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Animal-Assisted Therapy as a Trauma Intervention

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Animal-Assisted Therapy as a Trauma Intervention

by

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MSW Clinical Research Paper

Presented to the faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

Abstract

Trauma has a significant impact not just on the individuals who have experienced it, but on families, communities, and society as a whole. While significant improvements to treatment modalities have been made, there continues to be a need for further research and exploration to establish a range of efficacious and accessible treatment modalities in this area. Animal-assisted therapy (AAT) is a promising intervention with a long history, which may be uniquely suited to treating a broad range of clients with trauma histories and/or diagnoses. The purpose of this study was to gather the practice wisdom of clinicians working in this field to develop a more cohesive understanding of why and how AAT is an effective trauma intervention. Practitioners in the field of AAT were identified via purposive and snowball sampling and a total of eighteen individuals completed an online qualitative survey, via Qualtrics. Findings were consistent with existing literature and expanded upon the unique role that the human-animal bond can play in healing and growth for those who have experienced trauma. Specific themes that emerged from the data were: the non-judgmental nature of the human-animal bond; non-verbal communication; physical and emotional safety; and the experiential and individualized nature of AAT.

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Animal-Assisted Therapy as a Trauma Intervention

In the field of social work there are two primary sources of wisdom. First, the often referred to standard of “evidence based practice,” and second, the equally important but often less acknowledged, “practice-based evidence.” Practice-based evidence refers to the wisdom gathered by clinicians over time in real world application. The modality of animal-assisted therapy (AAT) is one which has been steadily growing in both of these forms of evidence. First documented as an intentional intervention in the 9th century, the reciprocal relationship between humans and animals – and the healing power of these interactions – has been well researched and supported by years of “practice-based evidence” (Morrison, 2007). The American Veterinary Medical Association (AMVA) acknowledges that the human-animal bond has existed for thousands of years, and defines it as “a mutually beneficial and dynamic relationship between people and animals that is influenced by behaviors that are essential to the health and well-being of both. This includes, but is not limited to, emotional, psychological, and physical interactions of people, animals, and the environment.” (2014).

However, despite the overwhelming agreement that the human-animal bond is therapeutic, AAT has taken some time to be accepted into the world of social work and psychotherapy. While AAT has consistently been associated with positive client outcomes, it is only fairly recently that emphasis has been placed upon the need for empirical research and a standard of evidence-based practice in the field. In light of recent research and practice wisdom, it seems clear that further exploration is needed to determine the possible benefits of utilizing AAT to address a broad range of presenting challenges. One such potential application is trauma treatment; a rapidly expanding field

within which significant progress has been made, but one where there remains a need for additional effective and accessible treatment options. This research study will attempt to gather the practice wisdom (or “practice based evidence”) held by those currently practicing AAT as a trauma intervention, as well as seek to add to the body of empirically supported evidence. Social workers, especially those working in a therapeutic setting, have a duty to provide the best possible interventions to their clients. Greater evidence for the use of AAT in trauma work can help them to do so.

Literature Review

Animals and Humans in History

Humans and animals share a long history. As noted by Nepps, Stewart & Bruckno (2011), “it is thought that prehistoric man forged a bond with the most sociable and least fearful of wild wolves, leading to the evolution of *Canis Lupus familiaris*, the domesticated dog” (p.1). The Biophilia Hypothesis, introduced in 1994 by biologist E.O. Wilson, suggest that this move toward domestication is due to “a predisposition to attune to animals and other living things is part of the human evolutionary heritage, a product of our coevolution as omnivores with animals and plants on which survival depends” (Wilkes, 2009, pp. 21-22). The dog and cat, the “first to achieve the status of domestic pets” paved the way for the integration of animals into the everyday fabric of human lives (Wilkes, 2009, p. 20). Today the AMVA (2012) reports that 56% of the US population owns at least one companion animal and the American Pet Products Association [APPA] projects that in the year 2014 Americans will spend an estimated 58.51 billion dollars on their pets (2014). The bond between humans and animals has, over time, become the subject of significant interest and investigation.

The Human-Animal Bond

The American Veterinary Medical Association (AMVA) acknowledges that the human-animal bond has existed for thousands of years, and defines it as “a mutually beneficial and dynamic relationship between people and animals that is influenced by behaviors that are essential to the health and well-being of both. This includes, but is not limited to, emotional, psychological, and physical interactions of people, animals, and the environment” (2014). While there is still an ongoing need to generate awareness and study in more depth, progress has been made to identify the psychological and physiological benefits associated with human/animal interaction (Fine & Beck, 2010). Today, the scientific study of human-animal relationships is the focus of the multidisciplinary field of *anthrozoology*, which is largely concerned with “the effects of relationships with animals on human health and wellbeing” (Nepps, Stewart & Bruckno, 2011, p.1). Beckhoff (2007) builds on the theory underlying the human-animal bond while cautioning against the potential perils of going too far in imposing human attributes onto animals. Beckhoff also notes that anthropomorphism can be used “as a strategy to identify commonalities and then use human language to communicate what we observe” (as cited in Fine & Beck, 2010, pp. 4-5). Mithen (1996, as cited in Fine & Beck, 2010), takes this further and asserts that “without anthropomorphism, neither pet keeping nor animal domestication would ever have been possible” (p. 5). Similarly, Reichert notes that in Piaget’s model it is natural during development for children to ascribe human traits to animals – a practice that does not necessarily cease with maturity (1998). While it remains a subject of research, it appears clear that many in the field agree that the human-animal bond supersedes pure function to provide a higher level of mutual benefits.

Animals in Therapy: Historical Context

The utilization of the human-animal bond in the context of treatment and therapy has a long history, much of which remains largely undocumented (AMVA, 2014; Morrison, 2007; Chalmers et al., 2011; Reichert, 1998; Nepps, Stewart & Bruckno, 2011; Hamama et al., 2011). Existing literature often cites the therapeutic inclusion of animals in treatment plans for people with disabilities in Gheel, Belgium in the 9th Century as one of the first documented practices of AAT (Morrison, 2007). Since then, the inclusion of animals in the treatment of both physical and mental illness across a variety of populations and age ranges has continued to gain traction. Jon Locke, noted 17th century philosopher and physician, is said to have advocated for “giving children dogs, squirrels, birds, or any such thing to look after as a means of encouraging responsibility for other” (Serpell, 2010, p.12; Parshall, 2003, p. 47). By the late 18th and early 19th century the therapeutic benefit of interaction with animals was being utilized in various medical, mental health, and retreat settings (Morrison, 2007; Parshall, 2003; Nietfeld-Sundermann, 2006). In 1830 the British Charity commissioner himself recommended animals for mental institutions, and documentation points to a widespread acceptance of animals (both large and small) in mental health settings throughout Europe and the United States, albeit inconsistently practiced (Parshall, 2003; Serpell, 2010; Morrison, 2007). Florence Nightingale, whose “legendary compassion inspired the profession of nursing,” is also considered by many to be the “mother of therapeutically using the human/animal bond” (Jalongo et al., 2004, p. 10; Nietfeld-Sundermann, 2006, p. 12). She is quoted as saying that, “a small pet animal is often an excellent companion for the sick, for long chronic

cases especially. A pet bird in a cage is sometimes the only pleasure of an invalid confined for years to the same room” (Nepps, Stewart & Bruckno, 2011, p. 1).

While it is clear that the practice has its foundations in early history, Boris Levinson is often considered one of the primary founders of AAT in its modern form. In 1962 he published a paper entitled “The Dog as Co-Therapist” after incorporating his pet dog Jingles into his work as a psychologist (Morrison, 2007; Thompson, 2005). Nietfeld-Sundermann (2006) makes the distinction that while he is often referred to as “the father of pet therapy” it may be more accurate to view Levinson as the “father of pet therapy research,” as his work occurred in the mid-1900s while, “records show that animals were being used a therapeutic tools long before that time” (Nietfeld-Sundermann, 2006, p. 12). According to Cole (2009), Levinson’s use of the term “pet therapy” marked “the emergence of interest by researchers and practitioners in the psychological effects of human and animal interaction, and highlighted the critical shift to regard animals as a partner in therapy rather than a tool to be exploited” (p. 3). Following in Levinson’s footsteps, the field of AAT continued to grow, as did the research into the theoretical foundations behind the work. However, as will be discussed in greater detail later, it has only been recently that an emphasis has been placed on the importance of empirical support for continued practice. This is due in part, to the founding of professional organizations such as Pet Partners, as well as a push toward empirical research.

Research on the human-animal bond

Fine and Beck (2010) note that over time, numerous interventions have been developed based on the “strong belief that relationships with animals contribute to the well-being of people” (p. 4). However, they make the important note that animal-assisted interventions have grown, in part, based upon anecdotal evidence and clinicians’ personal

convictions, with a lack of proper research and limited scientific evidence. The existing literature almost unanimously agrees that prior to 1990, there was very little documentation of scientifically sound research on the value of using animals in therapy, as most previous research was based on anecdotal reports or individual case studies (Parshall, 2003; Nietfeld-Sundermann, 2006; Fine & Beck, 2010; Hamama et al., 2011). Likewise, many practitioners in the field note that much of the early research on AAT was not “scientifically vigorous” (Zeglan, Lee and Brudvik, 1984, as cited in Nietfeld-Sundermann, 2006, p. 12), and early reports have been called “a-theoretical” due to the lack of baseline or pretest data, as well as the lack of a control group in the research design (DeSchraver and Riddick, 1990, as cited in Nietfeld-Sundermann, 2006, p. 12). While “animal assisted therapy programs have been associated with positive effects in many studies,” Nepps, Stewart & Bruckno (2011) concur with those who question the quality of early research and note the existence of “poor designs and small sample sizes which have limited conclusions” (p.2). In fact, in a comprehensive review of the literature completed by Nimer and Lundahl, only 39 of the reviewed studies met criteria for meta-analysis based on research procedure, and only 23 of those 39 utilized a control group (as cited in Nepps, Stewart & Bruckno, 2011).

The need for “scientifically vigorous” research is echoed by Chalmers et al. (2011) who note that government funding for animal-assisted programs, crucial to ongoing advancement in the field, needs to be informed by empirical evidence. Such empirical research is now being undertaken, though the literature agrees that this has only begun in earnest in the last few decades (Nietfeld-Sundermann, 2006). In 1997 Delta Society (Now renamed Pet Partners) gave hope to advocates of AAT when they stated

that, “the physiological as well as psychosocial benefits of positive interactions” [between humans and animals] are not purely anecdotal; rather, there is a growing body of research to support the existence of the human/animal bond” (as cited in Jalongo et al., 2004, p.10).

Modern Animal Assisted Therapy

Definitions. There are a multitude of terms (and associated acronyms) used when referring to the use of the human-animal bond in a therapeutic context. In fact, the literature agrees that the wide variety in terms and definitions associated with AAT and related activities are often confusing for researchers, clinicians, and clients. There is an agreement that there is a need within the field for “consistent, universal definitions” in order to promote clarity and provide validity in practice, and to encourage the ongoing process of collecting empirical research in the area (Nietfeld-Sundermann, 2006, p. 65-66). While terms used in current literature and practice remain tremendously varied, and are often used interchangeably (Cole, 2009), the recent movement to “employ terms in a more consist manner” is hopeful (Chandler, 2005, as cited in Cole, 2009, p. 4).

Current terms used in this field include, but certainly aren’t limited to: *animal-assisted therapy [AAT]*, *animal-assisted activities [AAA]*, *animal-assisted interventions [AAI]*, *equine-assisted therapy [EAT]*, *equine-assisted psychotherapy [EAP]*, *pet therapy*, *animal-assisted therapy-counseling [AAT-C]*, *pet keeping*, *animal facilitated activities*, *nature-based therapy*, *pet visitation*, *service animals*, and *therapy animals* (Nieteld-Sunderman, 2006; Cole, 2009; Chandler, 2005). Definitions for these terms range from “untrained animals being present and providing company, to a trained animal lead by a trained therapist who works with clients on goals outlined in a treatment plan” and refer

to work that is both “short to long term, and with individuals and groups” (Nietfeld-Sundermann, 2006, p.16).

For the purpose of this paper, two broad categories as described by Pet Partners, will be used: animal-assisted activities (AAA) and animal-assisted therapy (AAT), with an emphasis on AAT (Pet Partners, 2014). Animal-Assisted Activities (AAA), as defined in 1996 by the Delta Society (now Pet Partners) refers to “the integration of animals into activities to facilitate motivation, education and recreation, encouraging casual interaction without following a specific set of criteria or goals” (as cited by Cole, 2009, p. 5). It should be noted that “while considered therapeutic in nature, there are no set goals, and no planning or evaluation required” in AAA (Cole, 2009, p. 5). AAT, in contrast, was defined in 1996 by the Delta Society (now Pet Partners) as “intentional and therapeutic, whereby the animals role is integral in assisting with mental health, speech, occupational therapy or physical therapy goals, and augments cognitive, physical, social, and/or emotional well-being” (as cited in Cole, 2009, p.5). The criteria to be considered therapy rather than activity are: the animal must meet specific criteria that fit the therapeutic goals; the animal is considered a necessary part of treatment; therapy is directed by a qualified professional or practitioner; therapeutic intentions include physical, social, emotional, or cognitive gains; therapy can occur in group or individual sessions; and, all treatment must be documented and evaluated (as cited in Cole, 2009).

The AMVA (2006) echoes the Delta Society/Pet Partners and defines AAT as “a goal directed intervention in which an animal meeting specific criteria is an integral part of the treatment process,” designed to “promote improvement in human physical, social, emotional or cognitive function.” They go on to note that AAT must be delivered or

directed by health and human services providers with specific competencies in the area (AVMA, 2006).

Guidelines for Practice. With the growth of AAT, guidelines have been established in order to provide for clarity in the field and to ensure ethical practice. These apply to all practitioners of AAT, regardless of their discipline or practice setting. In 2006 the AVMA's Committee on the Human-Animal Bond (CHAB) published guidelines for "the practice of animal-assisted activities, therapy, and resident animal programs" based on "the belief that such programs should be governed by basic standards, staffed by appropriately trained personnel, and regularly monitored to ensure the health and welfare of both human and animal participants" (AVMA, 2006). Pet Partners is another organization that has established specific training guidelines for animals being utilized in therapy and maintains a registry of certified animals. Training topics for therapists licensed by Pet Partners include: interpersonal skills; the needs of specific client groups; confidentiality; as well as safety and health codes (Nepps, Stewart & Bruckno, 2011). While a variety of licensures and training programs exist, the literature seems to agree that they all should be based upon these universal guidelines (Cole, 2009; Nepps, Stewart & Bruckno, 2011). For the purpose of this paper, a brief introduction to this broad span will be presented with an emphasis on those working in the mental health field treating adults with a trauma history.

Established Benefits of AAT. As noted previously, there are many documented benefits that can be derived therapeutically from the human-animal relationship and the inclusion of animals in treatment. Clients at all stages of life may benefit from AAT (King, 2002), and "it is apparent that there are many animals, settings, interventions, and

client characteristics where the therapeutic nature of an animal can be tapped” (Nietfeld-Sundermann, 2006, p.68). Research into the physical benefits of animal interaction began in the 1970s (Morrison, 2007). A 1977 study completed by psychiatrists at the University of Pennsylvania explored the influence of animals on patient’s blood pressure and found that participants who interacted with pets, when compared to patients who did not, had lower blood pressure. In addition, patients with severe myocardial infarctions that had regular interactions with animals (generally pets) had improved one year mortality rates when compared to their peers who interacted only with people (Morrison, 2007). Studies have found that the introduction of an AAT component in care has increased motivation for patients completing physical therapy (Morrison, 2007), decreased pain levels (Johnson, 2001; Nepps, Stewart & Bruckno, 2011), and improved immune function through decreased stress for individuals with chronic and terminal illnesses (Cole, 2009; Skeath, Fine & Berger, 2010). Animals in healthcare settings have been connected to shorter hospital stays, reduction in need for medication and an increase in food consumption which improve patient outcomes and reduces healthcare costs (Johnson, 2001).

In mental health settings the benefits of AAT are slightly more difficult to quantify, but no less powerful. It is widely acknowledged that a strong positive therapeutic relationship between clinician and client is necessary for positive outcomes. Animals and the power of the human-animal bond as already mentioned, may serve as a “bridge between client and [mental health professional] and can be a transitional object” (Reichert, 1998, p. 178). For clients who have difficulty connecting with others or expressing themselves the inclusion of an animal in therapy decreases the “need for

language” and in this way may be a useful and cost effective modality for such people, including those with disabilities, trauma, or children (Reichert, 1998, p.180). The literature agrees that animals in therapy have been shown “promise in getting resistant patients to engage in counseling, build trust in others, and express emotions” (Nepps, Stewart & Bruckno, 2011, p. 1). Just as in medical settings, AAT programs have been shown to be safe and cost effective in mental health settings (Nepps, Stewart & Bruckno, 2011). Neitfeld-Sundermann (2006) cites the anxiolytic effect produced by animals as similar to that produced by many psychotropic medications – offering a safer and more cost effective means of treatment. For example, studies have found that psychiatric patients have a significantly reduced level of anxiety when interacting with animals. One study demonstrated that the effect of AAT on anxiety levels was twice that of standard therapeutic reaction interventions, and another study found a correlation between the “buffering effect” animals have on the stress of humans and a decrease in cortisol levels, heart rate, and blood pressure for mental health patients (Thompson, 2010).

Contraindications: Risks and Limitations. Integrating animals into therapy has both clear benefits and challenges. However, Beck and Katcher (1996) make the important notes that until recently, the literature in the field has tended to only make note of the positive aspects of AAT, without “clearly addressing the inherent challenges and ethical considerations of involving animals in counseling” (Cole, 2009, p. 1). As noted by Morrison (2007), there are very few clearly identified contraindications for the use of AAT. In her study of Minnesotan social workers, Nietfeld-Sundermann (2006) found very few respondents who identified specific concerns regarding the safety or efficacy of animal-assisted interventions of any kind. However, the literature is clear that we must

attend to the ethical implications for all participants (both animal, and human). For example, Reichert (1998) specifically notes that clients with a history of aggression toward animals may not be well suited for AAT. Special precautions to ensure the safety of all participants including the therapy animal must be undertaken in order for AAT to be both effective and ethical (Chandler, 2005; Iannuzzi & Rowan, 1991). King (2002) also notes that some clients will have allergies that limit the types of animal that they can work with. This creates limitations but does not make AAT impossible with such clients, as AAT has been practiced effectively with water animals, hairless animals, and even reptiles (King, 2002).

AAT with Trauma

Trauma. For the purposes of diagnosis, the American Psychiatric Association's [APA] DSM-5 defines trauma as:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) for the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend- in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to the details of child abuse) (2013, as cited in Briere & Scott, 2015, p. 9).

Others add that events may be traumatic even without a direct or perceived threat to body or life, and refer to the DSM-3 criteria which included "threats to psychological

integrity as valid forms of trauma” (Briere & Scott, 2015, p. 9). What exactly qualifies as “traumatic” is an ongoing discussion, but research suggests that the impact of a traumatic experience may be influenced by the pre-existing condition of the person or people exposed (Briere & Scott, 2015). While the stress of traumatic events decreases over time for many people, a significant portion of individuals experience ongoing residual symptoms which may qualify for an official diagnosis of PTSD. PTSD is often comorbid with substance abuse, major depression, other anxiety disorders, and high-risk behaviors including suicidality. Severe cases may be treatment resistant (Katz et al., 2011).

Modern trauma theory proposes a continuum for understanding trauma, with a wide range of severity and presenting symptoms (Jones & Cureton, 2014; National Center for PTSD, 2014). Trauma symptoms present in people and communities of all ages, ethnicities, and life experiences (NICE, 2003). The impact of trauma on the community, and on the medical and mental health systems is profound (Frank, 2013). The field of trauma treatment is evolving, and while various evidence-based treatment modalities have emerged, the need remains to improve upon existing models and explore additional options for treatment of resistant trauma-related disorders (National Center for PTSD, 2014). Across the spectrum of treatment modalities the literature agrees upon a number of basic principles for effective trauma-focused treatment including: the foundational role of providing safety and stability, the importance of a positive and consistent therapeutic relationship, the need for individualization based on client characteristics, and the importance of culturally responsive services (Briere & Scott, 2015). Based upon these principles and what is known about AAT, a closer exploration

of the efficacy of utilizing AAT either as a separate trauma intervention or in correlation with other modalities seems to be clearly indicated.

Findings by Brown and Katcher (2001) provide insight into the importance of the human-animal bond for those with trauma histories. In two separate studies (1997, 2001) they found a positive correlation between levels of pet attachment and levels of disassociation, which is strongly correlated with trauma experiences. Based upon these findings, the researchers theorize that those who have experienced trauma may “seek reparative relationships with companion animals” either as a substitute for people, or as way to learn how to trust, “thereby providing a bridge toward human contact” (p. 28). Wilkes (2009) provides her own experience as well as knowledge gained as a practitioner in the field of AAT, as supportive evidence for this theory, noting that seeking reparative relationships with animals may be an “instinctive protective behavior” for those who have experienced trauma as a means of seeking safety (p. 37). The author suggests that animals provide therapeutic value as both a means of developing a working alliance between practitioners and their clients, and in the support of long term growth and healing (Wilkes, 2009). The powerful positive impact of the human-animal bond is presented across the literature as an effective tool in the treatment of trauma, something that impacts nearly 80% of clients seen in community mental health clinics (Jones & Cureton, 2014).

Research Question

It is clear from a review of the literature that the human-animal bond can play a powerful role in promoting wellbeing and healing for people across the spectrum of needs, diagnoses, and cultural contexts. The field of AAT has a long history, and has

recently begun to gather significant support from empirical research for its efficacy and accessibility. Trauma care and treatment, an area of intense focus due to the pervasive and devastating nature of its impact on individuals, families, and society, is a promising field in which AAT has previously been found effective. However, the mechanism by which AAT provides a unique opportunity for healing and growth for this population is not yet entirely clear. The purpose of this study was to explore clinicians' perceptions regarding utilizing AAT in a mental health setting as an intervention with adult clients who have experienced trauma. Specifically, the goal was to gather the practice wisdom of clinicians in the field regarding the unique effectiveness of AAT with this population, as well as any unique challenges or concerns related to this modality.

Conceptual Framework

As noted by Carlson & Dalenberg (2000), a sound theoretical framework should be the basis for clinical assessment, intervention, and research (p.1). However, no unified theoretical framework has yet emerged in the existing literature and practice in the area of AAT. Participants at a Delta Society conference in 1984 (prior to name change to "Pet Partners") noted that, "it was apparent that no single conceptual framework dominated this area of study... lack of a theoretical framework leaves this area of study without an emphasis" (Netting, Wilson & New, 1987). Participants in this conference began to identify potential frameworks from within which this theoretical gap can be addressed and rectified including social role theory and exchange theory. However, the literature reveals that these theories have not been universally adopted by researchers and practitioners in the field since the conclusion of the 1984 Delta Society conference. The researcher will examine the collected data through the lenses of Social Role Theory, as previously identified, as well as Trauma Theory and its application in trauma-informed

practice, as well as through the psychodynamic theories of attachment and object relations.

Social Role Theory

Based on the idea that a role is “any set of behaviors that has some socially agreed upon function and for which there exists an accepted code of norms,” social role theory is applicable to AAT in the idea that animals play different roles in their relationships with humans, based on context and characteristics of both participants (Netting, Wilson & New as cited in Blankly, 2003, p.16). In the therapeutic setting the role played by the therapy animal can be healing to clients, a dynamic which can be utilized for growth in goal directed work completed by a trained clinician.

Trauma Informed Practice

Just as AAT has its roots in early history and has become increasingly better understood and applied within certain standards and theoretical orientations, so has the study and treatment of trauma. The relationship between trauma and mental illness was first investigated by the neurologist Jean Martin Charcot, often called the “Father of modern neurology,” during his work with traumatized women in the 1800s (Ringel & Brandell, 2012). Modern trauma theory takes into the consideration the impact of trauma on multiple systems: biological, cognitive, developmental, emotional, interpersonal, and spiritual. Trauma theory “promotes emotional well-being as dependent upon positive personal relationships throughout life” (Thompson, 2005). In AAT, the therapy animal may be utilized as a developmental repair object with whom the client can develop a secure, healthy attachment – which may be helpful in fostering a healthy attachment with the therapist, and then (hopefully) expanded to others outside the therapy dyad.

Attachment Theory

Attachment theory, founded by John Bowlby, is one of the major theoretical developments within the field of psychoanalysis (Holmes, 1993, as cited in Mensink, 2013). Trauma theory “promotes emotional well-being as dependent upon positive personal relationships throughout life” (Thompson, 2005). In AAT, the therapy animal may be utilized as a developmental repair object with whom the client can develop a secure, healthy attachment – which may be helpful in fostering a healthy attachment with the therapist, which can then be expanded to others outside the therapy dyad. This conceptual framework is supported by the findings of Brown and Katcher (2001), who propose that animals may provide “a safe way to learn to trust another living being, thereby providing a bridge toward human contact” which is “consistent with attachment theory as proposed by Bowlby” (p.28).

Methods

Research Design

A qualitative design utilizing a survey format was employed to collect data. As noted by Monette, Sullivan & DeJong (2008), qualitative research explores various topics through investigation across multiple settings to obtain a deeper understanding of the phenomena in real-life situations. Additionally, a qualitative method allows for “concepts, definitions, characteristics, metaphors, symbols, and descriptions” to emerge, something that is “extremely important” for research in this field (Berg, 2009, as cited in Deye, 2011, p. 18).

The primary research questions was “how do clinicians feel about AAT as an intervention for trauma?” as well as “what wisdom do those practicing in the field have to tell us about the process of AAT with trauma clients?” The research hypothesis was that

data collected would support findings by previous researchers that AAT is uniquely effective as an intervention for adult clients who have experienced trauma. It was hypothesized that respondents would provide support for this idea by citing the unique nature of AAT, along with their personal experience in the field and the documented healing power of the human/animal bond.

Recruitment

Participants were identified through purposive snowball and expert sampling. The research sought to glean knowledge and opinions from individuals with particular expertise: AAT with clients presenting with trauma who were most easily contacted through their status as members of larger organizations and/or their professional contacts. Recruitment was begun by sending of an IRB approved recruitment email message which can be found in appendix B to individuals identified for their leadership in the field of AAT, as well as their potential access to other practitioners. Those contacted were provided with a link to the survey which they were asked to share the request for participants, researcher contact information, and the survey link with colleagues, organizational members, and students. Those contacted during the initial phase of recruitment included educators in mental health programs with an emphasis on AAT, membership coordinators for national and regional organizations that provide training, licensure, or networking opportunities, and various identified practitioners of AAT. It was assumed, but not required, that the majority of those who were contacted for participation (either directly by the researcher or through the snowball process) would have degrees in human-services and mental health fields including social work, psychology, marriage and family therapy, physical therapy, occupational therapy, or

similar. This was both practical and purposeful due to the emerging nature of AAT and the predicted low-response rate should the research be limited to just social work participants. Likewise, it was important that this research demonstrates the versatility of AAT, and the impact that it has had on a number of disciplines.

Sample

A total of 30 recruitment emails were sent. From this a total of 28 individuals began the online survey, though only 18 completed all questions. The majority of participants held licenses in mental health or related fields. There were a total of nine social workers (LGSW and LICSW licenses), five licensed psychologists (LPs), four marriage and family therapists (LMFT), and two licensed alcohol and drug counselors (LADC). Other participants included two graduate students in AAT programs, two EAGALA Certified Equine Specialists, and one volunteer with extensive training but no current licensure. Eighty six percent of participants stated that they had completed supplemental training specific of the field of AAT, the most common of which was EAGALA certification. The most common animal partners reported were, as expected, dogs and horses. However, participants also reported having worked with a wide variety of unique animals including: goats, cats, llamas, birds, pigs, cows, rats, emus, and alpacas. Per their self-reports participants spent an average of 70% of their practice time working with clients whose primary concern was trauma, with a range from 15% to 100%. It should be noted that respondents were from throughout the United States, with a high number of participants from Colorado, Texas, and various states on the East Coast.

Protection of Human Subjects

Prior to implementation, this study was reviewed by a research committee which included a St. Thomas faculty member within the School of Social Work and two community members with expertise in the field. The role of the committee was to advise throughout the process and approve research measures including the protection of human subjects and assurance of ethical practices. Following committee approval, the proposal was submitted to the St. Catherine University Institutional Review Board (IRB). A shared responsibility between researchers, advisors, and the University, the board reviews all research involving human subjects to “ensure protection, privacy, autonomy, dignity and informed consent for research participants” (SCU, 2014). IRB approval was obtained prior to contacting subjects or beginning data collection.

Formal, written informed consent was obtained from all participants, a copy of this form can be found in appendix A. All respondents were required to read this document and acknowledge their understanding and consent to participate before being granted access to the survey. The informed consent process involved informing participants of any risks and/or benefits involved in the study, and assurance that their participation is strictly voluntary, and that they were able to withdraw from the study at any time without any consequence.

All identifiable data collected was kept confidential, and accessible only to the researcher and research committee chair. Data collected via the internet was stored in a secure online drop-box. Remaining research records were stored on a password protected USB flash drive. Data was analyzed and de-identified following collection, with a deadline of May 31, 2015 for destruction of all original reports and identifying

information. The resulting written report and public presentation of findings relies on de-identified and group data.

Data Collection Instrument and Process

Surveys and interview protocol contained both closed and open ended questions in order to allow for the collection of basic demographic data, as well as a deeper exploration of clinician's unique experiences and perceptions about their work. Survey questions are available in Appendix A. The use of an online survey allowed for responses from practitioners outside of the Twin Cities metro area, and may have also encourage a directness of response only possible through anonymity.

The instrument used in this study was a qualitative survey consisting of eight primary questions and six sub-questions. The survey questions can be found in appendix C. Participants were given the option to either answer the survey online via Qualtrics or to contact the researcher to complete a structured interview either via telephone or in person. It should also be noted that while structured qualitative interviews completed via telephone or in person were offered, only one participant expressed interest in using this method. That participant later changed her mind, and chose to complete the online survey.

The majority of questions were open-ended and exploratory in nature, with a final question soliciting any additional information that the participant wished to share about their experience in the field of AAT. Estimated time commitment for completion was between twenty and thirty minutes, depending on the amount and depth of information which participants choose to share. Surveys completed on-line resulted in written responses stored in the Qualtrics program, which were easily accessed for the purposes of coding and analysis. Surveys completed in interview format were to be transcribed and

analyzed first separately and then in conjunction with data collected online to control for variations in response based upon methodology. As no data was collected through this method this was not necessary.

Data Analysis

The data collected was analyzed and interpreted using a grounded theory approach. Grounded theory allows for themes and theories to emerge from or be “grounded in the data” (Monnette, Sullivan & DeJong, 2008). Emphasizing the interplay between data collection, analysis and theory development, grounded theory fits well for a qualitative study such as this concerned with finding themes in perceptions. As noted by Patton (2002), grounded theory methodology is used to complete in-depth analysis in a way that allows for a theory to emerge, rather than to support a pre-conceived theory. In this way grounded theory requires objectivity from the researcher, as well “systematic rigor and thoroughness from initial design, through data collection and analysis, culminating in theory generation” (Patton, 2002, p. 489). Content analysis, a method of coding and interpreting language in order to find patterns, themes, biases, and meanings was completed in four separate stages (Berg, 2009).

Due to the time and resource limited nature of this study, grounded theory was not utilized to its fullest extent but rather a “grounded theory light” approach was relied upon. To do this the researcher went through collected data four separate times. First, an open coding process was used to identify major themes or repeated phrases which appeared consistently throughout the data. Second, coding was completed looking for the major themes identified in the literature review. From this four major themes were found, each of which were used to code the data for a third time. A final analysis of the data was completed utilizing the identified themes and seeking any potential sub themes.

Findings

Four major themes regarding the use of AAT with clients presenting with trauma emerged from the data. These themes notably aligned both with the available literature regarding the healing quality of the human-animal bond, and with the basic principles of effective trauma-focused treatment as outlined by Briere and Scott (2015). Themes were: the non-judgmental nature of the human-animal bond; non-verbal communication; physical and emotional safety; and the experiential and individualized nature of AAT.

Non-judgmental nature of the human-animal bond

Almost all participants made note of the therapeutic quality of animals as non-judgmental beings and the importance of this as a factor in the development of a therapeutic alliance. Clients, especially those with trauma, often face stigma and perceive others as judging them based on their history or symptoms. While a therapist has likely reviewed records or completed a diagnostic assessment prior to beginning treatment, their animal partners neither know, nor care about these details of a client's life. Rather, animals connect with clients in a way which is congruent with their nature and unencumbered by such data. In this new relationship with the animal, the client has the opportunity to experience and learn from the way that animals remain congruent and provide unconditional positive regard. This is consistent with the findings of Briere and Scott (2015) which cite a positive therapeutic relationship as one of the best predictors of positive outcomes in the treatment of trauma. Briere and Scott (2015) further state that clients who feel "liked and accepted" by their therapists have lower rates of treatment attrition (p. 109). The positive relationship established between client and animal cited by

participants may then play an important role both in the development of a therapeutic relationship between client and human therapist and in eventual treatment outcomes.

Table 1. Non-judgmental

Dominant Theme	Subthemes
Non-judgment	1. Congruence 2. Unconditional positive regard
Supporting Quotes	
a. "AAT allows for a nonjudgmental presence in the therapy" b. "I had one client state, "I love [therapy animal] because he listens without judging me" c. "The horses are non-judgmental, and always show up as exactly who and what they are. There is no hidden agenda or motive. Horses are congruent - there is no needing to read between the lines with horses. Horses heal because horses just 'are.'" d. "It [AAT] offers a way for them to connect with a nonjudgmental companion that offers unconditional love." e. "Animals provide an unbiased and natural connection with humans that the therapist cannot provide... an animal doesn't care about your past." f. "The pet doesn't care about your past or your mistakes. She takes you as you are." g. "Animals provide a transitional opportunity for people to feel safe and build relationships to people eventually."	

Non-verbal communication

The importance of the non-verbal relationship between clients and animal therapy partners was another significant theme in the data. Participants noted that clients, especially those who may have difficulty verbalizing their challenges in traditional therapy, often perceive animals as understanding and attuned to their needs. While clinicians may miss the incremental changes in body language displayed by their clients, animals are uniquely attuned to such shifts and are able to respond not just to the client's words but to their overall emotional and physical presence.

Table 2. Non-verbal communication

Dominant Theme	Subthemes
Non-verbal communication	<ol style="list-style-type: none"> 1. Attunement 2. Decrease in pressure to verbalize.
Supporting Quotes	
<ol style="list-style-type: none"> a. “Clients can process feelings, work through issues and build skills all non-verbally through work with animal.” b. “Animals provide a non-verbal bond... that adults seem to miss and may have grown out of.” c. “[AAT is] “particularly effective with horses as their hypervigilance makes them extremely in-tune with the emotional and body language of the client. By reading their body language, the client and the treatment team can learn without the pressure of 'talking'... it avoids the stigma of traditional talk therapy.” d. “Clients can process feelings, work through issues, and build skills all-nonverbally through work with animals.” e. “It goes beyond words to an actual internalization.” f. “Pets are an easy safe thing to talk about, and to refer to, and those involved can pet the animals and it takes pressure off of interacting only one on one with the handlers or other humans.” g. “Animals are able to accurately sense and reflect emotional states” h. “Animals provide unspoken comfort.” 	

Physical and Emotional Safety

The importance of safety within the trauma treatment environment cannot be overstated. The nature of trauma is such that “it is only in perceived safe environments that those who have been exposed to danger can let down their guard and experience the relative luxury of introspection and connection” (Briere & Scott, 2015, p. 104). The importance of both physical and emotional safety within the therapeutic context is emphasized throughout trauma literature (Briere & Scott, 2015; Ringel & Brandell, 2012; Katz et al., 2011). While animals can make a significant impact on client’s perception of safety and have been shown to reduce physical arousal, it is also imperative that AAT practitioners remain aware of the potential safety risks which are inherent in this modality. A large portion of participants in this study referenced various training and/or

evaluation processes which their animal partners had completed prior to beginning work. Likewise, respondents acknowledged that just as certain animals should not be utilized in therapy based on temperament some clients may pose a higher level of risk to animals. This reflects the consensus of the existing literature which notes that precautions to ensure the safety of all participants including the therapy animal, must be undertaken in order to ensure that AAT is both effective and ethical (Chandler, 2005; Iannuzzi & Rowan, 1991)

Table 3. Safety

Dominant Theme	Subthemes
Physical and emotional safety	1. Impact of animal interaction on arousal, 2. Safety of client and animal as paramount.
Supporting Quotes	
a. “Animals make it feel safer for trauma survivors to come to therapy and feel safe in participating” b. “Animals have lower heart rates and can help traumatized individuals lower theirs.” c. “Clients report feeling ‘safer’ and ‘calmer,’ they say that [therapy animal] makes them feel protected.” d. “Clients are able to remain more grounded and less anxious” e. “It is physically soothing to be with an animal, it decreases anxiety and lowers blood pressure” f. “This allows the client to feel safe, protected, and take on the low heart rate of [the therapy animal].” g. “[AAT] helps the client move from fight or flight mode to the neocortex part of the brain.” h. “[The environment in which AAT is done] is the literal translation of a safe space. The client is in control of what happens or does not happen, and is free to respond to the horses (and/or therapist) however he or she wants.” i. “It is our responsibility to ensure the safety of both our clients AND our animal partners.” j. “In order to be part of our program animals are evaluated and assessed for safety, soundness, and so on.”	

The experiential and individualized nature of AAT

Many participants in this study cited the experiential nature of AAT and its impact on the brain as a strength of this modality. There appears to be a consensus that AAT can take clients beyond cognitive awareness, and promote change on a physical and potentially even neurobiological level. Additionally, the bond between client and the animal therapy partner as well as the non-traditional nature of the space utilized (particularly to equine-assisted psychotherapy) was cited by multiple participants as a factor in client’s engagement and commitment to the work of therapy.

Table 4. Experiential and individualized

Dominant Theme	Subthemes
Experiential and individualized nature of AAT.	<ol style="list-style-type: none"> 1. Increased engagement. 2. Physical nature of trauma.
Supporting Quotes	
<ol style="list-style-type: none"> a. “[AAT] helps clients be in the present moment.” b. “Clients are more invested initially, they want to come to therapy” c. “The client is the one doing the work... they are more able to act/react/respond in an open pasture than in an office setting.” d. “This [AAT] provides for change not only cognitively (as does most talk therapies) but also in their bodies.” e. “AAT offers a medium that can be adjusted for each client to provide him or her with new learning experiences to correct developmental issues.” f. “Hands on animal work stimulates many brain pathways and can rebuild and form new neuronal pathways which is typically a necessary for trauma survivors to function at their potential.” g. “I think AAT works because it provides an experiential process in which the clients learn about themselves and others.” h. “Trauma is held in the physical body... this kind of work [AAT and somatic experiencing approaches] address the autonomic nervous system.” 	

Discussion

Overall, findings were consistent with the existing literature regarding the use of AAT as a trauma intervention. Specific themes which emerged included the non-judgmental nature of the human-animal bond; non-verbal communication; physical and emotional safety; and the experiential and individualized nature of AAT. These themes speak to the unique nature of the human-animal bond, and the healing power of experiential processing of trauma in collaboration with a clinician and animal therapy dyad. The safe space and potential for highly individualized treatment within this modality appear to make it uniquely suited to the treatment of trauma. Additionally, findings support a correlation between AAT and established best practices in the treatment of trauma. These include the importance of attending to client's physical and emotional safety within the therapeutic context, and the positive impact of a strong therapeutic alliance on engagement and outcomes. Based on the consistency of current findings with existing literature and a general sense of consensus between practitioners surveyed it seems likely that the existing "practice wisdom" gathered in this study will continue to align with empirical findings.

Implications for Clinical Social Work

Social workers value both "evidence-based practice", and "practice-based evidence" as sources of information regarding the provision of high quality and effective treatment to clients. Because social workers are "prominent members of the largest mental health profession treating trauma survivors" the Council on Social Work Education (CSWE) makes it clear that "it is imperative that social workers are prepared to provide "competent trauma-informed practice... as the likelihood of encountering

trauma survivors in every practice settings is very high” (2012, p.2). The findings of this study (which focus on the practice wisdom of those currently utilizing AAT as a trauma intervention), along with current research (with emphasis on empirical evidence) suggest that AAT is a unique and effective trauma intervention. Based on the consistency demonstrated within the existing research, it can reasonably be expected that future research will continue to support these findings. While not all social workers will practice within the field of AAT, this does not negate the responsibility outlined in the NASW Code of Ethics (2008) stating that “social workers should critically examine and keep current with emerging knowledge relevant to social work practice” (5.02). Therefore, Social Workers in all areas of practice should familiarize themselves with effective trauma interventions including AAT.

Social workers who integrate animals into their practice with clients are held to the additional standard that their practice in this area must be based upon “recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics” (NASW, 2008, 1.04). Because of the emergent nature of AAT and diversity in its application it may fall under the category of practice modalities in which generally recognized standards do not yet exist. The NASW Code of Ethics notes that in such emerging areas of practice “social workers should exercise careful judgement and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm” (2008, 1.04). The findings of this study, along with the existing body of literature (including the standards of practice identified by Pet Partners and other leading organizations) will continue to strengthen social work practice standards in this area.

Recommendations

Findings from the current study indicate promise in the field of AAT. Study results indicate that trauma survivors engaged in AAT may respond positively to experiential components related to human-animal interaction and the often unique environment associated with AAT. Practitioners suggest that participants gain relational skills that often transfer to daily life as experienced through interacting with a therapy animal. Additional research is needed to address specific benefits for trauma survivors from various cultural backgrounds, and to empirically determine the difference in efficacy between AAT and other existing trauma interventions, as well as the potential for AAT to be used in collaboration with other therapeutic modalities. This research would be most helpful if it is completed utilizing a mixed-methods format in which both qualitative and quantitative data can be collected.

Strengths and Limitations

As expected, the purposive nature of the sampling technique utilized in this research study led to a fairly small sample size. Likewise, a rather high attrition rate was found as the survey progressed. This was anticipated by the researcher, and was the reason that a high level of recruitment emails were sent. As predicted, the use of on-line surveys allowed the researcher to access clinicians from a broad variety of settings and the ease of online survey completion may have led to a higher response rate than could have been otherwise expected. However, while the anonymity provided by the online format may have encouraged higher levels of disclosure from some participants, the impersonal nature of the format did not allow for a dialogue between researcher and participant which may have led to a lack of depth in responses. It should also be noted

that nature of the sample population may also have created a barrier to in depth responses. As practicing professionals, participants have multiple demands on their time. This may have contributed both to a lack of depth in some of their responses as well as to incomplete or difficult to interpret responses.

Due to the small sample size, results cannot be generalized to the broader population of clinicians currently practicing AAT with clients presenting with trauma. However, based on the generally high level of training and/or licensure of respondents and their thoughtful responses it can be assumed that those who took the time to complete the survey from start to finish were indeed leaders in their field who feel strongly about their work and the need for ongoing research in this area. In addition, the clear emergence of core themes despite the diversity of respondents in both education/discipline and geographical location serves to strengthen the hypothesis that a broad range of clinicians would support the suggestion that AAT is a uniquely effective intervention for clients with trauma.

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APPENDIX A.

Animal-Assisted Therapy as a Trauma Intervention**INFORMATION AND CONSENT FORM****Introduction:**

You are invited to participate in a research study investigating the use of animal assisted therapy as a trauma intervention with adult clients. This study is being conducted by Erin McLaughlin, a Masters of Social Work student at St. Catherine University under the supervision of Dr. Lisa Kiesel, a faculty member in the School of Social Work. You were selected as a possible participant in this research because of your training and experience in the work of animal assisted therapy. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to gather information on clinician's experiences using animal assisted therapy, and their experience (if any) or informed opinions regarding utilizing this modality in working with adults who have experienced trauma.

Procedures:

If you decide to participate, you will be asked to complete a qualitative survey in the most convenient medium for you – either via a secure internet server, or through in person or telephone communication. Should you choose to complete this survey in person or via telephone your answers will be audio recorded for transcription purposes. Questions will not differ regardless of chosen medium. There will be eight questions in the survey, you are asked to answer all to the best of your abilities though you can choose how much depth you wish to provide. This will take approximately 20 - 30 minutes of your time.

Risks and Benefits of being in the study:

Beyond contribution to the body of knowledge in the field of animal-assisted therapy there are no identified direct benefits for participating in this study. Participation has minimal risks though will require a commitment of time. Every effort has been made to expedite data collection methods (online format option, a limit of 8 questions with no word minimum or maximum for responses) to decrease the level of inconvenience that may be involved in participation.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no individual participants will be identified or identifiable. All data collected via the internet will be anonymous and will be securely stored through the Qualtrics program. Remaining research records (including audio records and resulting transcriptions as well as consent forms) will be stored in a locked file cabinet behind a locked door either in paper form, or on a password protected USB flash drive. I (the researcher) and my advisor will be the only people with access to de-identified data. I will finish analyzing the data and destroy all original

reports and identifying information that can be linked back to you (including audio recordings) by May 31, 2015.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with the University of St. Thomas or St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Erin McLaughlin, via email at mcla2567@stthomas.edu. You may ask questions now, or if you have any additional questions later, I or my Research Committee Chair, (Dr. Lisa Kiesel, kies0954@stthomas.edu), will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

Online participants are encouraged to make note of this contact information prior to beginning the survey.

Participants completing this form online must indicate their agreement by selecting the appropriate button prior to beginning the survey. If you wish to retain a copy of this form for your records you may print this page before continuing.

Participants completing the form in person or over the telephone will be provided with a physical or electronic copy of this form which must be completed prior to participation. A copy of this form will be provided for your records upon request.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study.

I consent to participate in the study, and (if applicable) I agree to have my responses audio-recorded.

Signature of Participant

Date

Signature of Researcher

Date

APPENDIX B.

**Animal-Assisted Therapy as a Trauma Intervention:
Recruitment E-mail**

Hello [individual name or “to whom it may concern”],

I found your contact information [name of person, website etc.], I apologize if I have reached you in error. My name is Erin McLaughlin and I am a third year student in the MSW program at St. University & the University of St. Thomas and a clinical trainee at the Hamm Clinic in St. Paul, MN. I am currently seeking participants for my final research study. The purpose of this study is to explore clinician’s perceptions regarding utilizing Animal-assisted therapy (AAT) in a mental health setting as an intervention with adult clients who have experienced trauma. Specifically, the goal is to gather the practice wisdom of clinicians in the field regarding the unique effectiveness of AAT with this population, as well as any unique challenges or concerns related to this modality.

I am seeking practitioners in the field to complete a seven question survey either online or via phone call or in-person structured interview. The eight questions and expected time commitment (20-30 minutes) will be the same across all platforms. I am wondering if this is something that your [graduates/members/ colleagues] may be interested in participating in. If so I would appreciate your assistance in either providing them with my name and contact information as well as a link to my survey, or by providing me with their contact information. I recognize that you may receive similar requests often and not want to bombard your [students/alumni/members/colleagues] with requests to participate in research. However, I would love to speak with someone if you are open to discussing the possibility.

My study can be accessed here: [LINK TO SURVEY]

Thank you for your time,

Erin McLaughlin

APPENDIX C.

Animal-Assisted Therapy as a Trauma Intervention:**Survey & Interview Protocol**

Thank you for your participation in this research study, please answer the following questions fully and to the best of your abilities.

These first few questions will provide information on your training, licensure, and practice experience. These questions are meant to be demographic in nature, and require full but not lengthy responses.

1. Have you provided Animal-assisted Therapy (AAT) in the past five years? (yes/no)
2. What is your current licensure (if any) and level of training?
 - 2a. Have you completed any supplemental training specific to the field of AAT?
 - 2b. What type(s) of animal(s) have you practiced with in an AAT context?
 - 2c. Have the animals that you work with received any specific training or certification to work in AAT?
3. What model or type of Animal-assisted Therapy do you practice?
4. What diagnosis and/or presenting problems have been most common in your client population?
 - 4a. What is the age range of your clientele?
 - 4b. What percentage of your work focuses on clients with trauma – either DSM diagnosed or not?

The following questions are intended to provide more in-depth information about your expertise in the field, and the specific application of AAT to work with clients who have experienced trauma. Please answer them fully, and provide as much detail as you feel comfortable with.

5. Why do you think AAT works with your clients?
 - 5a. What (if any) changes have you noticed in your clients who have received AAT services?
6. In what (if any) contexts would you not utilize animal assisted therapy? Are there certain diagnosis or populations in which you feel AAT would be contraindicated?
7. Why (or why not) do you think AAT is an effective intervention for clients with trauma history?
8. OPTIONAL: Is there anything else you would like to share about your work as it applies to utilizing AAT with clients who have experienced trauma?

Thank you for your participation!

Contacts and Questions:

If you have any questions, please feel free to contact me, Erin McLaughlin, via email at mcla2567@stthomas.edu. You may ask questions now, or if you have any additional questions later, I or my Research Committee Chair, (Dr. Lisa Kiesel, kies0954@stthomas.edu), will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu. Please take note of this information prior to closing this window as you will not be able to access to page again.