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Carolyn M. Duncan
“Unconditional Positive
Regard”: Clinicians’
Reflections on the Impact of
Animal Co-Therapists In
Therapy

ABSTRACT

This study explored the benefits of animal-assisted therapy (AAT) in formal therapy practice, its unexpected outcomes, and examples of its use as a novel intervention. This study explored the clinicians' perceptions of AAT as it is practiced in the field today, their examples of novel and/or unexpected benefits, and their thoughts on the future of the field. This study utilized interviews of nine animal assisted therapists, who had higher education in the areas of social work, psychiatry, or psychology, as well as at least six months of experience practicing AAT.

The findings showed AAT was found to be a useful intervention across almost all populations and treatment needs. Clients were excluded from AAT if the clients expressed an aversion or lack of interest, if the therapist thought there might be resistance by the family, or if there was a trauma history related to animals that contraindicated its use. The findings also showed that the presence of an animal sometimes provided an immediate catalyst for a therapeutic breakthrough, and this was often how clinicians who happened upon AAT by chance discovered its novel use.

In addition, the study found that clients who had problems trusting other humans could benefit more from AAT as a supplement to therapy, than therapy without AAT. AAT was often crucial to helping the therapist access the client's psyche, as the animal provided a stable and trusting relationship. Finally, this study found that the field of AAT is in need

of consistent and nationally applied curriculum, and most likely a requirement of certification so as to protect the therapist, the animal co-therapist, and the client. However, the lack of standardized requirements and curriculum around practice is a reflection of the fact that AAT is still not widely accepted as a formal intervention. While some social work and psychology programs now include AAT in the curriculum, it is still not recognized as a specialty by the field at large. Many of the participants felt that it should be treated as such, and that such recognition was necessary to creating consistency in formal education and practice.

“UNCONDITIONAL POSITIVE REGARD”:
CLINICIANS’ REFLECTIONS ON THE IMPACT OF ANIMAL CO-THERAPISTS
IN THERAPY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements for
the degree of Master of Social Work.

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2013

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CHAPTER I

Introduction

Clinicians have utilized animals in the therapeutic context as early as Freud (Brown, 2004). One of the earliest documentations of the formal use of AAT was in 1919, when it was introduced with psychiatric patients at St. Elizabeth's Hospital. It was also used in 1941 at an Air Force Hospital (Chandler, 2005). Later, Altschuler completed a quantitative study based on observations of his own patients in treatment for PTSD, and theorized that a study of attachments to pets and animals in therapy would show animal-assisted therapy to be beneficial (1999).

Dr. Levinson introduced the notion of AAT as a formal intervention and practice in 1962 and coined the terms “pet therapy”, “pet-oriented psychotherapy” and “human/companion animal therapy” in his work (Fine, 2000). At the time, clinicians and academia at large did not take “pet therapy” seriously. Today, the term “Animal Assisted Therapy” is typically used today to differentiate between informal animal assisted activities, and formal therapeutic interventions. Organizations such as Pet Partners (formally known as Delta Society) have aided the development of standardized (but not required) guidelines and recommendations for animal and clinician training, assessment, and certification. For the purpose of this study, the term Animal-Assisted Therapy (or “AAT”) was used in all contexts, except when the clinicians specifically used a different term themselves, to eliminate potential confusion.

Recently, the large population of veterans returning from the Middle East with PTSD, and the need for novel treatment choices with otherwise impassible cases, has caused a

recurrence of interest in AAT and a bounty of quantitative research. Thus, the interest in the use of AAT has come full circle: to its use with veterans suffering from PTSD. However, it is important to continue to note and explore the other potential usages as a “novel stimulus” (Sacks, 2008). Therefore, the purpose of this study was to further our understanding of current uses of AAT in therapy, as this approach continues to gain importance in clinical work. To that end, this study explored how and why the clinicians decided to use AAT, their training and education, their observations on uses and outcomes, and their recommendations for future practitioners and the field in general.

CHAPTER II

Literature Review

This literature review provides an overview of the development of animal-assisted therapy as a formal therapeutic technique and what studies have revealed about AAT's efficacy and its limitation. Various animals have been utilized in AAT with success; however, not every population studied has been proven to benefit from AAT.

Guidelines for Practice

Though AAT has become more popular and research has expanded due to its usefulness with veterans returning from war, clinicians still find it difficult to get the guidance they want and need starting out in the field of AAT. Pet Partners, formerly known as The Delta Society, now focuses on volunteer work, and had been considered the "Gold Standard" for training and vigorous assessment of the human-animal AAT team. There are local and interstate AAT organizations, but there is still a lack of nationwide requirements regarding training and education in the same way that a clinician is required to have a license in their field of practice.

Some research institutions are seeking to step into this gap. For example, the Institute of the Human-Animal Connection at The University of Denver was responsible for making the university the first school in the United States to offer an AASW, otherwise known as an Animal-Assisted Social Work Certificate, and has seen approximately 20 human-animal teams graduate from this specialized program that supplements the MSW curriculum (www.du.edu). This certificate specifically serves the function of formalizing a track in AAT for social workers

at this institute, and represents the fact that they have undergone specialized training and education in that field. As AAT becomes more widely accepted, and perhaps with greater advocacy by those who can affect policy, perhaps this sort of certification program will become part of curriculums across the country for social work and other fields of mental health treatment.

Whether the clinician is practicing AAT formally or informally, a guide can provide some sense of what to expect, as well what to watch out for and what not to do. For the clinician who has not undergone voluntary training with his or her animal, guides at least provide a framework of some basic dos-and-don'ts. Widely used and accepted guides are Audrey Fine's *Handbook of Animal Assisted Therapy* (2000), and Chandler's *Animal Assisted Therapy in Counseling* (2005). Other important guidebooks include *Animal-Assisted Brief Therapy: A Solution-Focused Approach* by Teri Pichot (2013), *Animal-Assisted Therapy* by Donald Altschiller (2011), and *Professional Applications of Animal Assisted Interventions: The Blue Dog Collection* by Melissa Y. Winkle (2013). The Delta Society published a guidebook as well, *Animal-Assisted Therapy Standards of Practice* (1996), the first edition of which has apparently become a collector's item at the whopping price of \$1,500 from third party sellers.

Ultimately though access to formal training benefits the clinician, the patient, and the animal co-therapist. As Fine speaks of in *Afternoons With Puppy* (2008), one of the advantages of training was that he found he could now use signals to have his dog perform an intervention, such as going to the client in need of comfort.

One important recommendation across all guides is for the clinician to make sure the AAT animal has a safe space to retreat to, and that the therapist can intervene when the animal needs to terminate contact with a client. Sometimes this safe space is in the office (such as under the clinician's desk). Part of the therapeutic contract with the individual should also involve

explicitly stating that the animal's space must be respected if the animal decides he or she needs to rest and regroup. For clients who are aggressive or have problems with body language, this component of the therapy can actually be quite educational, as well as an exercise in empathy.

For the purposes of this study, it is necessary to differentiate between Animal-Assisted Activities and Animal-Assisted Therapy. As per Pet Partner's definition of AAA versus AAT, animal-assisted activities are "the casual 'meet and greet' activities that involve pets visiting people" without any formal treatment plan for an individual person (www.petpartners.org). Pet Partners is one of several institutions that offer formal training and guidance to clinicians, but even at this date a specialized license or certification in AAT is not required to practice it.

History of AAT and its Acceptance as a Formal Intervention

Animals have been beneficial for concrete, physical, reasons for many years: as companions to the elderly and to those who live alone (Netting, Wilson & New, 1987), as seeing-eye dogs, and as assistants to people with other physical handicaps (Strom, 2006). Animals in therapeutic contexts have been found to be beneficial in many different clinical settings, including use with the institutionalized elderly (Colombo, Buono, Smania, Raviola, De Leio, 2006); group treatment with sexual traumatized girls (Reichert, 1994); and clients with mood disorders (Kogan, Granger, Fitchett, Helmer, Young, 1999). As shown in the Reichert study, the pets provided "unconditional positive regard" as 'silent listeners'" (Standal, 1954). In some instances girls would tell the therapeutic dog their trauma prior to the group, which allowed for a graduated build towards vulnerability in the group. In short, the animal co-therapist acted as a transitional object for the girls expressing their trauma in therapy.

Reference to animal-assisted therapy appears in literature as far back as the 18th century. It is worth noting that the founder of Western psychoanalysis, Freud, informally practiced AAT

with his dog Jofi (Coren, 2003). Though Freud may have focused on the family drama in his formal works, the benefits of having an animal co-therapist still figured into his actual practice. In his diaries, Freud recorded how the “libidinal pair bond” reflects the capacity for a human-animal attachment that is of “undisputed solidarity” (Coren, 2003, p. 141). In short, animal-human bonds are instinctual and difficult to rupture.

Documentation in regards to AAT’s first informal use in an institutional setting varies according to different sources, but one documented early instance was at the Army Air Force Convalescent Hospital in New York according to Beck in “The Use of Animals to Benefit Humans: Animal-Assisted Therapy” (2000). In this early use of AAT, animals were present to help war veterans. Now, there is a renewed interest in AAT on a national level due to the need for a novel therapeutic intervention with veterans returning from the wars in the Middle East. Thus, AAT has come full circle. This has also created a surge in research on AAT. However, in the interim AAT grew in use and was expanded in its applications.

The exclusion of animals in theory as well as documentation and research of formal practice is due to a human-bias by clinicians and systems in general in a world where industrialization and urbanization have divorced human society from an organic interaction with the environment. However, one need only look at human behavior to see how important animals are to people. In an article titled “To Protect Battered Women, You Have to Protect their Pets” Kathryn Joyce discussed the fact that researchers found the inability to ensure the safety of a companion animal caused many women to delay getting help. In New York alone, this issue was found to affect 65% of the women who needed a safe haven. Only as of this year, in New York City in particular, have new policies have been put in place to create pet-friendly shelters to remedy this issue (2013).

In addition, if one looks at the issue from a psychoanalytic standpoint, Anita Sacks reminds us “the ‘person’ least spoken of is often the most significant family member to the patient. Could this be so with one’s pet?”(p. 520). Pets show up as identified patients, and are sometimes in the family system to displace issues. As aforementioned, individuals may be afraid to leave certain situations due to the fear that aggression will be displaced on to the pet, if it isn’t already. This shows how crucial animals are to any family or individual’s support system that includes one.

Of course, this relationship isn’t one-way. Interestingly, a study by Lisa Horn, Ludwig Huber, and Friederike Range titled “The Importance of the Secure Base Effect for Domestic Dogs – Evidence from a Manipulative Problem-Solving Task” (2013) found that dogs display the same type of attachment styles as Ainsworth’s famous study found between infants and their caregivers. The study accounted for all possible variables that could interfere with the results, such as familiarity with objects and tasks, and ultimately found that the presence of the animal’s owner affected the dog’s ease with the task presented. A “replaced owner” component was also factored in to see if an unknown person could have the same effect as an encouraging owner. It was only the actual dog’s caregiver that had an impact on the dog’s affect and motivation.

In addition, the systems framework with which a clinician approaches a case in turn affects the ability to analyze an individual’s environment and support structures. A study titled “Social Work Practitioners and the Human-Companion Animal Bond: A National Study,” found that while most clinicians had some sort of varied understanding of the use of AAT, only one third of the study participants asked about pets in the family system when doing an assessment. (Risley-Curtiss, 2010). This could be attributed to the human-centric nature of therapeutic practice in Western society; AAT is still arguing its case in more conservative circles. The

exclusion can also be attributed to the fact that AAT is not part of formal training in educational institutions, and even today clinicians happen upon the usefulness of an animal co-therapist by chance.

The delay in including animals in biopsychosocial interventions can be seen in the field's initial reaction to the very notion of using animals as co-therapists. Dr. Levinson coined the term "pet therapy" in 1964, but the idea of discussing AAT as a formal practice was regarded as "preposterous" (Arkow, 1998, p. 116). Levinson had found his dog Jingles to be conducive to therapy by mere chance. A boy and his mother had arrived early, and the boy's interaction with the dog made a notable difference in the boy's behavior in that day's session (Hooker *et al.* 2002, p. 18). Despite the fact he was seen as a "hippie" therapist, Dr. Levinson continued to pursue the matter as one worthy of research and discussion.

To this day, "accidental" discovery of the incorporation of AAT as a useful tool still occurs due to its exclusion from formal degree coursework at most institutions of learning. Participants in this study cited discovering the usefulness of their animals in practice by chance encounters between the animals and their patients. Due to fear regarding insurance and liability, some clinicians still use it in a very limited and informal fashion.

Some examples of these accidental inductions into the world AAT are found in the literature, by individuals who often went on to educate themselves about AAT and who often also sought out formal training. In "The Therapeutic Use of Pets in Private Practice" Anita Sacks discusses how she kept her dog in another room while she saw patients. Much like Levinson, she discovered how AAT could assist her own practice when she accidentally left her dog Sara in the waiting room. A patient who was 57 years old and was depressed arrived while Sara was in the waiting room. Anita Sacks noted that he responded to Sara's enthusiastic greeting with the

phrase, “I’m glad someone’s happy to see me”(p. 508). Through this chance encounter, Sacks realized that Sara could be a “novel stimulus” in her treatment interventions.

From thereon Sara, who had already undergone obedience training due to her former career in dog competitions, began to serve a role in Sack’s therapy. Sara had essentially retired from dog competitions around the age of 7. Now, at the age of 9 Sara had found a new “job” as a co-therapist (2008). Sacks and Sara also underwent formal training through TDI (Therapy Dog International).

Ethical Issues in AAT

Sack’s anecdote of her retired show dog attaining a new purpose brings us to another issue: the ethical questions surrounding AAT. One of the debates found in research and literature is whether the animal is being “used” or if the animal benefits from his or her role in some way.

Firstly, it is important to note that for many breeds, a “job” helps the animal maintain a sense of purpose and essentially keeps the animal psychologically healthy. This, in addition to the idea that each animal should be screened for temperament as well as interest in therapy work, is a valid response to controversy around AAT’s “use” of animals. As long as the animal’s boundaries and need for space and recovery from work are appreciated, AAT does not harm the animal or cause burnout.

As shown in the literature of therapists who practiced AAT informally, and then underwent training to acquire more skills and knowledge, formal training can also enhance how the therapist utilizes AAT and improve its benefits. In his book *Afternoons with Puppy*, Fine talks about how prior to his formal training he discovered the usefulness of AAT by chance. After he underwent formal training with his next AAT canine and personal companion, he was able to use signals to engage or disengage his co-therapist when he felt intervention was

warranted. Formal training also typically reinforces the idea that an animal will need a safe space to go to in order to rest, and that sometimes the animal will need to leave the room altogether.

Populations Treated, and AAT Efficacy With Those Populations

As a result of the field's slow acceptance of AAT, not a lot of research can be found in research databases prior to 1999. In 1999, Altschuler observed in an op-ed call for further research that the use of AAT had expanded in applicability beyond treatment of PTSD in veterans. In Altschuler's proposal for further study of this intervention in the field, he called for a quantitative study using control sample of a group with no pet versus a group with a pet and different scales, such as the *Clinician-Administered PTSD Scale* and the *Civilian Mississippi Scale*, to be given at the beginning, at intervals during the trial, and at the conclusion. In 2005, a response to Altschuler's proposal was written by Lefkowitz, C., Paharia, I., Prout, M., Debiak, D., and Bleiber, J., titled "Animal-Assisted Prolonged Exposure: A Treatment for Survivors of Sexual Assault Suffering Posttraumatic Stress Disorder". The writers proposed that AAT become part of PE therapy, to decrease attrition rate caused by the intensity of such therapy, which "is the most effective treatment package for PTSD," but had the worst attrition rate (277). This interest in AAT as a unique intervention to decrease attrition and/or improve treatment success can be seen across many populations. As noted by Kruger, Trachtenber, and Serpell (2004), humans are wired to note the response of animals to the environment for potential danger, a calm animal in the presence of a therapist will signal to the patient that the therapy environment is safe and non-threatening.

Young children and adolescents. AAT has been shown in both qualitative and quantitative studies to work in group settings for young survivors with PTSD. As previously discussed, Reichert's (1994) article on group work with a canine co-therapist analyzed its

effectiveness from a qualitative standpoint. Reichert intended the article as a potential framework for application of the technique of AAT in group therapy settings. However, the article is also in qualitatively important in its narratives about how the canine co-therapist assisted the process of the group therapy work.

Sometimes young populations require a particularly unusual intervention for change to occur. One example would be the use of farm and wilderness therapy with child and adults with severe psychological and behavioral problems. E. Chardonens (University of Lausanne, Switzerland) presented several case studies that exemplified that children and adults can develop a sense of competence through responsibilities, and in turn develop relational competencies as well, through AAT work in a farm setting (319-320). Chardonens says of the bond between children and animals, “[s]ome human-animal relationships are particularly strong, for example between children and animals. And even though not all animals are able to reach the same degree of closeness with children, the relationship can be amazingly strong and rich. This is particularly true with abandoned, rejected, or abused children, who can often find hope, trust, and self-esteem through their relationships with animals”(321).

Clients afflicted with developmental disorders such as autism. In addition, AAT can improve basic social and communication cues and skills. Dolphin therapy was found to be therapeutic for children with social and communication disabilities (“Dolphin-Assisted Therapy” by E. Breitenbach, E. Stumpf, L. Fersen, and H. Ebert). It was found that “Post therapy, children with autism appear to allow more physical and social proximity and cooperate with children for the first time”(278). Such a novel intervention was warranted, as researchers found that “Many parents of children with severe disability have little faith in their own and their children’s strategies to deal with challenging situations”(278). The researchers noted that intervention could

only work if the parents are included; though the children may be the identified patients, DAT was applied using a family systems approach. DAT increased reciprocity between child and caregiver (279). In an unexpected outcome, children in the farm group (one of the control groups for the experiment) benefited from the therapy, but the effects seemed to disappear at approximately six months post-treatment (285). This is an example of a gap in knowledge that warrants further study.

Adults With Dual Diagnoses. AAT has been used with dual-diagnosis patients, who are also usually socio-economically challenged and “in the system” due to drug or alcohol related behavior and possession. In “Animal-Assisted Therapy in the Treatment of Substance Dependence” by Martin C. Wesley, Neresia B. Minatra, and Joshua C. Watson, the researchers found mixed results in a quantitative study of AAT intervention in such populations. It is important to note, as they did, “[t]hese clients are most likely to come to treatment under the worst of circumstances”(145), and as a result “new treatment strategies are needed to help with client retention in treatment and [to] increase treatment efficacy”(138).

This population ranged from young to middle-aged adults, but none were older than 55 (140). The study found that the therapeutic alliance was enhanced with a dog, but results were varied with the subgroups. AAT was helpful for mandated clients, those with multiple substance dependencies, those with meth or cannabis dependence, and those who owned or had recently owned pets (145). Some of the clients were homeless or living in shelters, and many were facing felony charges. It was theorized that the “dog might remind them of better days and give them a sense of home and normalcy”(145).

Limitations to AAT’s Success. Interestingly, AAT was found to be statistically ineffective for clients who were being investigated by Child Protective Services, as well as

clients suffering from alcohol dependence (146). While the clients who were treated for alcohol dependence self-reported that AAT helped the therapeutic alliance, the data supported the opposite: the intervention had a nominal impact on treatment (146). The researchers theorized that in these cases several AAT sessions might be required before AAT can statistically improve the therapeutic alliance (146). It should also be noted that this study dealt with group therapy.

Counterindications. AAT is counterindicated for any individuals suffering from pathology or traumas that would suggest that the patient would not benefit from the intervention, and/or if the animal may be put at risk. This also avoids the rare but inevitable occurrences where a therapist's need to protect the animal is at odds with an appropriate therapeutic response to the patient's behavior.

Approaching AAT from a Self Psychology and Narrative Perspective

Symons's "Choreographing Identities" (2009) is a contemporary and relevant example of how a narrative approach reveals the wealth of therapeutic potential in the AAT approach. Symons expands on Brown's notion that self-psychology can and should include animals as potential self-objects ("The Human-Animal Bond and Self Psychology: Toward a New Understanding," 2004). Sometimes the therapeutic potential is found in a psychological link to patients' own past pets; sometimes it is the fact that the animal acts as a mirroring self-object. Symons notes how geriatric patients are able to retain parts of their identity otherwise lost in this institutional space thanks to their interactions with her canine co-therapist, Fergus.

In using an autoethnographic approach, Symons acknowledges her own subjectivity and countertransference as a clinician observing and participating in the benefits of AAT. As Sharpiro and De Mello put it in "The State of Human-Animal Studies,"

positions inform [the clinician's] research by shaping the questions they ask, the priorities they establish, and even the investigatory methods they employ” and that for the natural sciences there is essentially no such thing as this ‘view from nowhere’ (Nagal, 1986). (2010).

Since objectivity is a faulty construction, a narrative approach is open-ended, and allows new material and questions to be incorporated into the findings.

Aiding the Therapist or Caregiver

As Symon’s readily admits, the animal can also be for the therapist’s “own emotional comfort” when a scene is “distressing” or a therapist is facing an unfamiliar situation or milieu (116). A quantitative study by S. Barker, J. Knisely, N. McCain, C. Schubert, and A. Pandurangi looked at how therapy animals buffer stress for both pet owners and non-pet owners (“Exploratory Study of Stress-Buffering Response Patterns from Interaction with a Therapy Dog”, 2010). The Stroop Color Word Test was administered (a test in which the words of colors are purposely given different colors, and participants have to discriminate between the two). This took approximately 5 minutes. The intervention was a half hour non-structured interaction with a therapy dog. Both self-reporting and biochemical data reflected that individuals felt less stressed when interacting with a therapy dog.

An unexpected outcome, again warranting further study, was that while therapy dog owners self-reported that they felt more comforted by their own dogs, biochemical data showed the unfamiliar dog was more helpful in reducing stress indicators. The researchers could not definitively point to a cause for this outcome, and the lack of a control group (one with no therapy dog intervention at all) also indicated a need for further studies to better understand how and why an unknown therapy dog may work better than a known one, or to rule out that the

small study sample was not actually an aberration in this finding, rather than reflective of a universal inverse relationship between familiarity with a therapy dog and stress reduction.

As a last note on stress reduction for the caregiver, one interviewee for this research study readily admitted that the animals also comforted her during distressing or difficult moments—petting an animal helped with any anxiety or stress. This can be a case for how AAT can prevent therapist burnout, as much as it can reduce attrition in mandated clients or those facing several socioeconomic and psychological hurdles.

Conclusion

Some populations have not benefited from use of AAT, though some outcomes require further quantitative study to understand why and how AAT does not work for certain populations. This will aid future treatment planning and interventions, and may also help clinicians discern more quickly how an individual may or may not benefit from AAT intervention. The more these failures and successes can be understood, the more AAT can be managed as a pliable tool in practice.

The quantitative approach to evaluating the quality of AAT as a therapeutic approach has increased in the present day due to the increasing demands for evidence-based practice both in the theoretical world, as well as the practical realm of insurance demands and limitations. AAT has also experienced a resurgence of interest due to the need for novel interventions with veterans returning from military involvement in Afghanistan and Iraq. Many researchers continue to seek data validating the use of AAT. However, like all methods AAT cannot be broken down into the sum of its parts, and quantitative methods can only be as objective as its human researchers can allow. This study seeks to fill more of the gaps left by controlled studies.

While material evidence is important for the real-world issues of funding and insurance coverage, a purely quantitative approach inevitably leaves out the intersubjective part of the process of AAT. As researchers note, the theoretical model and interventions account for only 15% of the therapeutic outcome (Asay and Lambert, 2002; Anderson *et al*, 2009). This leaves a large part of the outcome up to the quality of the treatment itself and the therapeutic relationship.

In particular, the lack of AAT coursework throughout the United States highlights the need to investigate where a clinician's ability to observe and intervene with AAT serves as training outside of the formal degree process. As Symons puts it, "huminality takes us past the animal-Nature/human-culture frontier into uncharted territories [...] with nonhuman others. Encounters with animals, even on a geriatric ward, can transform our universe and our selves"(115). Here, "our universe" applies as much to the therapist as it does to the patient. It is the qualitative area of research to which this writer wishes to add with this study by inquiring into the narratives of clinicians' ongoing learning processes as practitioners of AAT.

CHAPTER 3

Methodology

This flexible methods study (Anastas, 1999) explored the different ways in which clinicians decided to utilize Animal-Assisted Therapy (AAT) in their practice, how they originally came to incorporate AAT in their practice, and what they learned from the process of incorporating AAT as a method of treatment. The narratives informed the qualitative research of this project. Rather than follow the push for a more empirical approach to biocentric studies (Melson, 2003), this researcher followed the relational approach to interacting with the human subjects based on a qualitative study approach. Consequently, the research also encompassed and utilized unexpected results. New discoveries about issues and misinformation in the clinical world (such as that AAT requires that the animal have a license) informed future research. The researcher's perspective on the research material was biocentric, meaning that the animals were considered co-therapists by this researcher, rather than just a tool of treatment. The inherent bias in seeking out new information on AAT while viewing it through this lens was compensated for by including questions about complications as a result of AAT treatment, as well as open-ended questions that allowed for the critique of current AAT practice and education in the field.

Recruitment of Participants

Recruitment was done by researching publicly available information about AAT clinicians, such as clinician databases available on the Internet, or via public referral sources. It also occurred via the "snowball" method whereby participants referred this researcher to other

animal-assisted therapists or resources. Each potential participant was contacted by letter, phone, or e-mail, and asked to write, e-mail, or call for further information if she or he was interested. The researcher then scheduled a time that worked with the clinician's schedule. Individuals were asked to confirm basic inclusive criteria at as part of the interview, e.g. whether he or she was licensed and in which field. From thereon the interview focused on the open-ended questionnaire. The questionnaire is available in the Appendix.

Sample

The study was carried out by interviewing 9 clinicians from the clinical disciplines of social work, psychology, mental health, counseling, and psychiatry, who were currently or previously involved in animal-assisted therapy for a minimum of six months in the last ten years. Clinicians from across the United States were eligible as phone interviews allowed a wider sample. This was intended to ensure that clinicians' experiences would be relevant to current issues with AAT in the field. The interviews were conducted with an exploratory, open-ended questionnaire.

Inclusion was based upon the following criteria: Clinicians who utilized animal-assisted therapy for at least six months in the last ten years and were licensed in his or her particular field. As the law does not require that the animal be trained for the purpose of therapy in every state, and training organizations and methods can vary, the animal itself may or may not have undergone formal training. No one was excluded on the basis of gender, age, ethnicity, race, or disability. The exclusion criteria was if any clinician who has not utilized this type of therapy, or who has utilized it for less than six months.

Due to the small sample size of this exploratory study, the diversity of clinicians on the basis of gender, age, ethnicity, race, or disability could not be assured and therefore was not

sought. However, as this researcher found evidence of AAT in unusual non-clinical settings during the research process, an attempt was made to include practitioners that might utilize AAT in non-traditional settings (such as outdoors and/or on a farm).

Data Collection

The subjects were asked to discuss their experiences with AAT in their clinical work in one interview lasting approximately half an hour to forty-five minutes. Participation in the interview included answering questions from a semi-structured interview guide that begins with a few demographic questions (see attached Interview Guide Appendix D). In this exploratory study questions were purposely open-ended to enable subjects to bring up different issues or new ideas, and so that the researcher could also pursue a particular avenue of content further if the interviewee's answer suggested it was an important piece of data to expand on. The interviews of the session were audio taped in order to help facilitate the research. The researcher also took notes on particular points of interest during the interview. This researcher transcribed the tapes.

Interviews were conducted at a time agreed upon by both the participant and researcher. In order to broaden the sample collection process, phone interviews were conducted with participants, as many were geographically inaccessible.

Informed Consent Procedures

Approval for this research was obtained on March 18, 2010 from the Smith College School for Social Work Human Subjects Review Committee (see Appendix A). In keeping with procedures set out by the Committee, and as noted above, consent from participants was obtained before they are interviewed in the study (see Appendix A). Updated criteria was approved on August 18, 2012, as this researcher found that including participants from other states via phone interview would yield more success in accessing a sample population.

Participants were sent the informed consent form prior to their participation in the interview (see Appendix B). The informed consent included the potential benefits and risks of the study, as well as the precautions taken to safeguard confidentiality and identifiable information, as required by the Committee. If participants did not mail or email the signed Informed Consent form prior to the interview, the participants were able to sign it at the time of the interview. At the first interview, the consent materials were reviewed to make sure the subject did not have any questions or concerns about the content of the form. One copy was provided for his or her records in cases where the form was signed in person and the clinician did not already have a copy.

Data Analysis

The interviewer recorded the interviews by the interviewer and audiotaping. The audiotapes were transcribed. The use of audiotapes and notes ensured that data could be reviewed for any missing content. The data was then analyzed for key descriptive words or phrases, which were used to illuminate themes and descriptive information about AAT practices and the ongoing learning process of the clinician in the field. The information was coded to ensure confidentiality with terms such as “interview four”. As a result, only the researcher would know which interview corresponded to which interviewee.

As the interviews were conducted with open-ended questions, this allowed unexpected data to emerge as the participants responded to the semi-structured questionnaire. As noted above, the data was analyzed using a non-numerical form of data analysis for themes or patterns in the sample population’s responses. A graphic organizer was designed to capture the occurrence of relevant data that emerged as themes from the sample group.

CHAPTER IV

Findings

This chapter contains findings from interviews with nine therapists who utilized Animal Assisted Therapy as part of formal therapy. Participants were asked open-ended questions about how they discovered AAT, what they learned through hands-on experience, and what recommendations they had for future practitioners. The interview guide was structured to elicit information regarding the process of choosing AAT as a method of therapeutic intervention, the clinician's perceptions of how and when AAT was most effective, as well as whether there were any unexpected positive or negative outcomes. Interviewees were free to elaborate on any part of the interview, and sometimes the interviewer asked questions to guide the clinician to further elaborate on a particular answer.

The interview questions also were intended to explore any contraindications, cultural differences, or unexpected negative outcomes the clinicians may have experienced in the utilization of AAT as a therapeutic intervention. Interviewees were also given a chance to comment on particular texts or learning experiences they found the most useful as an AAT practitioner. Finally, participants were given the opportunity to comment on any important issues or aspects they felt had not been included in the interview.

The data retrieved from these interviews are presented in the following order: demographic data of participants, participants' clinical education and work experience, any common elements in the choice to utilize, or not utilize, AAT with particular patients, the

necessary components of AAT for successful practice and safety for all humans and animals involved, and lastly particularly novel or unexpected outcomes the clinicians had observed in their practice.

As previously stated in the chapter of methodology, this study was composed of 9 participants in total. All participants identified themselves as Caucasian. The sample was predominantly female. The participants ranged in age from 52 to 69 years. All participants had advanced training and licensure in clinical therapy, including: social work, psychology, and counseling. Many had training particular to AAT. Several also worked or previously worked for organizations that provided AAT training, and had supervised other practitioners of AAT within a practice. One participant worked on a site dedicated to AAT only, with many types of animals available for therapeutic interaction. The number of years practicing formal therapy ranged from 15 to 46 years. The number of years practicing AAT ranged from 4 years to 25 years.

Animal Assisted Therapy- A Clinical Perspective

Participants were asked questions pertaining to their experience and perspective on AAT. The entire range of questions can be found in Attachment D: Interview Guide. The findings that resulted from the data presented in following sections: Discovery of AAT as a Clinical Intervention; Theoretical Approaches Paired with AAT Interventions; Deciding Factors for Inclusion or Exclusion of AAT in Treatment; Cultural Differences and/or Barriers to AAT as an Intervention; Unexpected Outcomes; Recommendations for Future Practitioners; and finally Comments on the Current State of AAT in the Field.

Discovery of AAT as a Clinical Intervention

This next section outlines how participants became familiar with AAT and ultimately decided to utilize this intervention in therapy. Many participants identified having had animals

as pets at home and/or a general interest in animals prior their incorporation of AAT in their practice. The majority of private practice participants described their path to AAT as "accidental" or "coincidental. Since many already had companion animals and were interested in the human-animal bond, the integration of animals into therapeutic work was a natural step after discovering the intervention could be a catalyst for change in particularly stagnant or resistant treatment relationships.

Discovery by Accident: Several practitioners cited AAT as an “accidental” or “coincidental” discovery, such as when a companion pet was present at the office, and a patient or family interacted with the pet. The therapist then observed the change in behavior or affect, and realized how useful an animal could be as part of therapy. One participant described it as a slow process:

“ I love animals, and it [...] started accidentally, so I didn’t even know I was doing Animal Assisted Therapy. I had a cat that started to come into my therapy sessions when I was working [...] in my private practice, so I started to build on that.”

Other participants described the discovery of AAT as more of a dramatic event, wherein the patient or family who interacted with the companion pet had a breakthrough outside of “formal” therapy. Once participants began to practice AAT consciously, they cited that often the companion animals they chose were ones that also had potential for AAT. As one participant put it, “Because this has been part of my professional life, when I search for a pet, I search for a pet that has potential to be a therapy animal”.

Discovery by Patient Request: One participant cited that a long-term patient who struggled with a developmental disability had “always talked about how she loved dogs” and had asked the therapist one day, “Can you bring one of your dogs one day?” The therapist

brought in her large canine companion, whom actually outsized the patient. The patient was able to “snuggle” with the dog as needed. This participant noted that the dog had a “calming effect” on the patient when she was anxious, and that the patient actually started to call up the therapist whenever she was having a bad week, and request ahead of time that the dog be present at the session. This particular dog became the primary AAT co-therapist in the sessions (the therapist actually had several dogs at the time), though the client came to know all of the therapist’s canines at one point.

Theoretical Approaches Paired With AAT Interventions

Participants ranged in their theoretical models for clinical work. Systems therapy, CBT, self-psychology, narrative, and classical psychoanalysis were some of the models reported. Regardless of theoretical orientation, participants widely acknowledged one aspect that the animal brought into treatment that was not there before: touch. Due to strict guidelines for practitioners around physical contact with patients, the animals offered a comforting and physical presence. One practitioner said that in a case where a client was extremely agoraphobic, to the extent that even attending therapy was a challenge, that

“We practiced calming methods with my dog, so she could lower her anxiety, [such as] method breathing, so she could do those things at home. She was able to reduce her anxiety to a 3 [on the scale of 1-10]. She was able to see how she could control her anxiety.”

Participants in this writer’s study repeatedly cited the “calming effect” therapeutic animals have on patients, which is particularly useful when dealing with issues or disorders that cause anxiety.

The animal can also be available for the therapist’s “own emotional comfort” when a scene is “distressing” or a therapist is facing an unfamiliar situation or milieu (Symons,

“Choreographing Huminality, 116). A participant in this study cited the benefits for the clinician as well, when prompted by the last question to make any remarks on any issues not previously addressed, “Counselors can use animals around him/her to self-soothe and prevent burnout. Self-care is really important. AAT is good for us [clinicians] as well”.

Deciding Factors for Inclusion or Exclusion of AAT in Treatment

Inclusion. Most of the participants revealed that AAT is useful with those who have had repeated traumas at the hands of other humans, and/or are used to receiving consistent negative feedback. The introduction of an animal, as one interviewee put it, gives the client the ability to “not hav[e] to utilize all their defense mechanisms constantly”. Many participants also thought of it an intervention that comes in handy for children, adolescents, and adults when other approaches have not worked. As another participant put it, “[a]nimals are an alternative to begin developing a functional interactional and relationship with them [the patients]. “In short, it gives the client a psychological breathing space that allows the therapist access to the patient.

That breathing space the animal provides is sometimes what ideally the therapist would provide: that nonjudgmental space of an alliance with a client. Regardless of a practitioner’s intentions, it is difficult to for some clients to see the therapists as allies due to negative experiences with people. Animals allow a triangulation whereby the animal represents a comforting presence that is aligned with the treating clinician. Sometimes a difficult client may be given the chance to find a different “self” as well—a self that is positive in self-regard, and socially appropriate.

One therapist described the use of AAT with a young client as a “chance to relax,” as he was “constantly in trouble at school at home, walking around looking like he’s in trouble all the time, with a long face”. The canine co-therapist gave this client a chance to let down his guard,

as his behavior had him on the defense and already prepared to be in trouble for something—anything. This in turn allowed the client to engage in therapy, as it “help[ed] him relax to the point where he can engage in conversation [...it] overcomes resistance”. The interviewee also described it as the giving the client the ability to live “in the present”. The presence of animal helps create mindfulness, and reduce anxious worrying.

Exclusion. Participants indicated that clients were not treated with AAT as an intervention if the safety of the animal could not be guaranteed. This was not particular to a diagnosis; as one interviewee stated, “schizoid stabilized clients can be very predictable”. Thus, the diagnosis on paper was not the issue so much as the observed behavior of the client, and the therapist’s ability to predict behavior in session.

Another issue, particularly for those working with hospital patients, was whether the patient has any open wounds or serious injuries. Such clients would be excluded from the use of AAT simply because physical interactions with the dog could bring harm to the client. Another exclusion based on physical criteria was if the client had allergies.

Sometimes clients chose to forego AAT for the simply reason of timing. One participant who worked with geriatric patients cited an instance where the patient said no because it was “too painful [...] I miss my dog too much”. Whether an animal had actually passed, or the patient was unable to care for the animal anymore due to living in an assisted-living facility, if the loss of a companion animal was still too raw then a client may choose not to use AAT.

While a history of animal abuse may be assumed to be exclusionary criteria, there were therapists who did the difficult work of using AAT as an intervention to help clients address the root of such behavior towards animals. One participant described how during one session the client actually turned to the dog and apologized for her abusive behavior towards a different

dog in the past. Another participant cited that as part of working with high-risk populations, that AAT had been implemented and successful with “clients that have [issues such as] self-harm, assaultive, high psychopathy”. The participant also cited “isomorphic qualities; participants will see the parallel issues going on with them in the animal that the therapist may not see because the therapist is not dealing with that issue”.

Any animal-related trauma was a reason for exclusion. One participant cited that in one case, a German Shepherd had ripped off a child’s entire calf. While perhaps at a much later date reintroduction to canines may have helped the child get over the phobia, the need to address more pressing issues around trauma made inclusion of AAT inappropriate for the patient. For example, another participant cited that one client had been hesitant about the canine co-therapist due to an encounter in the past with police that included use of the K-9 as a show of force and intimidation, but the client gradually became more comfortable with the animal. This encounter with the police had a racial element, as the client and her husband were African-American and were being harassed by police. It should be emphasized that the client’s hesitancy around canines stemmed from that specific incident, but this could be a potent area of exploration around how interracial issues and racism affects the use of AAT, in the case of racism-related trauma or anxieties.

Cultural Differences and/or Barriers to AAT as an Intervention

Most participants spoke to the fact that since all cultures value animals in one way or another, though perhaps with an emphasis on different animals, that the idea of AAT was not an issue in of itself across the variety of populations they encountered. However, one participant did observe that in immigrant families “sometimes the first generation of Asian-Americans and Hispanics are fearful or confused about the animals, especially the dogs”. However, the

participant also noted that “usually the kids are fine”, which may speak to a variety of socioeconomic factors that create this difference between first and second-generation immigrants. This may be an area that requires further study.

Unexpected Outcomes

Positive Outcomes: *Helping Disabled Individuals With Stressors.* One participant reported how her dog, whom she called an “ambassador” for AAT, helped convince a disability program at a college to incorporate AAT into the services offered:

A disabilities program in a college wanted me to come up with him because they were evaluating whether that might be useful to their population as a destressor, in a room where they could drop in during testing. The person who ran the program had heard about this and wanted to see [...] spent hours hanging out with the population. That turned out be very successful.

Another participant cited a case in which a patient had just been transferred to assisted living and had lost her mobility. The patient was engaged in physical therapy to rebuild her strength so she could walk again. The presence of the clinician’s animal not only helped her transition to her new setting and refocus without the use of anti-anxiety medication, but the canine co-therapist also bolstered her spirits when it came to her PT. When the clinician was present with the dog, the dog was a motivator for the patient to walk. Walking meant the patient could also walk the dog; the therapeutic relationship to the animal outweighed any grief or frustration for her over her loss of independence.

Helping Individuals Overcome Barriers to Treatment. One participant cited a case in which an agoraphobic individual was interested in participating in the multi-species AAT

environment the participant's practice offered. However, the agoraphobia itself stood in the way of the client reaching the treatment site. The participant said,

“It took her a couple months to even get up the courage to come here for her first appointment. She loved horses and had one of her own. For the first session we were just getting her comfortable. We just really wanted her to feel safe here. She wanted to walk the horses. She picked the horse she felt most comfortable with. She walked the horse around and talked. Walking the horse around, and being outside, being able to touch the horse, brought back some secure feelings”.

The use of AAT also helped reestablish a sense of mastery and control. The same participant cited this in reference to the same case:

“[She was] able to remember how she needed to talk to the horse in a firm voice. A lot of stuff came back to her that she was able to feel good about. [...] She said she was going to visit her horse, which she did, which was an hour and a half away”.

The fact that the client had been unable to visit her own horse due to her agoraphobia, despite her love of horses, showed how disabling her agoraphobia had become. The fact that she was able to utilize AAT to overcome that agoraphobia speaks to AAT's ability to help people regain a sense of control over their lives and anxieties.

Helping Individuals Overcome Repression. A participant who worked with patients in assisted living cited an instance in which a patient was overly formal. She was clothed from head to toe, and would often be physically restrained (hands clasped). She did not exhibit any sort of spontaneity. This researcher had the impression that this was a sort of “false self” that perhaps had been constructed throughout her life; the participant reported that the canine co-therapist allowed this woman to finally relax and enjoy herself. If the dog “laid on the floor [...]she] laid

on the floor by the dog”. The relationship with the dog extended to her exhibiting less concern about her appearance; the participant reported that if she had dog hair on her, she was not concerned and in fact didn’t want it removed. It is this researcher’s interpretation that the patient’s wish to keep the signs of her interaction with the dog (e.g. the hair on her clothing) indicated to the extent to which she had been deprived of the ability to feel physically comfortable in her own skin, and with another being.

Helping Clients Address Unresolved Losses. One participant reported how one client had unresolved grief over the loss of a dog as a child, and how without the animal co-therapist this may have never arisen as a topic. The client reported how her family refused to acknowledge her grief over the loss of her pet; her family said it was “just a dog”, that she was “making a scene” and that they didn’t understand what the “fuss” was about. As a result, the client had never been able to express her grief over her lost companion in a supportive environment.

Another example of the use of AAT in resolving loss was cited by a participant who recalled a case in which the patient enjoyed interacting with the canine co-therapist, and would spend approximately 10 minutes interacting with the dog during the time devoted to therapy. The patient revealed she had to give up her dog as a result of this interaction with this particular dog.

The fact that an animal co-therapist may bring up issues that may not have entered into the therapeutic conversation otherwise is a reflection of both society and the conventions of formal therapy. As covered in the Literature Review, one study found that only about one third of social work clinicians ask about pets as part of an assessment of the family system at the outset of therapy (Risley-Curtiss, “Social Work Practitioners and the Human-Companion Animal Bond: A National Study,” 2010). Again, this reflects the human-centric nature of current education, training, and practice in the field.

Helping Clients Deal with Job Loss in The Great Recession. One participant, when discussing the socioeconomics of the population she primarily worked with in her private practice, noted that job loss due to the economy had added another factor to the presenting problems people came in with to treatment:

I would say most people present with depression, anxiety, and relationship problems. I have a range because in this economy I have a sliding scale [...] I would say most of my patients are middle-class oriented, but some have lost their jobs, and so that's has been a whole new experience in these last two years.

This participant had worked in different modalities, as well as for agencies as well as supervised others in the past, and specifically noted that the interviewee wanted to keep incorporating AAT into work with different populations:

I want to use him in the military population, and I'm trying to find the right fit [in terms of agencies]. The research has shown how useful with PTSD therapy dogs can be, and so again...I want to combine using him [animal co-therapist] in something that I haven't done, a population I haven't worked with.

This part of the interview reflected an area that has proved fruitful to the rediscovery of AAT by the field in general: the need for unique interventions for veterans returning from war.

Helping Clients Resolve Issues Regardless of Patient's Disposition to Animal. One participant who worked with many different types of animals as co-therapists cited that while a patient might not like a particular animal, or species, that this could actually have a positive outcome, as "it gives the patient "[the] ability to reexamine beliefs or prior experiences [... it] brings up work that they need to do clinically [...] even if they don't like them the animal can

change something for them.” Another participant whose AAT practice included a variety of animals said,

If client has a preference, often they will be drawn to a particular animal. We will try to have them spend time with that animal for that session. Depending on the treatment goal, [we] may suggest a different animal. Most of the clients work with multiple animals.

Thus, client preference and treatment goals may not always be aligned in practices that utilize and effectively facilitate multiple interventions via different animals.

Group, Family, and Couples Therapy. The use of AAT was found to be helpful in couples or family therapy too. A participant cited an example in which a mother had gone blind due to a rare disease. The husband was having trouble adjusting change, and it had increased responsibility for the other members of the family. The presence of the dog gave them something else to talk about and helped the family relax. As the participant put it, the dog acted as a “prologue for [the] real issues”.

Negative Outcomes: Participants did not report any significant negative outcomes of AAT. However, there were some expectable complications reported. One participant said that he noted that termination and transitions could be particularly difficult: “Termination and transition can be challenging because of the level of the connection the client may have to the animal”. For patients, the fact that a relationship had been established with not just the therapist but the animal as well meant that transition or termination was even more complex.

Another situation that arose for some participants was the death of the animal during the course of treatment. The aforementioned participant noted that the loss of the animal also provided treatment opportunities around other unresolved losses for patients. Any issues around countertransference and clinical support for clinicians processing bereavement of an animal co-

therapist and personal companion is perhaps something of interest for further studies dealing with the need for support structures for AAT specialists. The loss of the animal co-therapist not only affects the patient, but the clinician as well, and introduces a new complex dynamic into the treatment process for both the clinician and the patient.

As far as the relationship with the animal co-therapist, none of the participants reported any negative outcomes in the relationship as a result of incorporating those animals into therapy. Many said it strengthened the bond instead, due to the fact that the animal could come to work, as opposed to staying home. Since many of the animals had been vetted as suitable for AAT, those animals had been assessed as able, as well as interested, in working with people. Like other working animals, such as guide dogs, animals understood when they were “working” as opposed to off duty. However, it should be noted that the attunement of animals can vary, just as every patient and clinician brings his or her own level of attunement into the relationship.

Sometimes the triangulated nature of the relationship with a client and the animal could pose a temporary hurdle for the therapeutic relationship. One participant said, “[The] client sometimes feels bad if the cat wants to come to me, and I can’t push the cat back to the client since the animal has to be able to choose”. Of course, the animal’s ability to move to another space, including away from the client, is part of the guidelines that organizations such as Pet Partners stress as crucial for the health of the animal. It can also present a therapeutic opportunity, whether it is dealing with the client’s sense of rejection or abandonment, or with a client’s ability to empathize with others’ needs.

Recommendations for Future Practitioners of AAT

Those who supervised other practitioners of AAT, or had practiced for an extended period of time, made sure to emphasize the need for proper training and education. The stress

was put on the education and training of the clinician as the first priority, so that the clinician could be sure he or she was able and interested in taking on AAT as a therapeutic approach.

This researcher also found that there was a correlation between observed confidence and the level of training and support a clinician had in practicing AAT. A participant without any sort of “formal” training and support was more likely to hesitate to utilize AAT if the family of a client was resistant. One participant said that “[s]ome parents are uptight and challenging,” and so the participant would not use AAT with children from such families. This was explicitly addressed as due to a fear of making a mistake that would have repercussions not just for the client, but also their practice as a whole due to the concerns around insurance, as the participant also noted it was a “liability issue”. One might suggest that with the proper supports, a clinician utilizing AAT might feel more confident in recommending that intervention, and working with resistant parents so that the parents could support the use of AAT, thus allowing the clinician to perhaps be even more effective at his or her attempts at intervention.

Comments on the Current State of AAT in the Field

Many participants’ responses either spoke to the issue of support structures and requirements both locally and nationally, or it was reflected in the content of their responses as a whole. One participant who had supervised and trained AAT clinicians spoke of the need for “built-in structure”, and that there needed to be a place to “air difficulties”. The ability to utilize peer supervision or informal conversation with colleagues about AAT interventions, much less a direct supervisor knowledgeable of AAT, can be lacking for some practitioners due to geography and/or lack of resources.

Another issue brought up explicitly or implicitly in many responses was the lack of legitimacy surrounding AAT. While someone might be called a Marriage and Family Therapist,

a clinician who identifies as an AAT clinician is not recognized as such by the field at large. Looking at many of the databases for providers, one can see that “AAT” is not a common option. Pet Partners, formally known as Delta Society, no longer makes the practitioner list available to the public on their site, as Pet Partners has gone back to its original focus on volunteer work. Potential clients interested in AAT may need to seek out very specific resources in order to access information about AAT providers, or find websites if practices have them.

Summary

Some of the findings validated existing literature, such as Symons’s observations about AAT in a geriatric setting: that it helped individuals resolve losses, or enabled them to feel more “normal” in an institutional setting. Some findings were new, such as the use of AAT as a catalyst for individuals to find an authentic sense of self, for individuals to address the loss of companion pets which may not have come up otherwise, as well as the use of AAT for individuals where it might seem to be contraindicated, e.g. those with a history of terrible abuse towards animals.

One of the most important findings was the inconsistency of support and resources for new or existing practitioners of AAT, and practitioners’ interest in developing a stable curriculum and recognition of AAT as a specialty by the field in general. Interestingly though, one participant did say that “[m]aking it [AAT] traditional may take away some of the value”. This however speaks to whether the novelty of AAT as an intervention is necessarily part of its ability to act as effectively, which only inclusion into regular practice and research thereafter could determine.

The Discussion Chapter that follows will examine these findings in relation to previous literature, as well as discuss the new findings that add to the body of literature.

CHAPTER V

Discussion/Conclusion

The focus of this study included how clinicians decide to use Animal-Assisted Therapy, how long they have been utilizing AAT, cases in which they have seen unexpected results, and the practitioners' recommendations in terms of both practice of AAT and thoughts on the field in general. Although this research utilized a relatively small sample for its qualitative research, the findings present complexities of Animal-Assisted Therapy that are supported by the literature, as well reveal new faucets of interest for future research and inquiry. This chapter discussed the findings in the following order: Strengths and Weaknesses Presented by the Sample Size; Participants' Education and Training with AAT; Participants' Recommendations for AAT Practitioners and the Field. Finally, this chapter discusses the implications for clinical practice found in the data of this study in a section titled Implications for Future Clinical Practice and Areas of Interest for Future Research.

Strengths and Weaknesses Presented by the Sample Size

The central limitation of this study was also one of its greatest strengths. By drawing qualitative data from a narrative-focused study, this research accessed understudied and/or unexpected uses and results of Animal-Assisted Therapy. Studies that offered qualitative observations and experiences of the clinicians, such as Symon's autoethnographic study (2009), have made way for broadening the theoretical and narrative understanding of AAT. This study continued in that tradition. In response to the interest need for new interventions (including

AAT) for U.S. veterans returning from the Middle East with PTSD, evidence-based research in AAT by other researchers has contributed the quantitative evidence for the purposes of evidence-based practice and agency and to inform policy. In contrast, this study aimed to add to the qualitative aspect at the heart of clinical decisions and work.

Nine participants were interviewed for this study. The participants fulfilled the criteria for inclusion. The participants ranged in theoretical perspective and practical application and length of experience with AAT. All of the participants identified as Caucasian. Unfortunately, due to the small sample size, it was not possible to achieve a culturally diverse sample.

The sample was varied in terms of educational background, gender, and geographical location. Participants had advanced training and licensure in clinical therapy, including social work, psychology, and counseling. Many had training particular to AAT. Several also worked or previously worked for organizations that provided AAT training, and currently or previously supervised other practitioners of AAT. Several had worked with multiple species concurrently. The number of years practicing formal therapy ranged from 15 to 46 years. The number of years practicing AAT ranged from 4 years to 25 years.

Participants' Education and Training with AAT

When this researcher began this study it was assumed that training and some type of certification was required to practice AAT. However, as it became evident in the literature and in the research process, this is not the case. While associations such as Pet Partners (formerly known as Delta Society) has standardized assessments and guidelines, and emphasizes training of both clinician and animal, there is no type of certification process currently in place for the practice of AAT in the United States. However, it should be noted that the lack of certification

process and standardized curriculum in the educational setting is reflective of the fact AAT is still not widely accepted as a specialty.

The lack of perceived legitimacy lends to the fact that discovery of AAT by accident still occurs; many of the clinicians happened on AAT by chance, or in one case in this study by patient request. The fact that many had companion animals, and that AAT was discovered by chance when a patient interacted with an animal in a way that suggested significant benefits, reflected the fact that animals can be integrated into clinical practice easily if the setting allows.

This integration is ultimately a win-win for both patient and clinician. Since therapy dogs in particular have been shown by quantitative studies to have a beneficial effect on clinicians' and patients' nervous systems, the physiological benefits are present for both. A quantitative study by S. Barker, J. Knisely, N. McCain, C. Schubert, and A. Pandurangi looked at how therapy animals buffer stress for both pet owners and non-pet owners, and found that both biochemical data and self-reporting supported the hypothesis that therapy dogs can reduce stress ("Exploratory Study of Stress-Buffering Response Patterns from Interaction with a Therapy Dog", 2010). Moreover, during the course of this thesis research clinicians reported that the bond with the animal strengthened for the better once the participants began to practice AAT, as the animal became part of their work. Participants noted that the animal enjoyed the work, and that the presence of the animal and the clinician must first be suited to the work in temperament and skill set.

Again, while agencies may forbid any non-AAT and untrained animals on their grounds for insurance reasons, or private practitioners may use AAT cautiously due to insurance concerns and lack of training, there is no set of legal or professional rules in place around the use of animals in practice with clients. Since all of the participants were required to be licensed in their

fields of therapeutic practice, and thus had formal education and training in a mental health profession, the lack of required AAT certification meant that there were some strong deviations from the majority who had some type of voluntary formal training in AAT. Most had been educated and trained to an extensive amount by the time of the study, and many also supervised others. However, a couple were not formerly trained by Pet Partners or any similar society, and thus lacked formal guidance around the use of AAT as a tool in his or her practice.

Participants' Recommendations for AAT Practitioners and the Field

However, the lack of formal and standardized requirements around AAT only reflects the need for a standard curriculum, a track for AAT in mental health programs, and a certification process. While some programs now offer classes related to AAT, it is not part of the curriculum at every institution devoted to training and education individuals in the practice of mental health treatment. The fact that AAT is not offered as an area of focus at most institutions also lends to the fact that many clinicians may not find the resources and support they need when they decide to practice AAT during their careers. Due to geographic limitations, a couple of practitioners spoke to the fact that there were no conferences or peers in their immediate area that could serve as support and guidance in AAT.

The lack of nation-wide directories on the Internet is another issue that affects both clinicians and patients. Pet Partners used to have an open directory that listed mental health professionals who practiced AAT, and their office contact information. However, access to this directory became limited via login to trainers, evaluators, and other members of Pet Partners society. This excludes anyone interested in AAT (including a researcher such as this writer) from finding clinician information, and moreover excludes any practitioners or potential patients from accessing the information as well.

Thus, for patients interested in AAT, they must become knowledgeable about the resource through a third party, whether it be another mental health professional or by word-of-mouth. While some AAT agencies and practices have websites, these are by nature limited to their own immediate resources in the area or state. Just as clinicians often stumble onto AAT by chance, patients may also have to stumble into this treatment by the luck of knowing someone knowledge about the field.

Participants' Recommendations for AAT Practitioners and the Field

The need for a formal educational structure around AAT, and a licensing or certification requirement for the AAT practitioner, has been highlighted several times in interviews and this researcher's own observations during the data collection process. Bringing AAT into coursework, whether as a specialty or as an elective area of focus, will not only validate AAT as a formal practice but also bring more consistency to its use.

It will also allow support systems such as hospitals and day treatment centers easier access and knowledge of clinicians and institutions that use AAT, if a particular case seems to call for AAT intervention. As AAT was found to act as a catalyst in both the literature as well as this study in cases where clinicians were otherwise at an impasse with a patient or a group of patients (such as in family treatment), its formal applications cannot be underestimated. Its incorporation into assessment and treatment planning is vital to widening the field and increasing the possibilities for successful treatment outcomes. This is especially true for those who are cognitively developing and still have time to avoid negative pathological outcomes, e.g. children, adolescents, and young adults.

Areas of Interest for Future Research

There were several issues outside the scope of this study that would benefit from future research. One was the death of an animal co-therapist during the treatment process. One potential area of focus could be exploring clinical support for the bereaved AAT clinician so that the clinician can continue to practice with supervision and support during this difficult time. Another area of focus could be expanding on the notion (presented briefly in this study) that the death of an animal co-therapist can be a treatment opportunity.

Another potential area of focus is around racial and cultural issues, and how they intersect with AAT. One participant noted that a racially charged incident with the police had made her client hesitant around canines; another noted that first-generation Asian and Hispanic immigrants were hesitant and/or fearful around animals, whereas the second-generation members of the families were not.

As one participant noted, attitudes within Western culture in the United States can vary depending on whether an individual lives with animals as companions in a more urban area, or works with them in a setting such as a farm where animals are perceived as working animals (or for milk and consumption). Thus, such a study would also need to take into account that certain ideas of relational “closeness” that may be influenced by Western notions around proximal closeness, or even by socioeconomic bias (such as living in the city, versus working in a rural area on a farm). Such cultural or personal differences would need to be accounted for in order to avoid a theoretical flaw or limitation in such research.

Finally, another issue was an unresolved question presented by the literature. In “Animal-Assisted Therapy in the Treatment of Substance Dependence” by Martin C. Wesley, Neresa B. Minatra, and Joshua C. Watson, the researchers studied the use of AAT as an intervention in

group therapy for people with dual diagnoses. The literature presented the finding that AAT did not affect outcomes for those who had dual diagnoses that included alcohol dependence, as well as Child Protective Services involvement (146). This quantitative study hypothesized that additional meetings may have been necessary to solidify the treatment alliance.

It would be interesting to explore why these particular factors affect the growth of the treatment alliance, and whether this has any implications for the use of group therapy in general for such individuals. Since the study also addressed attrition rate, resolving these questions will benefit the treatment goals overall. Even if AAT is found to not be a preferred method of intervention for such populations, the question of how and why the therapeutic alliance takes longer to form will be answered.

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APPENDIX A: APPROVAL LETTER FROM HSR AND APPROVAL FOR UPDATED
CRITERIA



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 18, 2010

Carolyn Svatek

Dear Carolyn,

Your amended materials have been reviewed. They are fine and we are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your interesting project.

Sincerely,

A handwritten signature in cursive script that reads "Marsha Kline Pruett / shw".

Marsha Kline Pruett, M.S.L., Ph.D.
Vice Chair, Human Subjects Review Committee

CC: Esther Urdang, Research Advisor

To Me, Elaine Kersten, Laura Wyman
Aug 18, 2012

Hi carolyn,
Your ammendment is approved. Thanks,
David :)

typed on my android, sorry for any typos

On Aug 18, 2012 6:31 PM, "Carolyn" <carolynmduncan@yahoo.com> wrote:
Dear Dr. Burton,

Attached please find my HSRB application and a request for amendment (amendment is in the body of the email). I would like to open up the geographical restrictions by allowing for phone interviews of clinicians of any area.

Also, please find my thesis advisor's approval below.

Thanks,
Carolyn Duncan

----- Forwarded Message -----

From: Elaine Kersten <tootieedward@verizon.net>
To: Carolyn <carolynmduncan@yahoo.com>
Sent: Saturday, August 18, 2012 6:21 PM
Subject: Re: HSR Application

Thanks.. I read this and yours below. I do recommend that you send this to Dr. Burton, requesting an amendment to your approved HSRB Application to the defined geographic area for sample recruitment. Be sure to attach the original HSRB Application. You are welcome to include this message in your message to Dr. Burton. I would also include me in the 'cc' of your message. Be in touch with any questions.

Dr. Burton:

By this email, I fully support Carolyn Duncan's request for an amendment to her HSRB Application regarding expanding geographic area from which to recruit study subjects.

Elaine Kersten
Thesis Advisor.
8/18/12

From: [Carolyn](#)
Sent: Saturday, August 18, 2012 3:33 PM
To: [Elaine Kersten](#)

Subject: HSR Application

Hi Elaine,

Included below is the section of the HSR application that cites recruitment will be limited to the researcher's location and surrounding areas. Due to the need to expand the potential sample by accessing clinicians who are further away than MA, CT, RI and the surrounding areas, I would like to amend this to include "all clinicians available for a phone interview that fit the licensing and training criteria requirements of the study." The recruitment process already cites that a telephone interview may be utilized if there are issues with physical access to an in-person interview; this will simply expand that idea to include clinicians who may live further away but are appropriate for the study.

I am not sure if this is also necessary to request, since a formal letter could be emailed technically (as an attachment or in the body of an email)?

I would also like to amend the sentence that "Recruitment will be done via formal letter, in order to [...] provide a written record" to "Recruitment will be done by formal letter or email," as many clinicians do not have a physical address listed, but do have an email address listed in the AAT directories (such as Pet Partners). The language of the email will be the same as that of a formal letter, and this still provides a physical record of contact.

Thanks,
Carolyn

APPENDIX B: INFORMED CONSENT FORM FOR IN-PERSON AND PHONE INTERVIEWS

Dear Participant,

My name is Carolyn Duncan and I am a Master of Social Work student at Smith College's School for Social Work. I am conducting this research project to learn more about the experience of clinicians who utilize Animal-Assisted Therapy. Through this research I hope to explore the meaning of Animal-Assisted Therapy to you in terms of both your motivation in using it, it, and your experiences of the positive and negative outcomes of its use. This research will be included in a thesis that I am completing as part of my degree. This study may be used for potential publication or presentations.

I will be interested in interviewing you one time for a ½ hour to 1 hour session. It will be done at a time and/or place of convenience and comfort for you. I will take notes, and these interviews will be tape-recorded. I will be the sole transcriber. I will disguise your name, and all identifying personal information about you and your clients to ensure your confidentiality in the transcripts and all reports from the data.

Should you become anxious or uncomfortable during the interview, please let me know.

Discussing your experiences may raise some uncomfortable feelings, and you are free to decline answering any questions during the interview and can end the interview at any time. I cannot offer you any compensation for your participation, but I am hopeful that you will benefit from sharing your experiences as well as assisting in disseminating information about pet therapy. Your point of view regarding your experiences with the benefits and problems of animal-assisted therapy is invaluable.

Your name and identifying data will not be included in the tapes or transcriptions; my

notes, audio-tapes of the interview and transcriptions will be stored in a locked file cabinet for three years as mandated by federal regulations; after which time they will be destroyed. My research advisor will have access to the interview data after identifying information has been removed. This informed consent that you are being asked to sign will be kept separate from the tape/transcriptions. Anything that I elect to present or write about the research will not include any reference to your identity, or the identity of your clients. If illustrative vignettes are presented, they will be in a disguised form. If I should need these records beyond three years, I will continue to keep them secure until they are no longer needed, at which time I will destroy them.

Once again, participation in the study is voluntary and you may withdraw from the study at any time without repercussion. Should you withdraw, please let me know via email, phone, or mail, and all data pertaining to you will be immediately destroyed. However, withdrawing from the study should be done before the results section has been prepared, which will be by October 31, 2013. You may email me cduncan@smith.edu should you have any questions, or contact the Smith College School for Social Work Human Subjects Review Committee Chair at (413) 585-7974.

YOUR SIGNATURE INDICATES YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature: _____ Date: _____

Investigator Signature _____ Date: _____

APPENDIX C: RECRUITMENT LETTER/EMAIL

Inquiry Regarding an Interview for an AAT Research Project

Dear Clinician,

My name is Carolyn Duncan and I am a post-residency MSW student at Smith School for Social Work conducting a study on the use of animal-assisted therapy for my Master's thesis. [As applicable:] I was referred to you as a potential interviewee by [name].

The purpose of my study is to learn more about what clinicians like yourself think about doing animal-assisted therapy, how you developed an interest in this way of treating clients, and how you actually work with the animal in your practice. I am interested in the advantages as well as the problems you see, and your thoughts and recommendations for others currently practicing AAT or potential AAT practitioners. There has been increasing interest in this approach, and as a practitioner you are in a unique position to provide insight into this experience from your own perspective. Being a subject for this study would involve participating in one interview with me, which would last an hour to an hour and a half at most, and would take place via the phone due to your geographical location.

If you are interested in participating in this study, you should have utilized animal-assisted therapy for at least six months total and within the last four years. I can provide the questions ahead of time so that you may prepare any thoughts on the matter. If you are interested, please respond by e-mail at cduncan@smith.edu, or by phone at (xxx-xxx-xxx), and we can set up a time for the interview. I will be happy to answer any questions you might have about this project. If you agree to an interview, I will send you the Informed Consent form.

Thank you for considering this pertinent research.

Sincerely,

Carolyn Duncan

APPENDIX D: INTERVIEW GUIDE

Demographics and Introduction

Please provide the following demographic information about yourself:

- a. Age:
- b. Ethnicity

Educational and Employment Background

1. As a clinician, what is your professional field? [i.e. social worker, psychologist, etc.]
2. What degree or degrees do you hold?
3. How long have you been in the field?
4. Do you use the term "Animal Assisted Therapy" or do you prefer another term such as pet therapy?

NOTE: FOR THE REMAINDER OF THE QUESTIONS I WILL USE THE SUBJECTS' PREFERRED TERM- EITHER ANIMAL ASSISTED THERAPY OR PET THERAPY OR ANOTHER PREFERRED TERM. IN THE QUESTIONNAIRE THIS WILL BE DENOTED AS *** THERAPY.

5. Are you currently engaged in doing ***Therapy, or have you done this only in the past?
6. Was the animal you use/used your pet prior to his/or therapeutic involvement, or did you obtain a special animal for this purpose?
7. Did you and the pet receive special training in order to do this? If so, please describe.

FOR PAST PRACTITIONERS ONLY (RETIRED OR NO LONGER USING PET THERAPY I WILL ASK QUESTIONS 8 a, b, and c. AND THEN CONTINUE WITH REST OF QUESTIONNAIRE. THE REMAINING QUESTIONS ARE OCCASIONALLY MODIFIED

BY USE OF PAST TENSE FOR FORMER PRACTITIONERS.

8a.. Are you currently retired, or simply no longer using ***Therapy?

8b.For how long did you practice ***Therapy?

8c. What led you to stop it [AAT]? (If applicable).

CONTINUE WITH REST OF QUESTIONS FOR ALL PARTICIPANTS.

9. Do/did you have a specialty? If so, describe.

10. Do/did you work for an agency or agencies? If so, what is/was their function[s]?

11. Do/did you have a private practice? If so, please describe the population in terms of socioeconomics and any particular focus in terms of the type of disorders treated.

12. How would you describe your theoretical orientation [e.g. systems, psychodynamic, cognitive-behavioral, etc.]?

Background in Animal Assisted Therapy Practice

13 How long have [had] you been doing *** Therapy?

14. What led you to choose *** Therapy?

Process of Animal Assisted Therapy

15. Describe the role of the animal in your therapy, e.g. do or did you suggest activities to the client involving the pet?

16. Also, do/did you let the client decide on type of involvement with the animal? Please give some examples.

17. Do/did you use *** Therapy with all your clients?

18. If not, what is or was the basis of your selection?

19. Please give some case examples in which you found the use of the pet particularly helpful.

Were there any instances in which the ***Therapy had unexpected benefits?

20. Have there been cases where you felt the use of the pet caused complications? Can you give some examples?

21. What would you say was the range of attitudes of clients and their families to ***Therapy?

22. Did any of the clients have special reactions to the pets, which you felt were culturally determined? If so, please describe.

Supervision, Consultation, and Networking

23. Do/did you receive supervision, peer supervision or consultation for this aspect of your work? If so, please describe.

24. Do/did you network with people who do this type of treatment, or attend conferences on this subject? If so, what are some of the issues discussed?

Concluding Questions

25. Do you think that being a(n) *** therapist affected your pet in any way? If so, can you describe how?

26. Has working with your pet in this therapeutic capacity altered your relationship with him/her in any way?

27. If clinicians were interested in becoming a(n) *** therapists, what suggestions and recommendations would you make to them?

28. What learning experiences, texts, or books do or did you find most useful?

29. Is there anything we haven't discussed that you feel is important? Do you have any additional questions, comments, and or concerns?