifies me because I can't be trusted or my brain can't be trusted, at least that's how I take it. So right from the get-go, the

location is great, it's a beautiful piece of property and the bit of nature that we get to experience there is good. It's nice that it's not totally secluded."

81-33 "I always felt comfortable in that situation because of the whole comfortable atmosphere of the place, everyone is loving, the mentors are understanding, they've all been through it before so the whole immersive experience I think makes it successful."

3.2.2. Immersion—Being in the Grinder

In addition to the home-like environment, participants also identified program intensity as being a key component of effectiveness. Participants shared that an intensive program wore down many of their strongly embedded defences and avoidance techniques, and in this way, "forced" them to talk about their psychological wounds and opened the space to potentially do some psychotherapeutic work and healing. Numerous participants identified that treatment intensity was very different to the standard one-hour bi-weekly sessions with a therapist, where they noted that they could waste time, avoid speaking about painful emotions or cognitions, or simply not have enough time to complete the work. Engagement in intense, full days of activities lessened avoidance of painful emotions, cognitions or traumas, and enhanced their openness to what came up.

105-39 "The immersion is critical because it just slowly wears you down, you are just in the grinder right and you can't get out. And it breaks down your defences, and then you let go. It's just freaking brilliant."

103-38 "It's quite different. You are doing 15 hour days, you are there for 6 days and every moment is filled with something. To get to that in an hour a week is almost impossible to get to that level of insight with yourself or what is going on, and even we were interacting with the group, it's not really downtime you are still learning about yourself and others, downtime was filled with interacting with others and the group."

3.2.3. Perceived Credible Facilitators—Peer Support

Having facilitators who were perceived as credible by participants was another important mechanism. In particular, peer support was central to establishing the perception of credibility. Participants noted that talking to and exchanging stories with fellow participants and peer mentors was the most important factor motivating active engagement and self-disclosure. Participants stated that it was "comforting to know that others have experienced the same things" and that "you are not alone". Many participants talked about how peers who intimately understood, accepted, and did not judge their experiences were extremely helpful. The inclusion of the peer mentors also allowed participants to "see the benefit of the program even before starting it" as the peer mentors provided tangible evidence for the possibility of positive change.

146-46 "What it has done for me, is it's connected me with I think I have a bigger family now."

135-45 "I'd say that was probably the most meaningful . . . to know you are not alone and you are not isolated, you are not different from everybody else. We all have different traumas, we are all at the same place in our lives."

3.2.4. Experiential Learning—Learning How to "Do"

Another important mechanism identified by participants was the use of experiential learning; that is, by participating in hands-on activities, participants not only learned the tools to support their mental health but actively practiced them. For example, instead of just learning about the importance of meditation, participants started and ended every day engaging in the practice. Participants indicated that experiential learning facilitated getting "you out of your head and... into your heart" and helped them learn skills, techniques and resources that allowed them to safely remember their trauma before applying or "doing" a skill. Participants identified that having the opportunity to practice and integrate different

coping techniques within the safety of the program and with the support of the retreat team was beneficial.

55-29 *"I liked the experiential learning . . . like I like doing things and things with a message . . . [it] was very interesting because you could tell it was learning to let go but you experience it rather than just talking about it."*

105-39 *"It's the difference between somebody telling you, "oh you should let that go", and actually having somebody walk you through the very process by which you then can let it go. Experiential learning is the best way to do it! Because then it takes it out of your head and gets it into your heart. It gets down in your emotional core so it's not just a cognitive agreement."*

3.2.5. Holistic Approach—Integrating Spirituality

Participants also identified an unexpectedly important mechanism to the retreat which was the use of a spiritually-integrated holistic approach. Numerous participants indicated during the interviews that they were not religious and, therefore, were surprised that they would find spirituality to be a meaningful component of their treatment. Participants strongly resonated with the idea that trauma could impact a person's body, mind, and spirit. Moreover, using spiritual language helped participants give voice to aspects of their traumatic experiences that had often not been addressed such as their sense of hopelessness, lack of meaning and purpose, feeling of being "broken", existential suffering, doubt, and experiences of MI. Participants also expressed surprise at being encouraged to be open to the spiritual realm including ideas of awe, wonder, beauty, connection, love, something bigger and more powerful than themselves, and to see themselves and others positively.

92-34 *"I think one of the things to . . . the whole idea of spirituality instead of bringing religion in that was a good approach because most people aren't religious in the military but the spiritual sense of it [the retreat] was really comforting and the exercises that we did whether it was being around the fire the first night and tossing away your inhibitions that in itself was just "ok we are starting to break a barrier" and I can see where we are going with this."*

120-42 *"It's a more holistic approach, you are kind of dealing with the whole body and the mind at the same time. So for me, that was far more effective."*

3.2.6. Putting Down and Letting Go

Building on the above two mechanisms, participants were encouraged to "put down" or "let go" of past hurts, wounds, and traumas. Participants were encouraged to see the tremendous weight of constantly carrying around their traumas, ruminating on traumatic emotions and/or distorted cognitions, the need to be in control, hypervigilance coping, and anger, hatred and hostility—including at themselves. "Letting go" was facilitated through rituals and ceremonies, breathing techniques, art therapy, and equine therapy opportunities where the focus was on helping participants get in touch with their traumas, express their emotions, symbolically let go, and try to integrate this experience in a meaningful way. Some participants described this in terms of finally being able to grieve what happened to them, gain perspective of their trauma, and be open to new possibilities.

120-42 *"Also you are not sitting on the couch across from a health care professional talking about things. [The program] gets you to actually do things so you know throwing rocks in the fire that you wrote a phrase on or going for a walk, walking the labyrinth umm . . . making a safe jump from a platform, going canoeing or even drawing and there's music as well. All of that stuff, it's a more holistic approach, you are kind of dealing with the whole body and the mind at the same time. So for me, that was far more effective."*

49-28 *"Just opening up and facing the things that have been bothering me for so long, getting those things out there and realizing that other people are experiencing the same*

things, talking and learning different ways to deal with it, and better understand what's going on."

3.2.7. Forward Focus—Reconnecting to Self

The final mechanism that facilitated participant recovery focused on transitioning participants from a point of learned helplessness to practiced hopefulness. In particular, participants were encouraged to not identify solely with their mental diagnosis (i.e., PTSD, depression, anxiety) or prior occupational identities (i.e., soldier), but to consider, plan, and begin executing tasks that could help to move them towards meaningful identities and life goals (e.g., being a good husband or giving back to their communities). In so doing, some participants noted feeling more future-oriented, hopeful, and optimistic. As one participant stated, they found *"a reason to want to live and to continue on knowing that [they] are not alone."*

75-32 "It really gives us a hope for the future and a reason to want to live, and to continue on and to know that we are not alone and there are a lot of traumatized people out there and we can work together and help each other."

95-35 "I guess with [the program], what I came away from it was this healing journey is my journey and it is different of everyone else and I really took ownership of it when I left there and went "it's no one else's job to make me better, it's mine."

3.3. Outcomes

Within an RE, outcomes are related to the ways in which the mechanisms both formal (i.e., components purposefully integrated into the programming) and informal (i.e., components that are unplanned but meaningful) result in either desired or undesired participants' behaviors. For this study, four behavioral outcomes were noted and included: re-finding self, symptom management, social reconnection, and hope for a meaningful life.

3.3.1. Re-Finding Self

The first behavioral outcome some participants noted when they returned home was the sense of re-finding "self". From some participants' perspectives, this resulted in having a better sense of self-worth, self-acceptance, self-compassion/forgiveness, identity, motivation, and self-control. In particular, participants expressed changes in thought patterns and the ability to use tools they had learned from the program. Participants observed that the retreat helped to provide them with the necessary tools to begin enhancing their quality of life once they returned home.

7-23 " Yeah it's almost like I came home and I realized that I've got more self-worth and things that I was tolerating weren't kind of facilitating how I felt about myself."

28-25 "It was like a key opened a few doors because with this, I feel like you get into this negative reinforcement cycle and how you view yourself. And that is hard to get out of by yourself. And even though I look back and think yeah I have come a long way but there were still some fundamental questions that I couldn't move forward on."

3.3.2. Symptom Management through Self-Efficacy

Participants' management of their mental health symptoms supported the re-finding of self. Most of this improvement was attributed by participants to the teachings from the program's team and tools which were learned. Participants indicated feeling more self-efficacious either in their ability to apply tools they had either learned at the program or in previous therapy and programs or, at a minimum, being more aware of negative thought and behavior patterns. Participants also reported noticing that some of their symptoms had changed or decreased in intensity. For example, some participants noted that they were no longer as angry but were instead experiencing emotions such as sadness or grief. Similarly, some participants reported changes in physical symptoms such as being less agitated or hypervigilant, having fewer flashbacks and pain, and increased sleep and energy.

26-25 *"I'm a little more conscious of that point where I feel like I'm sliding down that slope and I can sort of catch myself most times and stop, preventing my mind from going in a darker spot than I would have before."*

75-32 *"I am realizing I do have those symptoms which I hadn't been so aware of, and now I am starting to be more aware of it. Not so much they decrease, but I am more aware. And now I am looking ok, so in this situation, what can I do to calm down. I can do deep breathing, think about something else, but I am starting to say that it is me being anxious, that I am being afraid, that I am being wary."*

3.3.3. Social Reconnection

Related to re-finding self and symptom management, participants also expressed some positive behavioral changes within their interpersonal relationships, including with partners, spouses, children, parents, friends, and new relationships with program peers, mentors, or the larger community. Some participants reported that they were open to authentically communicating with loved ones and had greater patience. Participants noted that learning about PTSD and other mental illnesses helped them to understand their patterns of behaviors and how that could potentially affect their partners, spouses, children, and other loved ones. Additionally, participants also noted that participation in the program gave them new social connections into which to lean on when they returned home. For some participants, this was highly significant as they had experienced long periods of loneliness and isolation. This experience, however, was not the same for everyone, with some participants finding that returning home was problematic and being on the retreat intensified problems at home.

53-29 *"I have reconnected with my children in a very honest way and also have left behind a lot of judgment and resentment. I feel our relationships are stronger now."*

111-40 *"I have identified with other people, I have connected with other people, I am not alone, I don't need to be alone, my armor has come off. And my armor served a very specific and necessary purpose for a very long period of time, to keep things out. But for the last, probably 10 years or so, the armor has unfortunately kept things from getting out if that makes sense."*

3.3.4. Hope for a Meaningful Life

Finally, participants expressed how the program facilitated hope for a meaningful life. For some, especially for active-duty members, this meant returning to work; for others, it meant taking responsibility for their own mental health. For still others, it was finally being able to accept the realities of their life (i.e., being a veteran or having a disability) while still recognizing that their lives could be fulfilling and meaningful.

24-25 *"I was wondering if I would ever get back to wearing the uniform again or even being a member (of the CAF) at all . . . and I mean now they reinforce that just because things didn't happen doesn't mean they get to . . . like define who I am kind of thing. Knowing this really helped to really break free from those sorts of thoughts."*

9-23 *"I've been told that I am more relaxed, I don't worry about the future, I'm not too concerned about the future, it will just kind of unfold, I just enjoy my time with my family and my friends so I just try to live in the moment with them."*

3.4. Gendered Analysis

Differences within the qualitative data were identified based on gender. For women participants, these differences were focused on aspects of the program that they disliked, experiences they felt impeded their healing, or the specific challenges they faced once returning home from the retreat. These differences resulted in four gender-specific themes: limiting "the invasion", creating gender-specific programming, addressing group dynamics, and psychological protection and safety.

3.4.1. Limiting “The Invasion”

Some participants who identified as women expressed feeling a sense of discomfort or invasion when outsiders, especially men, were introduced to their cohort without forewarning. These interruptions often had the detrimental effect of altering the sense of privacy and “vibe” that had been built within the group and space. Some women noted that not all men were unwanted as some of the peer mentors were kind and gentle; however, having new, unknown men arrive or visit the program was unwelcome and unwanted.

54-29 “To me it was like an invasion... okay... and all these men came in and they invaded our private little group.”... “I am angry because the old school guys that invaded our cohort on Wednesday and I’m angry and resentful because an outsider came in and shared his story with the group and I don’t even know who this guy is, they haven’t introduced him to us and I haven’t had a chance to share my story.”

13-23 “And the other guy they had staying there (. . .), he was bothersome to me and maybe it was just me but he made a sexist comment right at the end at the very last hour of that thing.”

3.4.2. Creating Gender-Specific Programming

Women participants also expressed that the program curriculum should be adapted to reflect their specific gendered-experience rather than having content that is more male-centric (e.g., examples based on more male-dominated military professions in hyper-masculine cultures). Participants felt that the gender-specific cohorts could also benefit from more education on self-care practices as many shared the added struggles of focusing on family and home management (e.g., being a full-time spouse, parent, caregiver, etc.) while they simultaneously tried to manage their own physical and mental health. These participants wanted the retreat to include working on self-confidence and self-care, as these concepts were beneficial when returning home.

7-23 “I find that I put more emphasis on looking after myself, on that self-care component. Like I’ve continued doing the meditations on a daily basis, I’ve made a point of increasing my physical activity and those are things that were emphasized.”

154-47 “I think the idea of it is especially for women. You get away! You are not looking after your kids, you are not looking after anyone else, especially for women that are getting away, the residential portion is key!”

Finally, the participants were also very clear about the importance of focusing on sexual assault. Participants felt they would not be able to do their deep trauma work if these traumas were ignored or underplayed.

51-29 “For me... it makes a huge difference, because the guilt of being sexually assaulted and thinking it was my fault has been left there. The anger, the anger toward the system has been left there, the shame of being assaulted has been left there, and the shame of having my childhood traumas are left there.”

3.4.3. Addressing Group Dynamics

Like the men, women participants felt a sense of comradery and connection in the cohort. This bond was quite profound and the experience of participating in the retreat program together provided participants with a new “family.” However, while most participants noted the importance of having peers in the group, women participants were also much more aware of the challenges related to specific members in their cohorts and group dynamics. Participants expressed the need for the retreat staff to consider individual needs/triggers when making cohorts, and possibly considering how specific types of trauma experienced might impact group cohesion, including post-retreat.

11-23 “Was going from an environment where everything is taken care of for you and you know you’re safe. And all the sudden you’re sent out to the airport to fly home. That was hard. I wish in a way that the program... maybe stay a little bit longer where we were

before we were reintegrated into the human world. Honestly, it felt like my release from the military again."

50-29 "There were a couple people there that I thought were a little more needy, in light it needed something a little more personally designed for them."

3.4.4. Psychological Protection and Safety

The women participants also clearly identified the need for highly qualified mental health professionals on site at all times for cohort members to access, especially when revisiting traumas. Given the intensity of some of the traumas that they were sharing, participants felt that peer mentors or the retreat staff were not enough. They shared that greater care needs to be taken by retreat staff so that the therapeutic work done with participants is manageable and does not go too deep too quickly.

54-29 "I really think that there should be a psychologist or psychiatrist involved in . . . I'm not saying the entire program, but when people are unloading, unpacking, disclosing you know serious trauma, I think if someone says something if they say the wrong thing... so she tried to use one of her stories and compare it to my story when it's like comparing apples and oranges."

146-46 "So I had to be very mindful of protecting myself from some of the stories that I heard from the other participants and because I know what it can do to my brain if I go into victim mode or if I go into, you know that one time, then all of a sudden there is an inflammatory response or a flare up as I said so that was my biggest concern going into this and some people they ripped open old wounds."

4. Discussion

This qualitative study sought to understand the mechanisms of a trauma-oriented retreat based on the experiences of military members, veterans, and RCMP participants. Results illustrate that participants found the retreat to be a meaningful addition to standardized traditional mental health treatments. Central to study findings is the exploration of potential CMO configuration and theory as per RE. Simply, this research sought to better understand when, where, why, how, and for whom a trauma-oriented retreat may be beneficial. As there is growing interest in using trauma-oriented retreats to treat PTSD, this level of nuanced understanding may help to improve trauma-oriented retreats and provide valuable lessons for other evidence-based treatments for PTSD and MI.

The results of this study provide important information regarding potential clients who may seek trauma-oriented retreats as a form of treatment. Active duty CAF members expressed being fearful of career implications and the stigma associated with needing mental health treatment. The current results are similar to previous research indicating that soldiers are often reluctant to seek mental health help [27,28], and that "presumably, the low rates of service utilization are due to stigma and perceived barriers to care" [29]. In contrast, veterans entered the retreat after self-reportedly having tried numerous different types of therapy and treatments. Our results may support previous evidence demonstrating that traditional frontline PTSD treatments have lower therapeutic success when applied to military and veteran populations [30] or with complex PTSD (i.e., with elevated severity, acuity, and complexity of comorbidities) [31].

Exploration of the mechanisms of this trauma-oriented retreat may provide important insights. In particular, the format of trauma-oriented retreats raises crucial questions regarding the appropriate frequency and intensity of trauma treatment. While preliminary, these results support that persons experiencing PTSD may see more benefits, improvement, and recovery with more intensive and immersive treatments. Similar findings have also been observed in the use of intensive models for traditional trauma modalities such as Prolonged Exposure [32], Eye Movement Desensitization Reprocessing [33,34], Cognitive Processing Therapy [35,36], and, more recently, Accelerated Resolution Therapy [37,38].

Potential reasons for this may include limiting avoidance and defense strategies, and facilitating longer emotional processing.

Specific attention to emotional processing may be an important mechanism of trauma-oriented retreats. Recent studies suggest that difficulties with emotional regulation may exacerbate severity and maintain PTSD [39,40]. In particular, maladaptive or absent regulatory strategies, avoidance and repression of emotions, and or unawareness of emotions have been linked to PTSD symptom severity [41]. Emotional dysregulation may be especially important for military members and veterans (and arguably PSP) who appear to withhold emotional responses and use numbing more regularly [42]. Additionally, when considering MI, significant research highlights the importance of addressing deeply held negative moral emotions (i.e., shame, guilt, and anger) and the inability of morally injured persons to experience positive moral emotions (i.e., joy, awe, compassion, mercy) [43]. Tang et al. [44] found that combat-related treatment-resistant PTSD was positively correlated with MI and emotional dysregulation. Addressing emotional avoidance and dysregulation may be important components of PTSD and MI treatment that may be well-suited to frequent and intensive modalities.

Reflection on other mechanisms shows that the environments in which trauma treatment is delivered may be important. Sciarrino et al. [45] noted that having a residential component to intensive retreats could contribute to a reduced dropout rate because there are fewer logistical barriers to care and external stressors are removed. While no empirical research has explored the role of the physical environment in linking positive health outcomes with outdoor environments for veterans with PTSD, Wagenfield [46] suggested a transdisciplinary approach to outdoor environmental designs that support rehabilitation. Nature-based therapies have also been found to improve affect, cognition, restoration, well-being, and decrease symptoms related to generalized anxiety disorder and major depressive disorder [47]. More specifically, several studies found upon review of the literature showed that, while evidence was limited and weak, nature-based therapies were associated with a significant reduction of PTSD and depression symptoms, along with improvements in functioning, hope, a sense of control and self-efficacy to manage symptoms in veterans [48]. Similar qualitative results were also found in a study where Danish veterans with PTSD were given 10 weeks of psychotherapy in a forest therapy garden [49].

Peer support may also be an underutilized mechanism to support well-being. Research has shown that military and veterans are often fearful of the potential judgments associated with disclosure of their military traumas, and feel that civilians (including civilian clinicians) do not understand their culture or life experiences [50]. As such, research into military personnel and veterans shows that they frequently turn to informal support systems (e.g., family, peers, friends) when they are first seeking mental health help [51,52]. As illustrated by this trauma-oriented retreat program, the integration of peer support and/or peer mentors may be one way to help civilian staff be seen as “credible”, trustworthy, and authentic. This ability to develop rapport, trust, and a sense of safety with a treatment team has been suggested to improve when peer support is directly involved [53]. Research has shown that the integration of peer support in veteran programs often support greater uptake and engagement, social support, purpose and meaning, normalization of symptoms and hope, and therapeutic benefits [54]. Similarly, Jain et al. [55] found peer support was associated with favorable attitudes toward recovery, and a reduction in PTSD symptom severity.

Attention needs to also be paid to mechanisms of trauma treatment that embrace a biopsychosocial-spiritual approach. Retreats have historically included activities that integrate the spiritual domain. A systematic review by Smith-MacDonald et al. [56] noted negative spiritual coping (e.g., fear of judgment, alienation from a Higher Power, hopelessness, unforgiveness, etc.) was often associated with an increase in mental health diagnoses and symptom severity in veterans; positive spiritual coping had an ameliorating effect. Healing of MI has been noted to require a holistic, biopsychosocial-spiritual process (e.g., body, mind, spirit, community) [57,58]. Repair may include tolerating intense negative moral emotions (e.g., shame, guilt, anger), face personal failings, assess culpability (self

and others), and clarify distorted thinking (e.g., overgeneralizations) along with fostering connection, trust, and love, and seeking true justice rather than revenge. Brock and Lettini [59] have argued that given MI occurs in the community, it, therefore, must also be healed in the community and that spiritual ceremonies, rituals, practices (e.g., prayer, meditation, appreciate beauty) have been historically developed for this purpose. Spiritual language appears to be universal and has been noted to be conducive to giving voice to ethereal and existential concepts such as self, brokenness, evil, death, suffering, and redemption [58,60–62].

4.1. Cautions and Considerations

Given the intensity of trauma-oriented retreats, careful consideration is needed to ensure that participants of these programs are psychologically safe and that no undue harm occurs. A number of important risks regarding trauma-oriented retreats need to be acknowledged. First, within Canada, many of these retreats are being done within the community without any oversight or regulations. As such, the quality of the retreat material and qualifications of the personnel offering it can vary significantly. There is also a potential for participants in their vulnerability to be unduly influenced as they seek symptom relief or a sense of connection to ameliorate their isolation. As noted in this study, participants who identified as women especially noted there was a need for more highly qualified personnel to be conducting the therapeutic and trauma-oriented aspects of the retreat. Without standardization and oversight of these retreats, there is the potential for inadvertent risk of harm to participants. Second, the limited research to date challenges the notion that any trauma-oriented retreat is an evidence-based intervention that should be used as a first or even second line of treatment. Greater clarity is needed to ensure that potential participants understand what a trauma-oriented retreat is (i.e., a complimentary program) that may assist in the psychotherapeutic and healthy lifestyle interventions that have already been completed. Third, as trauma-oriented retreats are not integrating into standardized healthcare pathways (i.e., they are outside health systems), these retreats can become limited stand-alone interventions. Consequences may include the lack of continuation of the therapeutic work done during the retreat or participants' decompensation once they return home with no to limited psychological services (depending on the participant). Greater care must therefore be taken to ensure that trauma-oriented retreats provide the appropriate referrals and follow-up care so as to maintain the safety and well-being of all participants.

4.2. Learnings and Recommendations

Further research into the field of intensive trauma-oriented retreats is required before a clear and cohesive understanding of for whom, when, what, where, and how they are effective. Moreover, further exploration into some of the found mechanisms may be of potential importance to PTSD and MI recovery, and may impact the way current treatments are provided. Future research may further explore and address the following:

- Intensive treatments for PTSD that may be an effective way to treat severe PTSD and MI where patients may need more time than current models of one-hour psychotherapeutic appointments per week.
- Trauma-oriented retreats may be beneficial as a complimentary modality to first- and second-level evidence-based treatments.
- Current evidence-based treatments may benefit from incorporating experiential learning opportunities where clients have the opportunities to practice skills with clinical supervision.
- The use of holistic activities, including spiritual ceremonies and rituals, may be beneficial for the healing for MI.
- Peer support, may be an under-used resource that may improve engagement in treatments and also address issues of social isolation.

- Sensitivity to gender considerations and the impact of sexual trauma (especially occupational sexual trauma) is needed in trauma-oriented retreats and all PTSD treatments.
- PTSD treatments may need to support the person to re-establish a forward-focused identity and quality of life mindset that extends beyond their pathology.
- Models of intensive outpatient care used for other mental health conditions may be beneficial to guiding PTSD treatments.
- More robust and rigorous research that includes longitudinal methodologies is needed to explore the efficacy of trauma-oriented retreats.
- Standardization or manualization of trauma-oriented retreats is needed to address variation in the qualifications and experiences of personnel, length of intervention, evidence-based merit, effectiveness and efficacy.
- Exploration using RE or similar methods to continue to answer the question of for whom, when, where, and how trauma-oriented retreats may be beneficial.

4.3. Limitations

There are several important limitations to consider regarding the findings of this study. First, the overall sample was a convenience sample that may have biased the data as participants were recruited directly through the program rather than an external third party. This may have limited the robustness of the data collection. Participants may also have been hesitant to share their opinions for various reasons because they came from a convenience sample. Participants in the program were self-selected, with word-of-mouth being the most frequent form of how participants come to know about the program and seek admission. Second, participants were already screened by a medical team at the organization prior to being accepted into a cohort, resulting in a very selected sample from which the study could draw.

Third, all participants were provided with funding to attend this program via grant funding. Given that it would not be possible for many participants to attend the program without such funding, the financial resourcing may have influenced participants' openness to try the program and their sense of gratitude for receiving psychotherapeutic support. Equally, participants might have developed a feeling of loyalty to the program because of the financial support, and thus may have been more hesitant to criticize the program.

Fourth, as the research team members were not physically present during the on-and-off boarding process, it is possible that participants may have misunderstood aspects of the on- and offboarding process.

Fifth, all qualitative data were collected remotely. Interviews were done over the phone or via video call, which, while common in qualitative research, may have influenced the comfort level of participants to share and speak freely.

Sixth, ensuring a homogenous sample in terms of employment status (i.e., active-duty, veteran, first responder) was challenging as many military veterans often serve in the CAF reserves, or in first responder roles and thus continue to be exposed to occupational stressors and trauma. It is difficult to know if the intervention is effective for this specific population and their traumas.

Seventh, not all participants responded to the invitation to engage in the interview, and it may be that persons who had a less positive experience declined to participate. Finally, the study was conducted during the COVID-19 pandemic and therefore, there were delays in the data collection because of public health policies.

5. Conclusions

Response from participants to the intervention was complex and multifaceted. While participants reported positive changes, it is crucial that these results are seen in the light of the CMO configuration. Exploring the underlying mechanisms illustrated that trauma-oriented retreats may be beneficial for a sub-population of active-duty members and veterans with extensive mental health comorbidities and who have self-selected this type of programming. For these individuals, the retreat offered mechanisms that capitalized on

their internal readiness and desire to seek help. The mechanisms also enticed participants to engage in therapeutic activities which addressed issues that were previously, and at times deliberately, avoided in previous trauma treatments. Care is warranted, however, as the effectiveness of these types of programs needs to be established and questions addressed regarding for whom, when, where, and how intensive trauma-oriented retreats are best suited. As military members, veterans, and RCMP continue to look for the best treatment and programs for their mental, social, and spiritual health challenges, it is imperative that researchers, policy-makers, and clinicians offer effective and safe military, veteran, and PSP-centered services.

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