Improving Mental Health Through Animal-Assisted Therapy

Liana Urichuk *with* Dennis Anderson

Inquiries about The Chimo Project can be mailed to:

The Chimo Project
Suite 200A-10140-117 Street
Edmonton, Alberta
T5K 1X3
CANADA

Or emailed to:
lurichuk@ualberta.ca or anderson@interbaun.com

Canadian Cataloguing in Publication Data:

Urichuk, Liana J. (Liana Joanne), 1969-
Improving mental health through animal-assisted therapy/Liana J. Urichuk with Dennis Anderson.

Includes bibliographical references.
ISBN 0-9732944-0-X

1. Animals -- Therapeutic use. 2. Pets -- Therapeutic use. 3. Mental illness -- Treatment. I. Anderson, Dennis (Dennis L.), 1949- II. Chimo Project. III. Title.

RC489.P47U74 2003 616.89'165 C2003-910710-8

Improving Mental Health Through Animal-Assisted Therapy

Liana J. Urichuk, BSc, PhD

with

Dennis Anderson

Dedication

This manual is dedicated to my friend of friends ***"Chimo"*** *who taught me of unqualified love, and to all other animal friends who have selflessly provided comfort, compassion, and unparalleled commitment to humans. This dedication is generally without measure of our right to such gifts or of our own commitment to reciprocate.*

It is this affection that has given me the ability to survive, with relative sanity, in an often difficult world. The healing power of this unqualified love has been the inspiration for this manual and the project that produced it. May this book bring the healing power of an animal's love to those who need it to better handle an increasingly complex world. May this manual also give us a better appreciation for those creatures with whom we share the earth.

Dennis Anderson

Acknowledgements xii
Preface xiv

CHAPTER 1
Introduction to Animal-Assisted Therapy

1.0 Chimo Project Overview
1.1 The Human-Animal Bond
1.2 The History of Animal-Assisted Therapy

1.3 Anecdotal and/or Case Studies of Animal-Assisted Therapy
1.4 Experimental Studies of Animal-Assisted Therapy
1.5 Current Use of Animal-Assisted Therapy
1.6 References

CHAPTER 2
Approaches to Incorporating Animals Into Mental Health Therapy Interventions

2.1 Goals and Strategies
- 2.1.1 Rapport/Relationship Building
- 2.1.2 Bonding
- 2.1.3 A Catalyst for Emotion
- 2.1.4 Empathy
- 2.1.5 Self-Esteem Building

2.1.6 A Catalyst for Nurturing/Giving
2.1.7 Enhancing Personal Growth and Development
2.1.8 Providing a Sense of Control
2.1.9 Reducing Abusive Behaviors or Tendencies
2.1.10 Psychological Benefits
2.2 Valuable Roles Animals Can Play in Therapy
2.2.1 Assessment Tool
2.2.2 Projective Tool
2.2.3 Tool for Storytelling and Metaphor
2.2.4 Role Modeling Tool
2.2.5 Teaching Tool
2.3 Alternative Ways to Utilize the Human-Animal Bond
2.3.1 Have an Animal Present
2.3.2 Use the Person's Relationship With Their Own Pet
2.4 Summary
2.5 References

CHAPTER 3

Guidance for Implementing Animal-Assisted Therapy Programs

3.0 Standards for Animal Selection
3.1.1 Problem or Unacceptable Behaviors
3.1.2 Age and Health Status
3.1.3 Socialization

3.2 Guidelines for Training and Orientation
    3.2.1 Training in AAT Techniques
    3.2.2 Administrative Support and Policy Development
    3.2.3 Program Planning and Design
3.3 Liability Issues
    3.3.1 Non-Profit Organizations
    3.3.2 Homeowner's and Renter's Insurance
    3.3.3 Professional Liability Insurance
3.4 The Chimo Project and the Future
3.5 Selected AAT Training Courses and/or Degree Programs
3.6 References

CHAPTER 4

Monitoring and Evaluating Animal-Assisted Therapy Programs

4.1 Performance Indicators
4.2 Outcome Measures
4.3 Efficacy
4.4 Testimonials as Outcome Measures
4.5 Safety
    4.5.1 Stress
    4.5.2 Health and Infection Control
    4.5.3 Preventing Accidents and Injuries
4.6 Ethical Issues
    4.6.1 Animal Welfare
    4.6.2 Animal Abuse
4.7 References

CHAPTER 5

Experimental Research Studies on Animal-Assisted Therapy

5.1 Experimental Studies of Animal-Assisted Therapy
- 5.1.1 Ownership
- 5.1.2 Visitation Within the Home
- 5.1.3 Visitation in Institutional Settings

5.2 Summary of Experimental Studies
5.3 References

APPENDICES

APPENDIX A
Canadian Canine Good Citizen Test

APPENDIX B
Canine Aptitude Test

APPENDIX C
Therapist Evaluation Questionnaires

APPENDIX D
Client Evaluation Questionnaires

APPENDIX E
Summary of Goals and Strategies for AAT in Mental Health Settings

Acknowledgements

There are not many times when your vision is so understood, so shared, that the end result is a product that is better than you imagined. This manual was my vision, but it is the work of the very qualified, capable, and committed **Dr. Liana Urichuk, Chimo Project Coordinator**. I will forever be grateful for her commitment to the Chimo Project and for her exceptional competence, which surpassed any expectations of her job responsibilities.

I also wish to thank those others who worked with the Chimo Project and have been dedicated to its concept: **Dr. Bonnie Dobbs**, the Project Evaluator, who not only provided research for the manual, but also moral support; and to **Sylvia Imbeault, Sherryl Husereau,** and **Anne Nield** who have provided dedicated administrative assistance.

The therapists and volunteers who have worked on the project, many of whom are contributors to the manual, deserve a great deal of credit for the success of this project. They have seen the results that are possible and they are proof that this manual is much more than fiction.

Without the support of the **Canadian Mental Health Association and Bosco Homes** the project would have had difficulty proceeding. They have our thanks.

The involvement of the Chimo Project volunteer advisory committee, the Edmonton SPCA, and the

Pet Therapy Society of Northern Alberta are gratefully acknowledged.

Last and definitely not least, we must thank profusely the Health Innovation Fund, an initiative of Alberta Health and Wellness, who believed in the vision and funded the project. In particular, we wish to acknowledge **Blair MacKinnon** and his co-workers for being the most helpful and cooperative funding agency staff that anyone could ask for. This made a world of difference in the making of the project and this manual.

Dennis Anderson

Preface

This manual is designed to provide mental health professionals and others with currently known information on how animals can act as adjuncts to the therapeutic process for individuals with mental health concerns. Most of the information in this manual is based on experiences of people who have incorporated animals into their professions for a variety of purposes. Much of the information was also gathered from mental health professionals who are currently working together with animals in their practices. This manual should be considered a "work in progress." Mental health professionals are encouraged to exercise their own good judgment in using the techniques herein, as well as other techniques that are deemed to be in the best interest of their clients.

Throughout this project, both advice and comments about the effectiveness and relevance of techniques used in animal-assisted therapy sessions were collected. The insights, observations, and innovations shared by mental health professionals were gratefully incorporated into the manual.

We believe that this manual may contain some of the best-tested and most comprehensive information available, to date, on using animal-assisted therapy to improve mental health concerns. We hope you find the information useful.

Liana Urichuk, Ph.D.

Chapter 1

Introduction to Animal-Assisted Therapy

The one absolutely unselfish friend that man can have in this selfish world, the one that never deserts him, the one that never proves ungrateful or treacherous, is his dog.

Samuel Taylor Coleridge

1.0 Chimo Project Overview

The Chimo Project concept was founded in 1999 by Dennis Anderson who, at that time, was the President of the Canadian Mental Health Association in Alberta. The Chimo Project is named after Dennis's animal friend "Chimo," a Blue Heeler/Labrador cross. Because Dennis has personally experienced the psychological benefits of human-animal interactions, he aspired to obtain evidence that animals may be beneficial in the treatment of persons with mental health concerns. The name Chimo comes from the Inuit toast to "good cheer", which is what the project hopes to bring to those suffering from mental illness.

Three organizations formed the original Chimo Advisory committee: 1) The Canadian Mental Health Association; 2) The Edmonton Society for the Prevention of Cruelty to Animals; and 3) The Pet Therapy Society of Northern Alberta. Through a series of meetings, and with the advice of therapists, the committee developed the backbone for the current project. Discussions also revolved around a potential second project that would concentrate on pet ownership by persons with mental health problems.

In early 2001, an application was made to the Alberta Health and Wellness' Health Innovation Fund for financial support. This application was approved and the eighteen-month project began in May of the same year.

Today, a professional advisory committee (with various therapists, animal experts, and a lawyer) and a general advisory committee (with various representatives from the founding organizations) provide useful insight for the small staff of the project. The Canadian Mental Health Association and Bosco Homes have been the recipients of the funding through the Health Innovation Fund and are generally responsible for the administration of the project. The Project has also received approval from The Health Research Ethics Board at the University of Alberta.

One of the goals of The Chimo Project is to identify various ways that animals can effectively be used in the treatment of mental illness. Currently, there have been limited scientific studies conducted to determine the effectiveness of Animal-Assisted Therapy (AAT). It is anticipated that information obtained from The Chimo Project may be useful in developing curricula on using AAT as an adjunct to other therapeutic modalities. The results may also be useful in helping to set up AAT programs in conjunction with various mental health facilities. Furthermore, the results may lead to exploration of ways in which barriers to animal ownership can be reduced for appropriate mental health consumers.

1.1 The Human-Animal Bond

Animals and humans have shared a special relationship since pre-historic times. Cave paintings indicate that the earliest human-animal relationships may have occurred between wolves and cavemen. Archaeologists suggest that, over

10,000 years ago, the wolf/dog was the first animal to be domesticated. The dog played a large role in hunting and carrying loads, but there is little doubt that real human-dog relationships began the first time a dog responded to a pat on the head with a wagging tail.

Man has shared significant relationships with many types of animals and has experienced physical and emotional benefits because of them. For example, the Ancient Greeks used hippotherapy (i.e., physical therapy on horseback) to rehabilitate injured soldiers. Then, about 5,000 years ago, Egyptians tamed African tabby wildcats to hunt mice and rats. Cats went on to be pampered and worshipped. They were known to eat from the same plate as their owners, wear valuable jewelry, and be well taken care of medically. In fact, ancient Egyptians believed that cats were immortal and would make special efforts to preserve cats' bodies after death so their souls would have a place to return to. Oftentimes, after death, the cat was embalmed and put in a coffin that contained food for the cat's soul. The coffin was then buried in a sacred vault along the banks of the Nile (Dale-Green, 1963). A story is told of how a Persian army once won victory over Egyptians by taking advantage of their reverence for cats. The Persians were besieging an Egyptian fort when their king had the brilliant idea of ordering his soldiers to throw live cats over the walls. The defending troops apparently allowed the city to be captured, rather than risk injuring the animals they knew to be sacred and which they suspected to be divine.

A dog is the only thing on earth that loves you more than he loves himself. -- Josh Billings

The belief that animals, because they are rational and know the difference between right and wrong, could be held accountable for their acts was prevalent in the ancient world. This belief continued into the Middle Ages. During this time, animals were entitled to the same legal protection as human beings (Hyde, 1956), but a distinction was made between domestic animals, which were tried in the ordinary criminal courts, and wild noxious animals such as rats, which were tried by the ecclesiastical courts. Both courts could impose the death penalty. In 1497 there was an interesting trial of a sow that murdered and then ate her piglet. She was found guilty and was hanged (Hyde, 1956). As late as 1906, a dog was sentenced to death in Switzerland.

Also during the Middle Ages, some animals (especially cats) were thought to be in league with witches or possessed by witches. It is said that during the famous Salem witch trials, a dog was condemned and hanged for being ridden by a witch (even though the witch was invisible) (Leach, 1961).

The emotional bond that develops between humans and animals, however, can be very powerful. Although many stories cannot be confirmed, it is fascinating to hear tales of incredible love and devotion between humans and animals. The following examples demonstrate the overwhelming strength of the human-animal bond.

> [One] *example is that of an Irish soldier in World War I, whose wife and small dog, Prince, took up residence in 1914 in*

Hammersmith, London, while he was sent with one of the earliest contingents to the battlefields of France. After a period of service he was granted leave to visit his family, but when he returned to battle Prince was utterly disconsolate and refused all food. Then the dog disappeared. For 10 days the wife tried desperately to trace him, to no avail. Finally she decided to break the news in a letter to her husband.

She was astonished when she heard from him that the dog had joined him in the trenches at Armentières, under heavy bombardment. Somehow Prince had made his way through the streets of London, 70 miles of English countryside, had crossed the English Channel, traveled more than 60 miles of French soil, and then had "smelt his master out amongst an army of half a million Englishmen and this despite the fact that the last mile or so of intervening ground was reeking with bursting shells, many of them charged with tear gas!"

Taken From: Dossey, L. (1997). The healing power of pets: a look at animal-assisted therapy. *Alternative Therapies,* **3**, p.15.

Not only do animals care for humans, they often appear to grieve when they are separated from the humans they love. When Auld Jock, a poor shepherd, died in 1858 and was buried in Greyfriars

churchyard in Edinburgh, Scotland, his Skye terrier, Bobby, would not leave his grave. The little dog endeared himself to everyone and became widely known. People brought him food and children played games with him, but nothing could lure him away from the grave for good. Every night, without exception, Bobby returned to the site of his master's burial, in wind, rain or snow. When he died after 14 years of devotion, a fountain with a statue was erected in his memory. "Edinburgh has many statues, but this fountain commemorating the memory of Greyfriars Bobby, the faithful terrier who watched over his master's grave until his own death many years later, is still a loved and revered landmark, esteemed more highly than statues erected to the famous."

Taken From: Dossey, L. (1997). The healing power of pets: a look at animal-assisted therapy. *Alternative Therapies,* **3**, p.9.

Napoleon, in his Italian campaign of 1796, strolled through a bloody battlefield in "the deep silence of night". Suddenly a dog leaped from the body of his dead master toward Napoleon, then retreated to lick the hand of the dead man, howling pitifully. The dog repeated the action over and over - rushing toward Napoleon and retreating to his slain master. This unbreakable link between the dog and the dead soldier moved Napoleon deeply. "No incident on any field of battle," he wrote,

"ever produced so deep an impression on me. I voluntarily contemplated the scene. This man, thought I, had friends in his camp, or in his company; and now he lies forsaken by all except his dog! What a lesson nature here presents through the medium of an animal!"

Taken From: Dossey, L. (1997). The healing power of pets: a look at animal-assisted therapy. *Alternative Therapies,* **3**, p.9.

1.2 History of Animal-Assisted Therapy

The first recorded use of animals in a therapy setting appears to have occurred at York Retreat in England (Levinson, 1965). This retreat was founded by the Society of Friends in 1792 and often incorporated animals into the treatment of patients with mental illness in an effort to "reduce the use of harsh drugs and restraints." The idea that pet animals could serve a socializing and/or therapeutic function for people with mental health concerns became popular during this time and by the 19th century the introduction of animals to institutional care facilities was widespread. For example, the use of animals in therapy was recorded in 1867 at Bethel, a residential treatment center for persons with epilepsy (McCulloch, 1983). In North America, one of the earliest recorded uses of animals in a therapeutic setting was at St. Elizabeth's Hospital in Washington, D.C. in 1919. Here, dogs were introduced as companions for residents in psychiatric care. Unfortunately, however, these early and preliminary uses of AAT were soon replaced due to the discovery of

But the poor dog, in life the firmest friend, the first to welcome, foremost to defend.
-- Inscription on a Newfoundland Don -- Lord Byron

psychotropic medications during the early part of the 20th century. There were no more substantial medical discussions of the value of animals as therapeutic adjuncts until 1944, when Dr. James Bossard published a paper which discussed the therapeutic value of owning an animal. Based on case studies and his own personal experiences, he discussed the many roles that the family pet may play (e.g., source of unconditional love; outlet for people's desire to express love; social lubricant; companion and teacher of children in areas such as toilet training, sex education, and responsibility). This article was reprinted by veterinary journals, animal welfare publications and several newspapers. Within five years, Bossard received over one thousand letters requesting reprints or referring directly to this article. In a follow-up paper entitled, "I Wrote About Dogs," written in 1950, Bossard stated:

> *[al]though I contributed more than a hundred articles to a variety of journals, many of them dealing with controversial issues and all of them confined to the field of human relations, no other article has brought forth such a flood of letters… The responses to the original publication of the article were so frank, so spontaneous, and from such a large segment of the population, representing such a wide range of social strata, as to leave no doubt that the love of animals by humans is one of the universals in the existence of both. Household pets are an integral part of family life; they must be considered as a*

basic implement in mental hygiene. (p. 387)

Since the early 1960s, there has been an increase in the number of professional therapists who recognize and value animals as therapeutic tools. In the State Mental Hospital in Lima, Ohio, the positive effect animals could have on people was discovered after a patient found an injured sparrow. Without any direction or approval, he began to care for the injured bird. Other patients, usually detached and withdrawn, began working together to help in caring for the little bird. Staff recognized the positive change in these inmates and soon incorporated animals into their treatment plans. Today, the hospital in Ohio is home to a wide variety of animals (e.g., dogs, cats, parrots, goats, deer, and snakes). The hospital also conducted a year-long study to determine the effects animals had on the patients. Interestingly, it was found that patients on wards with animals present used only half the amount of medication that was used on wards without animals. The study also demonstrated a reduction in violence and significantly fewer suicide attempts amongst patients who were on wards with animals, compared to other wards (Lee, 1984).

Two of the most significant events in the history of modern pet therapy were the 1969 publication of "Pet-Oriented Child Psychotherapy" and the 1972 publication of "Pets and Human Development" by Dr. Boris Levinson. His study of the therapeutic use of animals in treatment began quite by accident in 1953 upon a young patient's first visit to see him. The boy arrived early for his appointment and met and embraced Levinson's dog, Jingles, who was in the office that day. The dog helped Levinson develop rapport with the boy and facilitated a bond between them. Levinson recognized the powerful impact that the dog had, and thus began his future

A lean dog shames its master. –Japenese Proverb

specialization in the human-animal bond. Unfortunately, however, Levinson's promotion of pet therapy was received with cynicism and disapproval by many colleagues. It has been reported that during one of Levinson's presentations on pet therapy, one member of the audience asked, "*Do you share your fee with the dog?"* (Beck & Katcher, 1984). In his writings about pet-oriented child psychotherapy in 1969, Levinson states:

> *It has by no means been the intention of this writer to indicate that pets are a panacea for all the ills of society or for the pain involved in growing up and growing old. However, pets are both an aid to and a sign of the rehumanization of society. They are an aid in that they help to fill needs which are not being met in other, perhaps better ways, because society makes inadequate provision for meeting them. In the meantime, animals can provide some relief, give much pleasure and remind us of our origins. (p.3)*

In the 1970s, Sam and Elizabeth O'Leary Corson established a dog ward in their psychiatric hospital at Ohio State University to research animal behaviour in various settings. They believed that this would provide them with insight into the behaviour of children and adolescents placed in similar circumstances. The ward housing the dogs was not soundproof and, consequently, the patients in the adolescent ward could hear the dogs barking. Surprisingly, many patients began to break their self-imposed silence to ask if they could see or help take care of the dogs. The response of the patients

towards the dogs inspired the Corsons to conduct a research project to determine the effects dogs had on psychiatric patients who had not responded to a variety of other treatment methods. The incredible result of this pilot study was a dramatic improvement in twenty-eight out of thirty subjects (Corson, Corson & Gwynne, 1974).

Today, the Delta Society is considered to be the leading North American organization in AAT. The Delta Society was founded as a non-profit organization in 1977 with a mission to promote mutually beneficial relationships between animals and people, in order to help people improve their health, independence, and quality of life.

According to the Delta Society, AAT is a goal-directed intervention in which an animal that meets specific criteria is an integral part of the treatment process. The organization stresses that AAT should be administered by an appropriately trained healthcare professional, in normal practice, and should seek to accomplish pre-determined, quantifiable objectives. The Delta Society differentiates between AAT and Animal-Assisted Activity (AAA). Although both methods seek to bring about improvement in physical, social, or emotional function, AAT is always administered by a trained health professional and is goal-directed, with measurable objectives. In contrast, Animal-Assisted Activities (AAAs) are less formal opportunities for interaction with animals.

The Delta Society was also a founding member of the International Association of Human Animal Interaction Organization (IAHAIO), an organization

that is devoted to promoting research, education, and information-sharing about human-animal interactions and the unique role that animals play in human well-being and quality of life. The longest-standing organization devoted to the animal-human bond, however, is the Latham Foundation. The Latham family originated the Latham Foundation in 1918 to promote respect for all life through educational publications, videos, and other collaborative projects. Today, the Latham Foundation is a clearinghouse for academic and research-focused articles, journals, and publications. The Latham Foundation also provides information about humane issues and activities, the human-animal bond, animal-assisted therapy, and the connections between child abuse, animal abuse, and other forms of violence.

1.3 Anecdotal and/or Case Studies of Animal-Assisted Therapy

Much of the body of literature directed at assessing the value of animal involvement in therapy is comprised of qualitative case studies or positive anecdotal accounts (Bardill & Hutchinson, 1997; Carmack, 1998; Corson, Corson & Gwynne, 1977; Levinson, 1961; Mason & Hagan, 1999; McCulloch, 1983; Olsen, Anderson, Quigley, & Beahl, 1983; Smith 1984; Wells, Rosen, & Walshaw, 1997). The anecdotal literature does not generally attempt to quantify the clinical impact of AAT, but the descriptions of unique and magical experiences between people and animals is often what draws people into working with their own animals or into studying human-animal relations. The very fact that so many people enthusiastically

responded to Bossard's article in 1944 confirms the attraction of the field.

The numerous reports about the benefits animals provide to people have indicated that animals may not only contribute to numerous psychological benefits, but may also provide outlets for spirituality, education, recreation, and socialization. For example, Dr. Aaron H. Katcher, a professor of Psychiatry at the University of Pennsylvania, compares the comforts of talking to an animal to the comforts of prayer.

> *Prayer is frequently accompanied by sensual enrichment such as incense, music, special body postures, the touch of folded hands or rosary beads, just as a dialogue with an animal is accompanied by the enrichment of touch, warmth and odor. In both instances the talk is felt to be 'understood'.*

Taken From: Dossey, L. (1997). The healing power of pets: a look at animal-assisted therapy. *Alternative Therapies,* **3**, p.10.

It is also thought that a companion animal can provide a source for increasing one's own knowledge, resulting in increased self-respect. This may then lead to increased socialization and/or recreation activities. There are numerous reports of animals acting as an ice-breaker or a social lubricant during social interactions. In the presence of an animal, people tend to have fun and relax. For example, Peter R. Messent of the Animal Studies Center (Melton Mowbray, Leicestershire, England)

A dog is not "almost human," and I know of no greater insult to the canine race than to describe it as such.
-- John Holmes

recruited eight dog owners and asked them to take two strolls through Hyde Park, once with their dogs and once without. During their strolls, an observer followed and recorded the responses of the people who passed within five feet of the walker. The results indicated that when the dogs were with their owners, a significantly greater number of responses and more lengthy conversations took place. It did not matter whether or not the dog was pedigreed (Messent, 1983). Other studies have also shown that people with animals are perceived as being more friendly, approachable, and safe (Lockwood, 1983). Although the social lubricant effect of animals can be demonstrated in many different circumstances, this benefit is particularly relevant to individuals with special needs. For example, individuals who are physically impaired (e.g., in a wheelchair) or who have a mental health disorder (e.g., depression) notice substantial changes in their social environment if accompanied by a dog. Instead of ignoring or avoiding them, other people are more likely to approach and socialize with them (Mader, Hart, & Bergin, 1989). The presence of an animal may help people overcome their discomfort with another person's disability and, thus lead to positive social interaction. This is particularly true for children.

It is strongly believed by many people in several disciplines that animals increase motivation. For instance, in a study conducted in an in-patient psychiatric unit, it was determined that a higher percentage of attendance was attained in groups where animals were present (Halcomb & Meacham, 1990). Although attendance does not prove therapeutic effectiveness, this finding is important

because the individuals being studied were solitary and their attendance at the groups was voluntary. Thus, the results suggest that animals may be an effective medium to draw isolated individuals to group settings where they can be more easily assessed and treated.

Furthermore, there are several anecdotal reports which support the use of animals in physical, occupational, or speech therapy. It is felt that the animals may directly help to improve mobility, vocalization, coordination, balance, and strength (Dossey, 1997), not to mention provide psychological benefits. For example:

> *At the age of 20, BJ was in rehabilitation after suffering from severe electrical shock. He suffered the loss of both legs below the knee and his left arm below the elbow. After his rehab began, he met his "soul mate" – Vermont, a Lab and [G]olden [R]etriever mix trained by Canine Companions for Independence, an organization that breeds dogs from puppyhood to aid the disabled. BJ worked with several dogs before meeting Vermont, to see which ones would mesh best with his personality. "Vermont was too curious and frisky for some patients," he recalls. "But I knew that with my one strong arm I could handle him." BJ describes how he healed faster physically than emotionally. "I knew I could be fairly independent with my prostheses," he notes. "But I couldn't always explain what I was feeling inside. With a dog...no explanations are*

The dog is ever ready to lay down his life for me. -- Konrad Z. Lorenz

> *necessary." After being matched with BJ, Vermont can now anticipate both his commands and his feelings. Vermont's instincts to serve are so deep that when BJ manages on his own, Vermont pouts and looks hurt. "Being with me and helping me is what makes him happy," BJ says. "Makes me happy, too."*
>
> *Taken From:* Dossey, L. (1997). The healing power of pets: a look at animal-assisted therapy. *Alternative Therapies,* **3**, p.12.

You will find several other anecdotal accounts of the benefits of animal-assisted therapy in Chapter 2 of this manual. Although these anecdotal accounts are heart-warming, they are not sufficient to convince many health care professionals or schools of therapy that incorporating animals into therapy is worthwhile. The difficulty is that many individuals or programs that use AAT know, intuitively, that it works. In fact, clients themselves know it works. Terrance (Terry) Wilton relayed that when he was recruiting subjects to participate in the Chimo Project, many clients told him that they had no doubt that AAT is effective and that the project results would support this notion (T. Wilton, personal communication, 2002). For example, one of Terry's clients who has made remarkable progress in therapy told Terry that he attributed his success to his 4 doctors: 1) his psychiatrist; 2) his medical doctor; 3) his psychologist (Terry); and 4) Bishop (Terry's canine co-therapist). Thus, therapists involved in AAT will likely continue with their work without any real attempts to evaluate it. One can hardly blame them for this, but it does not

do much to further the acceptance of AAT as a recognized therapeutic adjunct.

1.4 Experimental Studies of Animal-Assisted Therapy

It is known that descriptive or anecdotal studies contribute to our knowledge of clinical phenomena, but they are not designed to quantify effectiveness or define causal relationships. Experimental studies that use control groups, however, are constructed to test hypotheses, to prove or disprove causal relationships, and to quantify the existence or magnitude of effect.

The concept of involving animals in therapy has only been investigated academically since the mid-1960s. Although AAT was pioneered by explorative and descriptive work (Levinson, 1965), the field has grown in size and depth and does include some studies of an experimental nature. Investigators have attempted to link animal interaction with a number of health benefits, including survival rates (Freidmann, Katcher, Lynch, & Thomas, 1980). Researchers have measured changes in indicators of physiological arousal (Baun, Bergstrom, Langston, & Thoma, 1984; Katcher, Segal, & Beck, 1984; Harris, Rinehart, & Gerstman, 1993; Wilson, 1991), levels of neuroendocrine chemicals that correlate with bonding behaviour and improved mood (Odendaal, 2000), and have also found some support for transient, yet significant, physical effects of interaction with animals.

Several experimental studies have also examined the effects of AAT in mental health settings (see Chapter 5 of this manual for a review). Critical reviews of the field of AAT have indicated that most of the experimental studies conducted to date have lacked appropriate sample sizes, thus providing insufficient power for statistics and limiting the potential for comparison with normal populations. Thus, there is a need for well-designed studies on AAT to build a scientific foundation that supports the use of this innovative therapeutic technique.

1.5 Current Use of Animal-Assisted Therapy

It is estimated by the Delta Society that, currently, there are approximately 2000 AAT programs in the United States and that the use of dogs is most common in psychotherapy and physical rehabilitation. A current estimate for Canada could not be found, but in 1993 Walter-Toews and colleagues conducted a survey of one hundred and fifty US and seventy-four Canadian humane societies and found that 46% of the US and 66% of the Canadian societies ran AAT programs. More than 94% of the societies used dogs and/or cats, 28% used rabbits, 15% used small mammals, and 10% used birds in these programs. More than 48% of US and 43% of Canadian programs consulted health professionals about zoonotic prevention. Nearly 10% of community-based and 74% of hospital-based programs had printed guidelines for their AAT programs (Walter-Toews, 1993). Thus, it appears that the interest in AAT is comparable between the US and Canada.

A recent study indicating that heart attack victims who owned pets may experience prolonged life (Freidman et al., 1980) has done much to increase interest in the medical value of pets. This study provided the impetus for additional studies, which examined the effects of animal contact, the use of animals as social support and the long-term health benefits animals may provide. Unfortunately, AAT research is still largely under-supported by government funding agencies and, as such, it does not receive a lot of attention in peer-reviewed medical literature.

1.6 References

Bardill, N., & Hutchinson, S. (1997). Animal-assisted therapy with hospitalized adolescents. *Journal of Child & Adolescent Psychiatric Nursing,* **10**, 17-24.

Baun, M.M., Bergstrom, N., Langston N.F., & Thoma, L. (1984). Physiological effects of human/companion animal bonding. N*ursing Research*, 33(3), 162-170.

Beck, A.M., & Katcher, A.H. (1984). A new look at pet-facilitated therapy. *Journal of the American Veterinary Medical Association*, **184**, 414-421.

Bossard, J.H.S. (1950). I wrote about dogs. *Mental Hygiene,* **34**, 345-349.

Carmack, B.J. (1998). Companion animals: social support for orthopedic clients. *Orthopedic Nursing,* **33**, 701-709.

Corson, S.A., Corson, E.O. & Gwynne, P.H. (1977). Pet dogs as nonverbal communication links in hospital psychiatry. *Comprehensive Psychiatry,* **18**, 61-72.

Corson, S.A., Corson, E.O. & Gwynne, P.H. (1974). Pet-facilitated psychotherapy. **In** R.S. Anderson (ed.), *Pet*

Animals and Society (30-31). London: British Small Animal Veterinary Association.

Dale-Green, P. (1963). *Cult of the Cat,* London, Heinemann Publications.

Dossey, L. (1997). The healing power of pets: a look at animal-assisted therapy. *Alternative Therapies,* **3**, 8-16.

Freidmann, E., Katcher, A.H., Lynch, J. & Thomas, S.A. (1980). Animal companions and one-year survival of patients after discharge from a coronary care unit. *Public Health Reports,* **95**, 307-312.

Harris, M.D., Rinehart, J.M. & Gerstman, J. (1993). Animal-assisted therapy for the homebound elderly. *Holistic Nurse Practitioner,* **8**, 27-37.

Halcomb, R. & Meacham, M. (1990). Effectiveness of an animal-assisted therapy program in an inpatient psychiatric unit. *Anthrozoos,* **4 (2)**, 259-264.

Hyde, W.W. (1956). The prosecution and punishment of animals and lifeless things in the middle ages and modern times. *University of Pennsylvania Law Review,* **64**, 696-730.

Katcher, A., Segal, J. & Beck, A. (1984). Contemplation of an aquarium for the reduction of anxiety. **In** R.K. Anderson, B.L. Hart, & L.A. Hart (eds.), *The Pet Connection: Its Influence on Our Health and Quality of Life* (171-179). Minneapolis, Minnesota: Center to Study Human-animal Relationships and Environments, University of Minnesota.

Leach, M. (1961). *God had a dog. Folklore of the Dog*. New Brunswick, N.J., Rutgers University Press.

Lee, D. (1984). Companion animals in institutions. **In** P. Arkow (ed.), *Dynamic Relationships in Practice: Animals in the Helping Professions* (229-236). Alameda, California, The Latham Foundation.

Levinson, B. (1969). *Pet-Oriented Child Psychotherapy*. Springfield, Illinois: Charles C. Thomas.

Levinson, B. (1965). Pet psychotherapy: use of household pets in the treatment of behavior disorder in childhood. *Psychological Reports,* **17**, 695-698.

Levinson, B. (1961). The dog as “co-therapist." **In** *Annual Meeting of the American Psychological Association*, New York City.

Lockwood, R. (1983). The influence of animals on social perception. **In** A. Katcher & A. Beck (eds.), *New Perspectives on our Lives With Companion Animals* (65-71). Philadelphia, University of Pennsylvania Press.

Mader, B., Hart, L.A., & Bergin, B. (1989). Social acknowledgements for children with disabilities: effects of service dogs. *Child Development,* **19**, 347-358.

Mason, M.S. & Hagan, C.B. (1999). Pet-assisted psychotherapy. *Psychological Reports,* **84**, 1235-1245.

McCulloch, M. (1983). Animal-facilitated therapy: Overview and future direction. **In** A. Katcher & A. Beck (eds.), *New Perspectives on our Lives with Companion Animals* (422). Philadelphia, University of Pennsylvania Press.

Messent, P. R. (1983). Social facilitation of contact with other people by pet dogs. **In** A. Katcher and A. Beck (eds.), *New Perspectives on our Lives With Companion Animals* (37-46). Philadelphia, University of Pennsylvania Press.

Odendaal, J.S.J. (2000). Animal-assisted therapy – magic or medicine? *Journal of Psychosomatic Research*, **49**, 275-280.

Olsen, G., Anderson, R.K., Quigley, J.S. & Beahl, N. (1983). Pet-facilitated therapy: a study of the use of animals in health care facilities in Minnesota. **In** A. Katcher & A. Beck (eds.), *New Perspectives on Our Lives with Companion Animals* (431-435). Philadelphia: University of Pennsylvania Press.

Smith, B.A. (1984). Using dolphins to elicit communication from an autistic child. **In** R.K. Anderson, B.L. Hart, & L.A. Hart (eds.), *The Pet Connection: Its Influence on Our Health and Quality of Life* (154-161). Minneapolis, Minnesota: Center to Study Human-Animal Relationships and Environments, University of Minnesota.

Walter-Toews, T. (1993). Zoonotic disease concerns in animal assisted therapy and animal visitation programs. *Canadian Veterinary Journal,* **34**, 549-551.

Wells, E.S., Rosen, L.W., & Walshaw, S. (1997). Use of feral cats in psychotherapy. *Anthrozoös*, **10**, 125-130.

Wilson, C.C. (1991). The pet as an anxiolytic intervention. *The Journal of Mental and Nervous Disease,* **179**, 482-489.

Chapter 2

Approaches to Incorporating Animals into Mental Health Therapy Interventions

I talk to him when I'm lonesome like,
and I'm sure he understands.
When he looks at me so attentively,
and gently licks my hands.
Then he rubs his nose on my tailored clothes,
but I never say naught thereat,
For the good Lord knows I can buy more clothes,
but never a friend like that!

W. Dayton Wedgefarth

<u>What We Do…</u> By Terrance Wilton, Chimo Project Therapist

My therapy assistant has a beautiful fur coat which he shares with all of my clients.

His cranium is slightly smaller than mine but I am sure that his heart is a couple of sizes bigger. He asks to leave the room if my clients cry too much but is always, and I do mean always, happy to see the next client come through the door. He goes to work willingly every day without thinking that he would rather stay at home in bed. He teaches me to live within some semblance of structure (if we work through lunch and he doesn't get his food he sure lets me know he is upset) and attention to bodily needs. He sets a good example for me that I should drink water through the day rather than coffee. He gets a daily massage and shares affection freely and easily.

My therapy assistant has never violated confidentiality. He doesn't care about scientifically verified therapy procedures but he has a keen nose for information that he feels is relevant to understanding the client. He functions purely on the basis of relationship giving no advice and never acting judgmentally. He works in every setting — in the van as I travel with clients, the play therapy room or park, the alternative high school where he has increased markedly the interest in

Buy a pup and your money will buy love unflinching. -- Rudyard Kipling

counseling felt by a tough teenage population.

He has never done anything gross or sexually inappropriate in session, except for the occasional self-grooming behaviors which are impossible to suppress when he feels the need.

When I am backed up with folk in the waiting room he volunteers to go out and entertain them until I am free. This way they don't complain about the wait. And he always takes time with me when I need a break. He helps me relax and unwind.

He knows when he has to sit out a session because of some peculiar feature of the client. It isn't a big deal, he just goes elsewhere and has — can you believe it? — a nap.

He rarely offers a complaint or an opinion about the administration of the office. The only exception to this comes at the end of the day when he is very clear about my needing to leave the computer behind, knock it off and go home.

His name is Bishop and he is pure gold, golden retriever, that is.

Reprinted from *Psymposium* (2001, May) with permission (copyright 1998, Psychologists' Association of Alberta). Note: T. Wilton is participating in the Chimo Project.

2.1 Goals and Strategies

Current Animal-Assisted Therapy is largely a volunteer-based field that involves volunteers and their animals in a variety of therapeutic settings (e.g., physical therapy, speech therapy, occupational therapy, group therapy). It is believed that the volunteer nature of the field is a factor in the limited amount of quantitative research on AAT. As mentioned in Chapter 1 of this manual, the plethora of qualitative and anecdotal research clearly describes the benefits animals have on humans, but does not provide a great deal of detail about the field of AAT itself. Even the quantitative research that has been published does not provide much detail about what the animals actually do to aid in the therapeutic process. Currently, the only real way to learn about AAT is to participate in it and to experience it first-hand, but this is easier said than done.

This section on goals and strategies is meant only as an initial guide to provide you (the therapist) with some examples of how you could employ an animal in a therapy session. It is by no means a comprehensive listing and is not meant to limit the work with the animal. Reading through the example strategies, it is clear that some are appropriate for adults, while others are best suited for youth. No attempt was made to separate the strategies by age category here because, often, slightly adjusting the strategy can make it age-appropriate for any client. Therapists are encouraged to use their imagination to employ other strategies and to document the successes or

limitations of these strategies so that they may be shared with others some day.

2.1.1 Rapport/Relationship Building:

Carl Rogers, a famous psychologist, once stated, "*the most important quality of the counseling relationship is the establishment of a warm, permissive, and accepting climate which permits the client to explore his self-structure in relation to his unique experience*" (Shertzer & Stone, 2000). Many therapy dogs are known for the enthusiastic greetings they give to clients (Fine, 2000). There are numerous reports in the literature indicating that animals frequently receive clients in a warm and affectionate manner, thereby encouraging attention from them. These initial encounters help to ease tension at the beginning of the meeting, and enrich the therapeutic environment.

In order for therapy to be successful, clients need to feel they are in a safe environment. The client must trust their therapist before they can talk openly about their personal thoughts and experiences. The importance of this point is demonstrated by a recent experience Terry Wilton had with a client. Terry's client, who we will call Karen, is a victim of sexual abuse. Karen was very apprehensive about being alone in an office with a male psychologist. The following comments from Terry and Karen demonstrate how Bishop, Terry's canine partner, helped Karen feel safe:

> ***Karen***
> *Having the dog here makes me feel more comfortable about being in a closed room*

with the therapist. I enjoy Bishop being in the room. It makes me feel a lot better, more safe. I feel like I can express myself more when Bishop is here. I like coming to these sessions, and Bishop makes it a lot easier for me to be here. The animals really help! I recommend that every therapy session be done with an animal.

Terry

Having Bishop present made the client feel very much safer and able to tolerate being in a closed room as a female with a male therapist. This is a MAJOR benefit! Bishop play[s] a very important role of both comfort and distraction…[Sometimes] when [Karen comes] to session she [is] very distressed. Focusing on Bishop allow[s] us to move out of that distress so we [can] come back to the issues at a decreased level of emotional intensity. The client is more relaxed and able to work in therapy when she is sitting on the floor with Bishop beside her...[she] spends the entire session petting Bishop and having close physical contact with him while we talk. [Karen] is more able now to move forward and talk through the things she needs to. We are establishing a *greater therapeutic alliance as therapy continues.*

Taken From: Comment sections from Client and Therapist Chimo Project Questionnaires (2002).

In addition, a therapist may appear threatening to a client because the client knows that the therapist

may have talked to family and friends about them (Mason & Hagan, 1999). The client does not know what the therapist was told or if they can trust the therapist to keep personal secrets that they may disclose. Observing the loving relationship between the animal and the therapist may make the client aware of how kind and caring the therapist is. This observation could, in turn, enhance the development of the therapeutic relationship. For example:

> *Georgie came to psychologist Bonnie Rude-Weisman as an adult dog and has some problem behaviors (e.g., licking). These quirks of Georgie's help people understand that they can have quirks too (e.g., it's okay to be different). Georgie gives people permission to not be perfect, thus helping to 'normalize' them. In the same sense, he helps normalize Bonnie. There is a perception out there that therapists have perfect marriages, perfect children, perfect pets, etc. By having a dog with "imperfections", the therapist becomes more like the client and perhaps easier to relate to.* (B. Rude-Weisman, personal correspondence, 2002; Bonnie is a participant in the Chimo Project.)

This point is also reflected in a comment made to counseling psychologist Ruth Shell, who is a consulting therapist for the Chimo Project. A client of hers told Ruth that she appreciated the chaos that Ruth's canine, Lucy, brings to the office. "*I like how all of her stuff is lying around on the floor, and her food dishes are over there. It makes me feel like there is more going on here than just my problems.*"

(Shell, 2002) There are also numerous anecdotal reports in the literature that indicate clients perceive their therapists as less threatening and more approachable when an animal is present (Beck, Seraydarian, & Hunter, 1986; Peacock, 1986; Levinson, 1965; Mason & Hagan, 1999; Fine, 2000).

Animals appear to decrease the initial reservations that people may have about entering therapy. The animal tends to have a "social lubricant" or "ice-breaker" effect by linking the conversation between the therapist and the client, and by promoting a relaxed, friendly atmosphere (Corson, O'Leary Corson, Gwynne, & Arnold, 1977; Mayes, 1998; Fine, 2000). In a pioneer article on the use of pets in the treatment of children with behaviour disorders, Levinson (1965) indicated that bringing in an animal at the beginning of therapy frequently helped a reserved client overcome their anxiety about therapy. Likewise, therapists in the Chimo Project find that working with an animal helps increase interactions in therapy. It is easy to ask questions about an animal, even if they are very general. This gets the clients engaged and they almost always have an animal story of their own to tell (Polzin, personal communication, 2002). Polzin notes that her dog, Jake, also helps to encourage eye contact with clients. Sigmund Freud was certainly aware of the positive effects animals could have in therapy, even though he did not write on this topic, and was known to frequently have his dogs with him during therapy sessions.

Even as therapy progresses, an animal co-therapist may help facilitate communication. For example, a

Dogs have not the power of comparing. A dog will take a small piece of meat as ready as a large, when both are before him.
-- Samuel Johnson

client of Ruth Shell's once stated, "*You know, I just noticed something interesting...when I look down at Lucy* [Ruth's canine co-therapist] *on my lap, I seem to be able to focus on my thoughts. And then when I look up, everything seems blurry again.*" (Shell, 2002)

Table 2.1: Example goals and strategies to develop rapport and foster relationships.

TREATMENT GOALS	AAT STRATEGY
Deepen trust with therapist (transference).	• Permit the client to hold or pet the companion animal while interacting with the therapist or the therapy group.
Develop rapport with therapist.	• The animal may be a common interest between the therapist and client and, thus, can create a bond and foster discussion.
Increase social interaction skills.	• Encourage the client to talk to the animal rather than the therapist. The client's focus on the animal may result in easier articulation of thoughts and words because animals are sympathetic listeners and cannot tell secrets. • Transfer the improved social interaction skills to family and peers.

TREATMENT GOALS	AAT STRATEGY
Increase socialization and participation (individual or group).	• Prepare a scrapbook of photos, information, or articles about a specific dog breed and share the information with others. • Document attendance in therapy groups to determine if it increases when an animal is present.
Improve relationships with peers.	• Use the relationships between the handler and the animal and between the therapist and the animal as a metaphor for human relationships. • Work at transferring this experience to peers.
Increase amount of eye contact with people.	• Work with the human-animal team to develop appropriate eye contact. • Work at transferring that skill to other relationships.
Improve appropriateness of voice tone with people.	• Work with the human-animal team to develop appropriate voice tone when training the animal. • Work at transferring this skill to other relationships.
Improve socialization, communication.	• Practice teaching an animal something new.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Dogs love company. They place it on their short list of needs. -- J. R. Ackerly

Case Study:

'Sam' is small for his eight years. His parents described him as a good student, outgoing with lots of friends; that was, until he moved schools last year. Since then his grades have plummeted, no friends come round for supper anymore, and Sam rarely says a word; except to beg his Mom not to make him go to school each morning. Sam refuses to talk with the school Counsellor, his teacher, or with the play therapist his parents took him to see. Sam's parents are at their wit's end. They desperately want their son back, but Sam won't tell them what is wrong, and the only living being he seems to trust is Benji, his pet guinea pig. Seeing this connection, Sam's parents take him to a place they'd heard about through their church; a place where they help kids through animals. This is where I meet Sam. I'm working with an Animal Assisted Therapy program in Arizona, and Sam is my newest client.

Sam stands slightly behind his Dad, looking at the ground. He looks scared. I gently explain that there are lots of animals here who would really like to meet Sam, if he wants to. Sam nods tentatively. As we explore the farm and meet first with the smaller animals, Sam starts to talk. First with the dogs and the goats and then, very quietly, he tells me that he has a guinea pig at home called Benji, and that Benji is his best friend. In our next session, Sam asks to see the horses. He notices Rosie, standing by herself.

'She looks lonely' says Sam, 'can we bring her in?' Once in the corral I show Sam how to do a 'join up' with Rosie. Sam spends time talking with Rosie and rubbing her, then gently asks her to move away from him. Through this process Rosie decides that Sam is someone to be trusted and respected, so when Sam walks around the corral Rosie follows. When Sam, with a gentle hand on her nose, asks Rosie to back away, she takes a few steps back. As he runs circles in the corral with Rosie trotting at his heel, Sam starts to laugh, and for the first time I see a glimmer of the boy his parents described: confident, happy, and in charge. Leading Rosie back to the field Sam looks me directly in the eye: "Rosie is so big and I'm so small, but she did what I asked her to do!" It is then that Sam starts to tell me about the kids at school, situations when he felt very small: the bullying. With Rosie's help, Sam's self confidence gradually returned, he talked to his parents and teacher, and together they found ways to address the bullying at their school.

Taken From: McIntosh, S. (2001, Dec). Four legged therapists reach children in need. *Synchronicity*.

Sue McIntosh has shared much knowledge and expertise with the Chimo Project. Her contributions are gratefully acknowledged.

Dogs love their friends and bite their enemies, quite unlike people, who are incapable of pure love and always have to mix love and hate. -- Sigmund Freud

Case Study:

Linda (not her real name) was referred to Dr. Fine for suspected selected mutism. Linda was 7 years of age and only spoke in her own home. She appeared to be very shy and uncomfortable in public settings. Naturally, her selective mutism impacted her school performance, where she interacted very little in class.

When her parents initially met to explain Linda's symptoms, they were quite certain that she would not speak in the office. Ironically, at our first meeting, Linda was greeted at the door by a loving, warm-hearted golden retriever named Puppy. It was amazing to watch Linda immediately become attracted to Puppy. Puppy, not being bashful, went full barrel into Linda. She wouldn't let Linda alone. She expected Linda to keep up the petting and constant attention. In observing Linda's reaction, I decided to take clinical advantage of the immediate bond between the child and Puppy. I called the golden retriever over to me and asked her to go to the back room. I alluded to Linda that if she wanted Puppy to continue to play with her, all she had to do was call her over. To Linda's parents' surprise, they watched and listened to their daughter call Puppy over. Tears rolled from the parents' eyes as they watched in shock as Puppy returned to interact with their daughter. From that day forward, Linda made remarkable progress. It appeared that Puppy had reached within her

and made it easier for her to speak. Our interactions were made easier. Through an approach that included successive desensitization, Linda began to speak very clearly in my office and outside. Goals were established and Linda soon began to speak more outside her home.

To help Linda speak at school, Puppy visited her class. Linda was responsible for introducing Puppy to her classmates (this was practiced in earlier therapy sessions). Although she spoke quietly, she amazed her classmates by speaking. After the class, Puppy, her teacher, Linda and myself had a short meeting to discuss how we could make it more comfortable for her to participate in various class meetings. Although Linda seemed apprehensive in our discussions, she did speak briefly. During the next few months, Linda spoke more descriptively. She appeared more willing to open up and interact. Her grades also improved.

One cannot only attribute Linda's growth to her contact with Puppy. However, it appears that her relationship with Puppy acted as an early catalyst for change. It seems the elderly golden retriever made Linda more comfortable in engaging.

Taken From: Fine, A. (2000). Animals and therapists: incorporating animals in outpatient psychotherapy. **In** A. Fine (ed.), *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp.182-183). San Diego, California, Academic Press.

Every animal knows more than you do. -- Native American Proverb -- Nez Perce

Case Study:

Nancy was an 8 year old child, physically abused by her mother to the point of multiple hospitalizations. She was court-placed at Green Chimneys Children's Services in their residential treatment center, a 150-acre farm, and met with her therapist twice a week for individual sessions. Nancy was essentially nonverbal and never opened up to discuss any of the issues pertaining to her abuse. The worker tried everything; dolls, clay, art; nothing seemed to work for her. One afternoon, the therapist decided to "take the therapy outdoors" and, knowing some baby animals had recently been born, suggested a walk up to the farm. Nancy agreed to go for a walk. When Nancy saw a group of baby rabbits with their mother in a pen, she panicked and told the therapist, "You better get those babies out of there!" When the therapist asked why, Nancy replied, "Because sometimes mothers hurt babies." After the therapist assured her that the mother rabbit would take good care of the babies, she asked if Nancy knew a mother who would hurt babies. Nancy nodded, holding her head down and mumbling. "Yeah, my Mom. This rabbit is a better Mom to her babies than my Mom was to me." This event provided the perfect opportunity for the therapist and Nancy to move into a discussion about her own history of abuse. In subsequent sessions, Nancy asked if she could spend time with the rabbits. She and her therapist ended each

session with a visit to the rabbits. Nancy seemed soothed by the rabbits and eventually was permitted by the farm staff to adopt a rabbit of her own.

Taken From: Mallon, G. P. (1999). Animal-Assisted Therapy Interventions with Children**. In** G.P.. Schafer (ed.), *Innovative Psychotherapy Techniques: Child and Adolescent Therapy 2nd edition* (p.430). New York, John Wiley and Sons.

Case Study:

It is just eight years since a boy who had been unsuccessfully treated over a period of time was brought to me by a desperate parent. Because this child exhibited increasing withdrawal, hospitalization had been recommended. I hesitated to accept the case but agreed to a diagnostic interview. As luck would have it, the distraught parent came an hour before the appointed time. I was busy writing. My dog was lying at my feet licking himself. I admitted the family without delay, forgetting the dog, who ran right up to the child to lick him.

Much to my surprise, the child showed no fright but instead cuddled up to the dog and began to pet him. The parent wanted to separate the two, but I signaled the parent to leave the child alone. After awhile the child inquired whether the dog always played with children who came to my office. Reassured by my affirmative answer, the child expressed a desire to return and play with the dog. It is anyone's guess what might have been the

Every dog is a lion at home. -- Italian Saying

child's reaction had the dog not been present that morning.

For several subsequent sessions this child, apparently unaware of my presence, played with the dog. Gradually, as some of the affection elicited by the dog spilled over onto me, I was included in the play. We came slowly to the establishment of a good working relationship and to the eventual rehabilitation of this young boy.

Taken From: Levinson, B. (1961). The dog as "co-therapist." **Paper Presented at** The *Annual Meeting of the American Psychological Association*, New York City, p. 59.

2.1.2 Bonding:

Many people in therapy may have attachment disturbances or may have difficulty trusting someone enough to bond with them. In many cases, their life experiences have taught them to expect to be hurt by those they love and depend on. These people often feel that it is dangerous to get close to another person and so they avoid any relationship that could put them in a potentially vulnerable situation (Mayes, 1998). An animal can be a safe living thing that these people can bond to. The person can benefit from giving affection to, or receiving affection from an animal. They can also experience predictable interactions from the animal that may help them learn about themselves and others.

Because animals can provide a non-judgmental ear and unconditional acceptance, children often turn to

animals for social support (McIntosh, 2002). Studies have shown that children regularly confide in their pets when they have a problem, and play with their pet when feeling stressed (Covert, Whiren, Keith, & Nelson, 1985). This is true for adults as well. According to an annual national survey conducted by the American Animal Hospital Association, almost half of the 1252 respondents indicated that they are emotionally dependent on their pet. Furthermore, 83% said they would be likely to risk their own life for their pet, 89% believe their pet understands all or some of what they say, and about 30% said they spend more time with their pet than with family or friends (Interactions, 1998).

Therapists can extensively facilitate and utilize their client's attachment to an animal for therapeutic purposes. The animal can then act as an adjunct to the establishment of a therapeutic relationship and bond (Mallon, 1994; Hoelscher & Garfat, 1993). Bonnie Rude-Weisman states that the most important role of her dog Georgie in therapy with kids is to make them feel loved and to provide them with affirmation that they are great people. "*Georgie is very enthusiastic with kids and they feel he loves them so much. They feel remembered in a world where they seem to get forgotten a lot*" (B. Rude-Weisman, personal communication, 2002). This is a great message to them, and Bonnie feels it makes the rest of her work pretty easy. With adults, Georgie acts more as a calming influence. He greets the adults enthusiastically, but as they become calm, he becomes more calm, which Bonnie calls "*vicarious relaxation*" (B. Rude-Weisman, personal communication, 2002).

He deserves paradise who makes his companions laugh. -- The Koran

Table 2.2: Example goals and strategies to facilitate client-animal bonding.

TREATMENT GOAL	AAT STRATEGY
Encourage bonding to a living being.	• Give the client a photograph of themselves and the companion animal to help strengthen the bond between sessions. • Establish predictable routines for greeting and saying goodbye to the animal at each session.
Acknowledgement of positive interactions.	• Observe the animal's recognition of the client at each session. • Observe and interpret the animal's happiness to see the client for each session.
Learn about appropriate touch.	• Observe and discuss the animal's response to human touch. • Learn gentle ways to handle the animal. • Receive apparent acceptance from the animal. • Give appropriate affection to the animal. • Compare appropriate animal touch to appropriate human touch. • Forecast "what would happen if...?"
Encouraging nurturing behavior.	• Allow client to nurture the animal with appropriate rewards and affection.

TREATMENT GOAL	AAT STRATEGY
Improve ability to trust.	• Interact with and learn about the animal and its behaviours. • Talk to the animal. • Receive affection from the animal.
Distract from discomfort and pain (emotional or physical).	• Focus the discussion on the animal, rather than the client.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

"Susan" is an adult female with attachment issues. She has suffered from abuse and poor relationships with her caregivers and family. The only emotional connection she seems to have is with animals. This led her therapist, JoAnne Dulaney, into trying AAT with her. Soon after they began their AAT sessions, Susan wrote in her diary that she didn't know why she was a part of pet therapy, because she didn't want to love an animal that was not her own. She did, however, continue with AAT and, over time, Susan has made substantial progress in therapy. She is more willing to engage in conversation pertaining to emotional connections to people, especially if she can use PauKat (the canine co-therapist) as an example of emotional attachment. (J.

Dulaney, personal correspondence, 2002; JoAnne is a participant in the Chimo Project)

Case Study:

...Several years ago, an 8-year old girl visited the office. She was very intrigued about the birds she saw and wanted to hold a few of the small lovebirds. Without asking if she could hold the bird, she eagerly put her hand toward the animal. To her dissatisfaction, the bird hissed at her. Shortly after this experience, I explained to the girl that she needed to ask the bird's permission (and mine) to touch the animal. Ironically, this was followed by a powerless response of "I know what you mean." Her response to my statement piqued my attention, since she was referred for depressive symptoms. I picked up the lovebird and began to scratch her head. I told the girl that the bird was very sensitive to touch, and there were certain spots that she didn't like to be touched. At this point, the girl became very teary eyed and responded once again by saying (very sadly this time) "I know what you mean". Shortly after, she began to reveal a history of sexual abuses by one of her grandparents. It was apparent the serendipitous use of the bird acted as a catalyst to promote a discussion on feelings that she had buried. During the course of her treatment, we used the example of the bird to help her gain insight on the importance of giving people permission to embrace you, and how you have the right to tell people that your body is private.

Taken From: Fine, A. (2000). Animals and therapists: incorporating animals in outpatient psychotherapy. **In** A. Fine (ed.), *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (p.186). San Diego, California, Academic Press.

Case Study:

The following describes an experience that occurred while using feral cats as an adjunct to psychotherapy:

Ms. G. is a 39 year old divorced woman who presented for her first exposure to psychotherapy after her experience of an extremely violent rape perpetrated by her fiancé. She did not disclose the fact of this trauma to anyone, including the therapist, for over one full year after starting therapy, and her chief complaint when she sought treatment was simply that she felt, "depressed and dead inside." She later described to the therapist that following the rape, she'd, "just kind of gone away inside herself...didn't have any feelings...couldn't look at anybody or anything...just gone away…" Ms. G. had a chronic history of extensive abuse and abandonment pre-dating the rape which precipitated her involvement in psychotherapy. Of considerable significance was the fact that she never discussed any of these painful experiences with anyone at length. Her efforts to cope had historically revolved around her pattern of avoidance of, "going away inside." Because this coping

strategy never allowed Ms. G. directly to confront the fact and impact of the many abuses and abandonments she'd experienced, she never adequately recovered from any of these traumas. As is true for many individuals in such a situation, the failure to recover from traumatic events and damaging relationships invites history to repeat itself.

While Ms. G. was difficult to engage in a meaningful and productive verbal interaction with the therapist, she made it clear from the onset of treatment that she valued, cared about, and identified with the cats. Her first comments during virtually all her therapy appointments were either questions about, or remarks to, the cats. As she learned about their life histories, Ms. G. began spontaneously to recall and talk about her own history in a chaotic, abusive, and primitive family system. When one of the cats was missing for over six weeks, Ms. G. remembered and discussed the loss of her only pregnancy two years earlier. She later asked about the offspring of her favorite cat, and was informed of the abuse two of this cat's kittens had experienced at the hands of marauding children three years ago. Ms. G. finally disclosed the fact and details of her own rape within the month following her discussion of the kittens' experience of abuse, and she went on to allow herself to trust the therapist and the cats to provide a safe environment for her recovery process.

Taken From: Wells, E. S., Rosen, L. W. & Walshaw S. (1997). Use of Feral Cats in Psychotherapy. *Anthrozoos,* **10**, p. 128.

Case Study:

My first real feedback that Lucy* [a therapy dog] *and I were identified as working together toward a client's goals came when I returned after a summer vacation. Susan, a 34-year old woman suffering anxiety, and Lucy greeted each other enthusiastically. I stood nearby nearly ignored. When the two of them finally settled on the couch together Susan said, "I don't know who I missed more – you or Lucy!"

This comment led Susan to express her special attachment to the dog and how she finds Lucy a benefit to her work in therapy. She spoke about how she gets so wound and holding and stroking Lucy in her lap helps settle her nerves. "Lucy's energy grounds me, and then I can talk about what I need to talk about with you. You guys are a great team." The enthusiastic and physical affection shared with the dog allowed this client to form a deep bond with the therapist team and the process of therapy itself.

Taken From: **Shell, R.(2002). Moments of Magic: Animal-assisted interventions.** ***In preparation.***

How many legs does a dog have if you call his tail a leg? Four. Calling a tail a leg doesn't make it a leg.
-- Abraham Lincoln

2.1.3 A Catalyst for Emotion:

Many people have difficulty expressing their emotions. Oftentimes, persons with mental health concerns have been told that their feelings are wrong and that they should not feel the things they do. They may also have learned that others regard their feelings as unimportant. This can lead to confusion or guilt when certain emotions recur and, consequently, suppression of these emotions. Interacting with or observing an animal can help individuals realize that it is normal to have emotions.

Animals within therapeutic settings help to elicit a range of emotions from laughter to sorrow. Although entertainment is not often the focus in AAT literature, there are many reports of therapy animals getting into comical and/or playful situations (McCulloch, 1984; Fine, 2000). Human expressions of laughter and joy can be therapeutic in that they are known to reduce stress and to positively impact a person's quality of life, even if just for a moment (Cousins, 1989). For example, a client of Terry Wilton's was not able to go into a hypnotic trance (hypnosis is another technique that Terry sometimes uses in his practice to help clients work through their problems). While they were trying, however, Terry's canine co-therapist, Bishop, fell asleep and started to snore. The client's statement, "*It didn't work on me, but you sure managed to put your dog to sleep*," was a point of humor between the client and the therapist and made them feel better. (T. Wilton, personal correspondence, 2002)

Animals are in a unique situation to display emotions and behaviours that may not be deemed professionally appropriate for mental health therapists. For example, even though "touch" is a basic need in human development, we live in a society where people often avoid touching each other. The appropriateness and safety of touch is something that is often debated without resolve. Thus, many mental health professionals try to avoid all physical contact with their clients. Contact with companion animals, however, is a safe way that individuals can experience the physical and emotional benefits of touch. The warmth and security of a dog who is sitting beside you or who has its head in your lap provides a touch that is lacking in many clients' lives. For example, when Sharon Smith studied interactions between ten dogs and their family members, she found that the pets provided both men and women with a socially acceptable outlet for touching, rubbing, scratching, patting, or stroking (Smith, 1983). These are behaviours that most American men are reluctant to engage in. Thus, holding or petting an animal during therapy may provide physical comfort and soothe all clients, irrespective of gender, in difficult sessions.

Having an animal present in therapy sessions may also help clients gauge excessive behaviours or emotions. The animals seem to regulate the emotional climate of the room (Fine, 2000). For example, there are numerous reports of clients (of all age groups) regulating their reactions during disputes when an animal was present in the session. Many clients appear to respect the animal's presence and do not wish to create uneasiness in the

animal. Clients who do display excessive reactions will see an immediate response from the animal and will often quickly calm themselves down. The response of the animal to various emotions can be a valuable teaching/discussion tool.

Furthermore, studies have indicated that animals may be an important source of emotional support for children. For example, while preschoolers to grade one children viewed their pets as playmates and protectors, children in grades three to five viewed their pets as confidants and sources of emotional support (Triebenbacher 1994). In addition, Salomon (1995) found that nine to thirteen year olds with higher scholastic performance reported seeking more emotional support from animals when they suffered with internal discomfort or felt lonely, compared to those with lower scholastic performance.

Table 2.3: Example goals and strategies to address client emotions.

TREATMENT GOAL	AAT STRATEGY
Differentiate between comfortable and uncomfortable feelings.	• Talk about events in the animal's life and ask the client to determine if the animal likely felt comfortable or uncomfortable during these situations. • Ask the client how they would feel if they were faced with similar situations. • Transfer this information to relevant situations in the client's

TREATMENT GOAL	AAT STRATEGY
	life.
Openly discuss feelings.	• Talk about traumatic events in the animal's life (e.g., being taken from its parents and siblings, going to live in a stranger's home, losing an owner due to illness, staying at a boarding kennel, getting in a fight with another animal.), and ask the client to describe how the animal may have felt during these events. • Ask the client how they would feel if they were faced with similar situations. • Encourage the client to talk about their feelings through the animal. • Ask the client to interpret the animal's emotions as they occur. • Learn about animal emotions. • Observe and discuss the animal's response to human emotions. • Use pictures of feeling faces (animals and people) to make a game out of identifying emotions that are depicted in the pictures. Talk about what events might have resulted in those feelings. Give bonus points if the clients can identify their own negative self-beliefs and then state rational contradictions to these beliefs.

I am I because my little dog knows me. –Gertrude Stein

TREATMENT GOAL	AAT STRATEGY
Improve verbal expression.	o Ask the client to answer questions about the animal (express opinions).
Identify different emotions.	• Observe and interact with the animal. • Ask the client to describe what the animal may be feeling in a variety of situations (e.g., excited to see them, eager to do a trick, bored by repetitive activity, ecstatic to see a toy, frustrated if they cannot have something they want, uncertain about a new activity, frightened by a loud noise, tired after a run, disappointed about not being allowed to play).
Learn about verbal and non-verbal expressions of feelings.	• Observe and discuss the animal's verbal and non-verbal expressions and what they mean. • Compare what is learned to human expressions.
Acquire socially acceptable ways of expressing feelings.	• Observe and interact with the animal. • Discuss the ways the animal expresses its feelings and what behaviours the client finds acceptable (e.g., prancing, wagging tail) or unacceptable (e.g., licking face, barking). • Discuss self-control and how to regulate behaviours in human relationships and experiences.

TREATMENT GOAL	AAT STRATEGY
Recognize how others are feeling.	• Observe and interact with the animal. • Ask the client to describe what the animal may be feeling. • Transfer this to the human situation.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Marta was an eight year old diagnosed as an emotionally disturbed child of a strict and abusive mother. She was aggressive and hyperactive, sexually precocious, and had temper tantrums. In her first few months at the residential school, no one could get her to talk about her relationship with her mother.

In the first session with a small furry rabbit, she held him in her lap and stroked him, telling the therapist that the rabbit's ears had been chewed by the mother rabbit. (The rabbit's ears were normal). The therapist asked her why this was so. Marta responded, "The mother rabbit chewed the baby rabbit's ears all up. She wanted the baby to leave home." The therapist then asked, "How did the baby rabbit feel?" In answering, Marta said "Sad. The baby rabbit loves the mother

rabbit but the mother rabbit no longer loves the baby." This dialogue about the rabbit was an opener for Marta to then talk of her own feelings about the mother who badly beat her.

Taken From: George, M. H. (1988). Child Therapy and Animals. **In** *Innovative Interventions in Child and Adolescent Therapy* (p. 413). New York, John Wiley and Sons.

I love a dog. He does nothing for political reasons. -- Will Rogers

2.1.4 Empathy:

A study conducted by Levine and Bohn (1986) found that children who live in homes where a pet is considered to be a member of the family were more empathetic than children in homes where there was no such pet. Another study found that children's scores on an empathy scale increased after attending a year-long animal humane education program in an elementary school (Ascione, 1992). Importantly, these more humane attitudes (towards animals and people) were still present in the experimental group one year after the program was complete. It has also been found that children will often quickly regard an animal as their peer, even if they do not have their own animal. Thus, teaching individuals to be empathetic with an animal may be easier than teaching them to be empathetic with a human because animals don't play games with feelings the way that some humans do. With time and experience, empathy will develop and may transfer from animals to humans (Levinson, 1965; Nebbe, 1994).

Recollecting and sharing stories about animals can evoke feelings and initiate discussions about

experiences and problems. Empathy for the animals involved in the stories can be reinforced when this occurs. In the process of AAT, most clients will learn more about the animal they are interacting with and, as a result, will develop more understanding, awareness and empathy for the animal and an enhanced appreciation for life (perhaps, even their own life). In fact, the mere presence of an animal may stir empathy in a client if the therapist is sensitive and caring to the animal's needs (Nebbe, 1994).

Table 2.4: Example goals and strategies for promoting client empathy.

TREATMENT GOAL	AAT STRATEGY
Demonstrate appropriate nurturing behaviour.	• Observe and discuss appropriate nurturing behaviour with the animal. Observe humane animal-handling techniques. • Observe the loving bond between the animal and the handler. • Transfer these observations to human situations.

TREATMENT GOAL	AAT STRATEGY
Demonstrate appropriate correction techniques.	• Observe the animal making mistakes and the correction techniques used to handle the mistakes. • Discuss these observations. • Observe and discuss the empathy that the handler has for the animal.
Demonstrate patience and understanding.	• Teach the animal something new or try to get the animal to respond to obedience commands given by the client. • Encourage patience and teach the client how to get successful results.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Carol had just been removed from her home by the court and placed in a foster home. She came to the counseling office to talk. The wildlife rehabilitator had just finished a presentation to Carol's class and had shared with the class a peek at week old baby raccoons in her care. While the rehabilitator conversed with the counselor, Carol sat down beside the orphaned baby raccoons. "I know how you feel," she said. "I bet you are really scared. I am. But you will be OK. I know she will take care of you."

Taken From: Nebbe, L. (1994). Animal-assisted activities/therapy as an animal and human welfare project. *Humane Innovations and Alternatives,* **8**, p. 5**.**

In their own way, therapy animals may display empathy for clients during difficult therapy sessions, as demonstrated by the following case study:

> *Judy, a 26 year old young woman sat at one end of the couch while Lucy* [a therapy dog] *napped on her blanket at the other end, seemingly oblivious of the building emotion in the therapeutic conversation. About half way through the session Judy encountered an internal reflection that evoked tears. The room was still for a moment and then without prompt, Lucy awoke and moved to take a new position on the client's lap. She quickly made herself comfortable, closed her eyes and resumed napping. Instantly, Judy began petting the dog, and with a smile joining her tears looked up at me and remarked, "Did you see that?" I nodded and asked if it was ok for Lucy to join her in her pain. She remarked, "Oh yes, I love it!" and we resumed our work.*

*Taken From***:** Shell, R. (2002). Moments of Magic: Animal-assisted interventions. *In preparation.*

2.1.5 Self-Esteem Building:

A faithful friend is the medicine of life. -- Old Proverb

Many clients in therapy suffer from low self-esteem. The ability of animals to provide positive regard and to not discriminate against people makes them a unique medium for increasing self-esteem. An animal's acceptance of a person is non-judgmental and uncomplicated by the psychological games that humans may play. For example, humans will often withhold love and approval automatically, even unconsciously, from those who do not measure up socially. Animals, however, do not care whether you are able to speak "normally" or whether your hand shakes when you reach to pet them. Animals don't care about how much money you have in the bank, what kind of job you do, or what kind of car you drive. They love you for who you are inside.

Another notable feature of animals is that they appear to be unaware, or unbothered, by their own physical attributes. Donella (Donnie) Scott, a psychologist participating in the Chimo Project, indicates that this feature can be very useful to help build self-esteem in a client. For example, it is common for people to mention how beautiful her dog, Charlie, is. This gives Donnie an opportunity to point out the character and breed flaws in Charlie that would prohibit him from winning a "beauty contest" (i.e., dog show). This is a great opener to a discussion about body image for people with eating disorders or poor self-image (D. Scott, personal correspondence, 2002).

Children who have regular contact with animals have been shown to have higher levels of self-esteem. One study, for example, showed significantly increased self-esteem scores in

children when an animal was added to their classroom for a period of nine months. Interestingly, children who had lower self-esteem scores in the pre-test demonstrated the most improvement (Bergesen, 1989). Similarly, using a sample of 300 families, Covert et al. (1985) found that adolescents who owned pets had higher self-esteem scores and Melson (1990) found a positive association between attachment to pets and self-esteem in kindergarteners.

Table 2.5: Example goals and strategies to build client self-esteem.

TREATMENT GOALS	AAT STRATEGY
Increase sense of purpose.	• Provide care for the animal (e.g., walk, brush). • Research options for getting a companion animal after discharge.
Increase self-esteem through learning a new skill or re-learning/adapting a skill to previous status.	• Learn how to teach the animal something by first learning how to treat the animal with respect, developing a relationship with the animal, developing observation and listening skills, learning proper praising techniques, learning to be tolerant of mistakes (their own and the animal's), and recognizing their progress. • Practice what is learned over a series of sessions. • Share the new skill with others. • Re-acquire an old skill (e.g., braid a rope that can be used as

TREATMENT GOALS	AAT STRATEGY
	a leash for the animal, throw a ball).
Improve self-confidence.	• Have the client earn the respect and trust of the animal over time so that the animal will respond to the client's instructions. • Provide care (food, water, brushing) for the companion animal. • Receive recognition and attention from the animal.
Improve self-image.	• Receive apparent affection from the animal. • Have positive interactions with the animal.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Jamie came from a broken home. He was eight years old, neglected, and the youngest of four children. He was tested with an IQ of 85, and often appeared to be confused or fearful of his surroundings. In his first months at the school, he was often angry and aggressive with his peers and acted out in class. It was very difficult to talk to him, even though he appeared to be cooperative and friendly in therapy sessions. The goals for

this child were to improve ego-functioning and socialization skills.

On my first day with Jamie, we went to the barn where he was allowed to choose the animal he would like to interact with. He chose a four-month-old kid goat. He was shown how to groom her and put a lead on her. In the second session, I showed him how to feed her from the hand. He was fearful and dropped the food at her feet. I showed him she had no upper teeth and could not bite him, but it was not until I placed my hand under his hand that he was able to hold the food for her. After three weeks, he walked the kid outside the barn on a lead. I then told him that he, who was still very quiet, had to talk to her and tell her what he wanted her to do. When she was good he had to praise her and when she was bad he had to tell her so in a stern voice; however, he was never to hit her. He often had to be told that he was the master of the goat and had to set limits for her.

Talking to the goat was the beginning of his talking to me. Within a month he was asking me questions about the goat. Later he began to talk about himself and how he was feeling. He was reported as being more vocal in class as well as interacting better with peers. In fact, his teacher and child care workers said everyone liked him. His building of self-esteem was noted one day when he took the goat for a walk near his class, which was out for recess. He said to each one as they came

over to him, "See how good I can handle her!"

Taken From: George, M. H. (1988). Child Therapy and Animals. **In** *Innovative Interventions in Child and Adolescent Therapy* (p. 414). New York, John Wiley and Sons.

Here, gentlemen, a dog teaches us a lesson in humanity. -- Napoleon Bonaparte

Case Study:

Michael was a charming six-year-old boy, with two older sisters and a younger brother (age four-and-a-half). The younger brother was "all boy," whereas Michael was loving, docile, sensitive and passive. He easily gave in to his younger brother who was already physically stronger. He cried when the siblings took his things – which was frequently. It was felt that therapy with an animal would benefit him in strengthening his ego and self-esteem. He arrived at the same time as a newborn Jersey calf. For weeks, Michael came to feed him, groom him, and play with him. As the calf grew stronger (and harder to deal with physically), so did Michael's self-esteem and sense of accomplishment. Because the Jersey was the smallest in a herd of Holsteins, Michael could see a relationship between himself and the calf. He was able to tell me how, even though the calf was smaller than some calves born after it, it could hold its own in the herd and seemed to be content. After a year of working with his calf, Michael is a different boy. He is still sweet and sensitive to others, more so than his peers, and he is now able to see his

own giftedness. Because he is more accepting of himself, he is more accepted by his peers.

Taken From: George, M. H. (1988). Child Therapy and Animals. **In** *Innovative Interventions in Child and Adolescent Therapy* (p. 415). New York, John Wiley and Sons.

Case Study:

Therapist Wanda Polzin ran a specialty group for AAT with lower functioning girls who all had a history of sexual abuse, and who had anxiety issues and some symptoms of depression. During the group, each girl worked with a dog. The girls taught the dogs obedience skills, but the goals of the group were really to improve self-confidence and assertiveness skills in the girls, themselves. One girl in the group, "Sarah" was partnered with a dog who looked very different from the other dogs in the group. Sarah was immediately annoyed and frustrated that her animal was different and said she no longer wanted to participate after the first session. After the therapist talked with Sarah and her mom about what might be happening to make her feel this way (i.e., transference of emotions), Sarah decided to stay in the group and work with her dog. Although her dog needed much more attention than the other dogs in the group, Sarah learned to appropriately handle and nurture the dog. Through working with her dog, Sarah was able to recognize her own issues about feeling different than everyone else and having

difficulty being confident because of it. She learned to recognize that it is not only okay for the dog to be different, but for her to be different as well. Sarah also realized that she, too, needs to be nurtured. The therapist feels that, of all the girls in the group, Sarah engaged the most over time and probably got the most out of it. (W. Polzin, personal correspondence, 2002)

Case Study:

Bonnie Rude-Weisman has been working with a female adolescent who was very withdrawn and immobilized. At first, the girl was unassertive, but Bonnie put her in charge of Georgie (her canine co-therapist) during their sessions and this helped her gain appropriate skills. Using walking therapy, Bonnie was able to increase her client's communication with others and her self-esteem. During the walks, they would pretend that Georgie was the client's dog, so when other people would ask questions about him, the girl would answer as if Georgie belonged to her. At first, the girl's mother was skeptical about AAT. She now believes it has helped her daughter make remarkable progress. (B. Rude-Weisman, personal correspondence, 2002)

2.1.6 A Catalyst for Nurturing/Giving:

Psychologically, when a person nurtures another living being, his/her own need to be nurtured is

fulfilled (Nebbe, 1994). Generally speaking, mentally healthy people are people who are able to give (e.g., love, affection, care, tolerance, understanding, assistance) or to nurture. However, many people who have low self-esteem or who have had difficult pasts may not have learned these skills. Thus, giving can be very difficult for them. An important outcome of AAT is the opportunity for one living being to help another.

The mutual giving and receiving of affection is an important component of the human-animal bond. The simple act of giving can make a person feel better and more worthwhile. In many cases, it is easier to give to an animal than to another person. During AAT, giving is healthy for the client as the giver of affection, for the animal as the receiver of affection, and *vice versa*. Ultimately, this mutual relationship may result in the person feeling a sense of accomplishment and pride. This can enhance their own life, as well as the life of the animal.

Further, taking care of animals is often the way children, and especially boys, learn to nurture. Studies show that as early as age three, caring for babies and young children is seen as “what Mommies do” or “women’s work." In contrast, caring for animals is not gender specific and may be the only way for a boy to learn to nurture (McIntosh, 2002).

I do honour the very flea of his dog. –Ben Jonson

Table 2.6: Example goals and strategies to promote "giving" behaviour.

TREATMENT GOAL	AAT STRATEGY
Learn about appropriate touch.	• Observe and discuss the animal's response to human touch. • Learn gentle ways to handle the animal. • Receive apparent acceptance from the animal. • Give affection to the animal. • Generalize the animal's behaviour to human circumstances.
Decrease self-talk and recognize the needs of others.	• Work with the human-animal team to determine the needs of the animal. • Discuss the importance of meeting the animal's needs. • Determine what might happen if the animal's needs were not met. • Transfer this information to other situations.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Carol was a normally developing five-year-old who began having difficulties integrating herself within the family after the birth of a sister. She told tales to gain sympathy from

outsiders and cried more than usual. She often told her father that he did not love her as much as he loved the baby, even though he tried to spend more time with her than before the birth.

Carol was brought to the farm [Green Chimneys Treatment Facility] *and given a newborn lamb to work with. Her mother was able to bring her a few days before the lamb's birth so that she could brush and feed the ewe. Hours after the lamb's birth, her mother brought her back. She held it and was able to help place it under the mother so that it could nurse. Carol came to work with her lamb once a week, caring for it and playing with it in a pen filled with hay. A special bond developed between her and the lamb and the therapist was able to make analogies for the child to see the lamb similar to herself. (A new lamb will come next year, but the mother will love this one still.) After only six weeks, Carol's mother reported that she was crying less, asking to help feed the family dog, and relating more to the baby sister. After three months, therapy was discontinued but Carol still comes to play with her lamb.*

Taken From: George, M. H. (1988). Child Therapy and Animals. **In** *Innovative Interventions in Child and Adolescent Therapy* (pp.414-415). New York, John Wiley and Sons.

I have felt cats rubbing their faces against mine and touching my cheek with claws carefully sheathed. These things, to me, are expressions of love. -- James Herriot

2.1.7 Enhancing Personal Growth and Development:

Many young children, and some adults, see animals as peers. When people are taught to be kind to animals and to treat them with respect, they also learn to be kind and to respect other people. A study by Melson (1990) indicates that kindergarten children with a family pet have fewer behavioural problems when transitioning to public school.

Personal development, such as speech and communication skills, can be enhanced by partnership with a therapy animal. For example, giving a command, saying the animal's name, or describing feelings while holding a therapy animal are simple, but often effective ways to encourage an individual to talk and communicate with others. Contact with animals is also thought to be beneficial for a child's cognitive development (Poresky, 1996).

Table 2.7: Example goals and strategies for enhancing personal growth and development.

TREATMENT GOAL	AAT STRATEGY
Increase leisure awareness and lifestyle choices.	• Learn about proper animal care. • Compare animal and human care. • Discuss possible changes that would improve the client's lifestyle.

Increase vocabulary.	• Learn new words relating to different dog breeds, obedience commands, animal characteristics, etc. • Read or talk to the animal.
Stimulate interest, desire for knowledge.	• Give the client a project relating to an animal they are interested in. • Allow the client to share their information with peers.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case study:

... donkeys are wonderful teachers of how we impact others in our lives. 'Mark', for example, is a young teenager with autism. At first Mark could not get near the donkeys. Naturally wary of people, the donkeys ran away from Mark as he marched after them purposefully with his hand held out in front, gripping the halter. But Mark was motivated, and with guidance and patience has learnt to approach the donkeys slowly and gently. He has become aware of the donkeys' feelings and of how his actions impact them; he has built a relationship with the donkeys based upon mutual trust and respect. He is now rewarded each week by Ceilidh running up to him to have her face rubbed. This is a new experience for Mark that we are working on transferring to his human relationships.

I would rather see the portrait of a dog that I know, than all the allegorical paintings they can show me in the world.
-- Samuel Johnson

Taken From: McIntosh, S. (2001, Dec). Four legged therapists reach children in need. *Synchronicity.*

Case Study:

I asked my client, P, to try to get Bo, my 24 year old gelding, to walk in a figure eight around some cones, without touching his halter. On the first attempt P tried to push, pull and generally force Bo to complete the task. Bo responded by wandering off in the wrong direction or just standing there and dozing off. I then guided P to play some…games through which she communicated with Bo, built trust and earned his respect. On their second attempt, Bo calmly followed P as she led the way around the cones – no pushing or pulling required. In debrief, P noted that on the first attempt Bo did not understand what she wanted him to do, which was frustrating for her and, she imagined, confusing for him. She then noted that on the second attempt, after they had built a bit of a relationship, he worked with her rather than against her. P also got to experience success and a sense of achievement in a job well done

Taken From: McIntosh, S. (2002). An Introduction to Equine Facilitated Counselling, pp. 120.

2.1.8 Providing a Sense of Control:

AAT offers a realistic basis for control therapy, whether focusing on internal-, external-, or self-control (Nebbe, 1994). The clients can be taught to

respect the self-control of animals, but they may also have the opportunity to exhibit control in subtle ways (i.e., having the animal perform obedience commands or tricks). Manipulation tactics or bullying does not work with most animals (as demonstrated in the case examples above) and this can be used as a teaching tool for individuals who have little self-control. On the other hand, individuals may find it very empowering to have an animal respond to them after they have taken time to gain the animal's respect and then to teach it something. This may be especially rewarding for someone who has low self-esteem and perceives that they have no control.

Sue McIntosh is an Equine-facilitated therapist in Alberta, Canada. Sue notes that when working with a survivor of abuse, an animal can provide a metaphor for how the person feels with regards to the perpetrator of the abuse or the assault itself. For example, for many of us the horse is a symbol of power. Through various groundwork exercises, a client can work to regain his/her sense of personal power, control and boundaries in the presence of the horse, which can open the door to experiencing these things in other relationships (McIntosh, 2002).

Furthermore, modeling animal behaviour may be useful in demonstrating control over one's own behaviours and emotions. JoAnne Dulaney emphasizes the psychoeducational role of animals in therapy. Her dog PauKat is instrumental in providing a conduit for learning and for teaching appropriate reactions to clients. For example, together with a client, JoAnne will arouse PauKat and get him excited, then make him calm down.

This can lead to discussions about socially appropriate ways to control extreme excitement, anger outbursts, etc. (J. Dulaney, personal correspondence, 2002) Similarly, Betty Hodnefield, a therapist participating in the Chimo Project, works with her canine, Bernard, to address impulse control issues with children. For example, Betty will ask a child to draw Bernard's brain and then indicate how much of his brain is used for certain activities (e.g., chasing cats, play, eating, chasing cars, sleep). They then have a discussion about what would happen if Bernard did not have "brakes," or a way to stop doing one activity so he could focus on another. The child is eventually asked to draw his own brain and, together with the therapist, the client's own impulse control issues are identified and discussed. (B. Hodnefield, personal correspondence, 2002)

Table 2.8: Example goals and strategies to provide a sense of control.

TREATMENT GOAL	AAT STRATEGY
Teach the animal a new trick or obedience command.	• Learn how to teach the animal something by first learning how to treat the animal with respect, developing a relationship with the animal, developing observation and listening skills, learning proper praising techniques, learning to be tolerant of mistakes (their own and the animal's), and recognizing their progress.

TREATMENT GOAL	AAT STRATEGY
Increase assertiveness as shown/measured by _____.	• Practice role-playing assertive responses, with the animal as either an antagonist or a victim needing protection. Practice non-verbal assertion (tone of voice, eye contact, body posture).

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Many of the individuals I have worked with have experienced abuse and violence in their lives. Power and control are key factors in the dynamics of abuse, and many survivors of abuse feel that they have no power or control in their relationships with others and with themselves. 'Jenna' first recalls experiencing abuse as an eight-year-old child, when her father followed her into the bathroom and locked the door. As an adult she married a man who beat her, did not allow her to have her own money, monitored her phone calls, and told her she was a lousy mother. Jenna felt she had no control over her life, she felt powerless with her family, with the system, with herself.

They know exactly what makes them happy - doing something for someone. -- John Richard Stephens

When first faced with a horse Jenna saw a thousand pounds of uncontrollable power, she felt anxiety and fear; she told me she was small and powerless. But she also felt a connection, was drawn to the beauty of the horse; the energy, freedom and hope which she saw represented there. We started with Jenna on one side of the fence, the horses on the other; Jenna chose the pace. Over time Jenna developed a relationship with the horses, she learnt to groom and feed them, she sat in the field and talked to them. Through groundwork exercises Jenna asked the horses to respect her boundaries, and experienced not anger or rejection, but acceptance and respect. Ultimately Jenna was able to ride the horses, she built a partnership with them in which she led the way. In debrief sessions Jenna explored her relationship with the horses as representative of her relationship with herself – and specifically with her life energy. Jenna learnt through the horses that while she can't always control every aspect of this energy, she can develop a relationship with it, take care of it, feed it, rest it and train it — trust it and respect it — so that it accommodates her and works with her, rather than against her. Once Jenna had developed a healthier relationship with herself, she started to work on other relationships in her life. Like many of my clients, Jenna had found in the horse a powerful metaphor that she could explore experientially and then, in her own time, transfer to other aspects of her life.

Taken From: McIntosh, S. (2002). An Introduction to Equine Facilitated Counselling, p. 123.

Case Study:

At one nursing home, a resident made it quite clear that she did not like dogs or cats and that she believed they should not be used in her facility. Instead of staying away from this woman, the social worker requested that the volunteer and her dog try to visit the resident every week.

During each visit, the scene was repeated. The volunteer and the dog would head down to the woman's room where she seemed to be waiting by her door. As she saw the volunteer approaching, she would begin to shout, "Get that animal out of here!" The volunteer would get close enough for the woman to hear her say, "I'm sorry to bother you. We will leave now." The volunteer and the dog would turn and head back down the hall.

The social worker believed this strong woman was in a situation (the nursing home) in which she had very little control. This weekly event gave her the chance to state her opinion strongly and get results. The social worker's theory was soon validated. The woman, who always enjoyed seeing her daughter, began declining her invitations to go out on days when pet visits were planned.

Taken From: The Delta Society (2001). Pet Partners Team Training Course Manual, p. 38.

To a dog the whole world is a smell. --Anonymous

2.1.9 Reducing Abusive Behaviours or Tendencies:

"At risk" youth may especially benefit from AAT because many of these youth are abusive (or have potential to be abusive) to animals as a result of their dysfunctional or abusive family history. Cruelty to animals was first included in the Diagnostic and Statistical Manual (DSM) in 1987 and has been found to be one of the earliest symptoms of conduct disorder to appear in childhood. In fact, it is estimated that approximately 25% of conduct disorder cases include a history of abuse to animals. The significance of these findings led the American Psychiatric Association (APA) to cite animal cruelty as a diagnostic criterion for conduct disorder in the DSM-IV (APA, 1994). The inclusion of animal cruelty in the DSM-IV has renewed attention to animal abuse as being a potential precursor to human mental health problems.

A chance to observe and to work with animal teams demonstrating kindness, compassion, and a reverence for life, may provide “at risk” youths with a strong role model and the realization that they have choices (Nebbe, 1994; Sue McIntosh, personal communication, 2002).

Table 2.9: Example goals and strategies to reduce abusive thoughts and behaviours.

TREATMENT GOAL	AAT STRATEGY
Promote empathy for living beings.	• Learn about and interact with the animal. • Discuss the animal's feelings in a variety of situations. • Compare the animal's feelings to human emotions.
Decrease negative comments and increase positive comments.	• Work with the human-animal team to learn appropriate praising techniques. • Directly confront this issue, using the animal as an example, and transfer it to other situations.
Decrease abusive tendencies.	• Observe and discuss compassion and understanding within the human-animal team. • Observe and discuss appropriate ways to address frustration or anger. • Learn about and then assist in the care/grooming/feeding of an animal. • Learn about animal emotions. • Discuss how animals might feel if they are neglected or abused (relate to client's circumstances). • Transfer these observations to relevant situations in the client's life.

To err is human, to forgive canine. -- Anonymous

TREATMENT GOAL	AAT STRATEGY
Decrease anger outbursts and increase appropriate reactions to frustration.	• When situations of frustration or nonsuccess arise while working with the human-animal team, use the opportunity to confront inappropriate or appropriate reactions. • Reinforce appropriate responses to frustration and nonsuccess. • Transfer the observations to relevant situations in the client's life.
Decrease manipulative behaviours.	• Observe the animal's behaviour(s). • Learn about the meaning of animal behaviour(s). • Observe and discuss the animal's response to human behaviour (immediate consequences). • Generalize animal behaviour to human circumstances. • Practice teaching an animal something new. • Develop a cooperative plan to accomplish something with an animal. • Forecast "what would happen if...?" • Engage in play with an animal.
Improve cooperation.	• Learn about and then assist in the care/grooming/feeding of an animal. • Develop a cooperative plan to accomplish something with the animal.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal

Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Sometimes the pet functions importantly later in the therapeutic process. Such a case was that of David, an adopted child of seven who was very much disturbed by the fact that his real mother had deserted him. He had threatened to kill his sister Helen (also an adopted child) and himself since he felt that they both were very bad otherwise they would not have been surrendered for adoption. This, in spite of the fact that Mrs. B. had read many stories to David which explained the fact that an adopted child was a preferred child because he had been picked out, while with a natural born child the parents had to take pot luck. However, David did not accept this explanation. He felt that it was not possible for his adoptive parents to love him since there must have been something inherently wicked about him, which brought about his desertion. He was convinced that he was taken on approval and that as soon as he misbehaved he would be surrendered.

Although our cat would sleep in her basket on the table, a few sessions passed before David noticed her. Eventually he began to fondle her and later he wanted to feed her. He asked many questions about the cat. Finally he wanted to know where the cat came from. I

To his dog, every man is King; hence the constant popularity of dogs. -- Aldous Huxley

explained that we had picked her up in the ASPCA from an abandoned litter of kittens. We love this cat very much; so much so that my two sons often fight over the privilege of having her in their room at night.

At first David found it difficult to accept the idea that a cat, even abandoned by her Mother and her owner, could still be loved and accepted by others. After several sessions during which he returned constantly to this subject, he began to consider the possibility that he was actually loved by his adoptive parents. I believe that this was the turning point in David's recovery.

*Taken From***:** Levinson, B. (1965). Pet Psychotherapy: Use of Household Pets in the Treatment of Behavior Disorder in Childhood. *Psychological Reports*, **17**, p. 696.

Case Study:

Although the following is not an example of AAT, it does demonstrate the power that a strong role model can have on "at risk" youths.

A wildlife rehabilitation presentation was given to a group of 6th graders where many of the students in the group were notorious for acts of violence and aggression, often towards animals. Two of the boys were currently on probation for vandalism. One of the boys often bragged about setting cats on fire.

Although none of the students commented or responded to the presentation, they did listen.

Later, when the two boys came to the rehabilitator, something was tucked under one of the boy's shirts. Tears were in the other boy's eyes. The first boy handed her a baby squirrel. They had found him clinging to his mother who had just been killed by a car. "Here, we don't know if you can help it or not, but we thought you could try," one boy said as he gently gave the baby to the rehabilitator.

The wildlife presentation provided a role model for the boys, one they never knew existed, one that was kind, compassionate, and demonstrated a reverence for life. Now the boys had a choice.

Taken From: Nebbe, L. (1994). Animal-assisted activities/therapy as an animal and human welfare project. *Humane Innovations and Alternatives*, p.8.

2.1.10 Psychological Benefits:

We all have basic psychological needs to be loved, respected, useful, needed, accepted, and trusted. An animal may fulfill these psychological needs by filling roles such as companion, friend, servant, dependant, admirer, confidante, scapegoat, mirror, trustee, and defender. An animal may also satisfy his human friend's need for loyalty, trust, respectful obedience, and even submission (Levinson, 1961). Thus, caring for or interacting with an animal can

mean the difference between loneliness and fulfillment for many people.

Animals are employed extensively in a variety of therapeutic settings. A large number of respondents to a survey conducted in the U.S. indicated that in psychotherapeutic settings, anxiety disorder is one of the diagnoses with which AAT is most effective (Mason & Hagan, 1999). Animals appear to have a calming effect on persons with anxiety, and the simple act of touching or petting an animal reduces anxiety in many (Barker & Dawson, 1998; Wilson, 1991). For example, a client of Terry Wilton's relayed to him that she is always somewhat anxious and feels despair when she walks down the hall to his office. However, when she opens the door and sees Terry's canine co-therapist, Bishop, her anxiety and despair dissipate. She becomes totally relaxed and can focus on the work she needs to do. (T. Wilton, personal correspondence, 2002)

Many anecdotal or case reports claim that AAT is beneficial for an extensive range of mental health illnesses. For example, a study of 612 primary school children in Slavonia, a region heavily affected by war, found that students with a dog or cat expressed emotions, sought social support and problem-solved more than those without animals, and demonstrated more differentiated coping strategies. This proved to be helpful in reducing post-traumatic stress reactions in these children (Arambasic & Kerestes, 1998).

Table 2.10: Example goals and strategies to address mental health concerns.

TREATMENT GOALS	AAT STRATEGY
Anxiety	
Decrease symptoms of anxiety or agitation.	• Hold or stroke the companion animal while interacting with the therapist or the therapy group. • Talk to the animal. • Receive affection from the animal.
Improve ability to relax using diaphragmatic breathing and relaxation techniques.	• Observe how a relaxed animal rests and breathes. • Practice imitating the animal while imagining stressful situations in anxiety hierarchy (desensitization).
Identify and reduce irrational thoughts which trigger or exacerbate anxiety.	• Discuss possible origin and symptoms of the animal's irrational fears (e.g., thunder) and relate to client's fears when possible. • Have client consider the origins of their own anxiety or phobia and identify the thoughts and sensations that trigger anxiety. • Have client explain why the animal need

TREATMENT GOALS	AAT STRATEGY
	not be afraid. Help client develop coping self-statements for client's situation. • If client is a child, then ask child to help animal confront fears with rational and more positive beliefs. A card game that matches irrational thoughts with the best counter ideas could be developed.
Reduce avoidance of anxiety-provoking situations, place, groups, etc.	• While client pets the animal, use guided imagery to desensitize fears (e.g., confrontations, using elevators, giving a speech, taking a test successfully, sleeping alone in the dark). • The animal may be able to accompany the client while they face some fears
Increase assertiveness as shown/measured by:_____.	• Discuss fight or flight reactions in animals (cowering vs. aggression) and apply to people. • Practice role-playing with the animal taking various roles. • Practice process of gradually getting the

TREATMENT GOALS	AAT STRATEGY
	animal to approach something it initially fears.
Identify and modify lifestyle variables that increase stress.	• Discuss stressors on animals and people (e.g., excessive noise, not eating or sleeping well, arguments, losses) and how these situations could be improved.
Reduce frequency of worrying, apprehension, and avoidance tactics.	• Write/tell stories (related to client's own anxiety and worries) about a dog or other animal that overcomes its fears by facing them and discovering they are not real. • If client is a child, then have them illustrate the story.
Reduce secondary symptoms of anxiety (e.g., restlessness, fatigue, irritability, stomach aches, sleep disturbances.)	• Include client's symptoms in above stories with ways to reduce them. • If client is a child, then exercise/play hard with animal, then practice relaxing while petting animal and imagining relaxing scenes together.

If a dog will not come to you after having looked you in the face, you should go home and examine your conscience.
-- Woodrow Wilson

TREATMENT GOALS	AAT STRATEGY
Depression	
Brighten affect and mood.	• Hold or stroke the companion animal while interacting with the therapist or the therapy group. • Teach the animal to do a trick, or engage in play with the animal.
Decrease learned helplessness behaviours. Increase sense of control over self and environment.	• Work with the human-animal team to effectively command the animal and to problem-solve when it does not respond correctly. • Directly confront this issue, using the animal as an example, and transfer it to other situations.
Reduce isolation, boredom, loneliness.	• Engage in play with the animal. • Learn about and then assist in the care/grooming/ feeding of the animal. • Reminisce about the past. • Remember and repeat information about the animal. • Learn about the animal, then introduce the animal to peers.

TREATMENT GOALS	AAT STRATEGY
	• Take the animal for a walk. • Receive apparent acceptance from the animal. • Give appropriate affection to the animal.
Decrease feelings of worthlessness.	• Provide pleasure for, or affection to, the animal. • Spend time caring for/grooming the animal. • Take the animal for a walk, play its favourite game (e.g., fetch).
Address grieving/loss issues.	• Talk about animals the person has known. • Reminisce about past animal loss(es). • Discuss how animals might feel when their animal companion dies, when baby animals leave their mothers, etc. • Transfer this to the human situation.
Reduce suicidal ideation/behaviour	• Ask: "If the animal were to die suddenly, what impact would his death have on those who love him? What impact would

If I have any beliefs about immortality, it is that certain dogs I have known will go to heaven, and very, very few persons.
-- James Thurber

TREATMENT GOALS	AAT STRATEGY
	YOUR suicide have on your family and friends?" • Reflect on the animal's total self-acceptance without shame, without judging or comparing himself to others. • If the client is a child, then talk about how the animal has suffered a loss similar to the child's. Discuss how the animal might feel sad, hopeless, or guilty and what could be done to help the animal feel better. • Then discuss how the animal could let you know that he was feeling better. Apply to the child.
Increase positive mood, attitudes for a period of ____ consecutive weeks.	• Consider the simple things that make animals/people happy. • Engage in some of those activities. • Have client keep a "Pleasure Journal" of small, enjoyable events. • Ask clients about their future and what will make them

TREATMENT GOALS	AAT STRATEGY
	happy. If client is a child, then ask him to draw picture of himself in the future.
Improve reality-testing and orientation (reduce dissociation, self-mutilation, etc.).	• Have client touch or stroke animal to help ground them in the present. • Have client describe the animal objectively in terms of their appearance, needs, activities; where the animal is now, what month it is, etc.
Increase energy, initiative, and activity level.	• Play actively with the animal, take animal on regular walks (either client's own animal or yours). • Have client plan and teach the animal a new trick.
Increase assertion.	• Have client obedience train their own animal or yours. • Compare the ways animals and people react to an assertive tone of voice, to "no," to positive reinforcement, etc.
Improve decision-making and concentration.	• Ask client what to do about a problematic behaviour of the animal's (parallel to client's behaviour

TREATMENT GOALS	AAT STRATEGY
	when possible). • Plan short-term goals and steps toward reaching goals. • Apply process to client's situation. • If client is a child, then allow the child to decide what food treat to give the animal, or which game to play, or to decide when the animal needs to go out. • If client is a child, then play "Simon Says" and "Mother May I?" using the animal's name (e.g., Rufus Says...) or the child's name (e.g., Jill says..."Sit!").
Reduce irrational thoughts that increase or maintain depression.	• Discuss the client's (or animal's) negative self-beliefs (e.g., I can't do anything right, nobody likes me) • Practice contradicting with rational statements. • As evidence to refute client's irrational thoughts, point out the animal's affection and loyalty to client, despite past mistakes,

TREATMENT GOALS	AAT STRATEGY
	imperfections, etc.
Increase social interaction.	• Have client interpret the animal's feelings based on the animal's behaviour. • Ask the client to talk about their own feelings and behaviours in similar circumstances. • In groups, take turns throwing a ball for the animal or demonstrating tricks the animal has learned to do. • Discuss amazing animal tales or feats.
Get an adequate amount of restorative sleep most nights for a period of _____	• Client observes how relaxed the animal is and how it breathes deeply. Practice similar breathing techniques while visualizing relaxing dream images for the client (or animal). • Try the same technique at night.
Increase interest and participation in daily activities.	• Monitor attendance and interaction at AAT sessions. • Talk about the client's daily activities and determine what may make them more fun. • Note how frequently

TREATMENT GOALS	AAT STRATEGY
	the client smiles at or pets the animal.
Improve appetite most days for a period of ____ consecutive weeks.	• Point out character flaws or flaws in physical appearance of the animal and how they do not affect the animal's self-image. Work on translating this to clients who have problems with their own self-image. • If client is a child, then have a tea party where the child feeds the animal and him/herself. • Play "red light-green light" when eating meals.
Attention-Deficit Hyperactivity	
Improve attention/concentration.	• Teach the animal a trick or an obedience command. • Transfer success in activities with the companion animal to treatment activities and daily living activities.
Decrease distractibility.	• Work with the human-animal team to help maintain concentration on the work with the animal when giving commands or

TREATMENT GOALS	AAT STRATEGY
	teaching a trick. • Directly confront this issue, using the animal as an example, and transfer it to other situations.
Improve memory (short-term or long-term) or recall.	• Recall information about the animal (name, age, colour, etc.). • Reminisce about animals the person knew or had in the past. • Remember details about the animal and the animal's care. • Describe the animal when it is not present. • Follow a sequence of instructions with the animal.
Improve reality orientation.	• Take the animal around and introduce it to others. • Interact with (pet, play, talk to, groom, etc.) the animal. • Give affection to and receive affection from the animal. • Reminisce about the past. • Remember and repeat information about the animal.

If you take a dog which is starving and feed him and make him prosperous, that dog will not bite you. This is the primary difference between a dog and a man. -- Mark Twain

TREATMENT GOALS	AAT STRATEGY
	• Describe the animal.
Decrease self-talk relating to the fantasy world.	• Work with the human-animal team to emphasize the importance of staying focused on the "here and now" with the animal when giving commands. • Directly confront this issue, using the animal as an example, and transfer it to other situations.

Information obtained from: The Therapy Dog Training Institute (1999), Utilizing therapy dogs in mental health settings; The DELTA SOCIETY (1996), The Human-Animal Health Connection, Standards of practice for animal-assisted activities & therapy; and The DELTA SOCIETY (1997), Therapeutic Interventions.

Case Study:

Patient Sonny was a 19-year old psychotic who spent most of his time lying in his bed. The staff tried unsuccessfully to get him to move about and interact. Nothing seemed to interest him; he would not participate in occupational therapy, recreational therapy or group therapy. In individual therapy he remained withdrawn and uncommunicative. His drug regime (haloperidol and other drugs) did not improve him. A work up for electroshock therapy (EST) was begun. A token system was introduced; but again Sonny showed little response.

Before starting the electroshock therapy, it was decided to attempt to use a dog as a component of the token reward system.

The patient was lying in bed in his usual mummy position. The psychiatrist sat beside his bed and spoke with him. When the psychiatrist's question concerned people, or Sonny himself, Sonny's response was very slow, the interval being as long as 26 seconds. When the question concerned dogs ("Do you like dogs?") or pets in general, the response came more rapidly, in 1 or 2 seconds. All of Sonny's responses were extremely brief, chiefly "Yes" or "no" or "I don't know". He did not volunteer any statements or questions. He continued to be motionless with a blank expression on his face.

When the psychiatrist brought the dog Arwyn, a Wire Haired Fox Terrier, to Sonny's bed, Sonny raised himself up on one elbow and gave a big smile to the dog's wildly friendly greeting. The dog jumped on Sonny, licking his face and ears. Sonny tumbled the dog about joyously. He volunteered his first question: "Where can I keep him?" Then to everyone's amazement, he got out of bed and followed the dog when she jumped to the floor.

In the next few days after being introduced to the dog, Sonny became active in working for tokens, though he did not exchange them for rewards. He began to notice other patients

on the unit, saw that some had benefited very much from the electroshock therapy, began to go to group therapy, and asked that he be given EST. Since he was still operating on a psychotic level, a series of 8 EST's was given to Sonny and he was later discharged much improved. At the time of his discharge, his responses to questions occurred in 1 second and the duration of his answers increased to as much as 20 seconds. The introduction of the dog was judged by the psychiatrist to be the turning point in the course of his recovery.

Taken From: Corson, S.A., O'Leary Corson, E., & Gwynne, P.H. (1974). **In** R.S. Anderson (ed.), *Pet Animals & Society* (pp. 31-32). British Small Animal Veterinary Association Symposium, Zoological Society of London.

Case Study:

Patient Marsha was a 23-year-old licensed practical nurse, who was brought to the hospital disoriented, shouting "Destroy the world", and making sounds like "puss", "scat" and "meow".

The diagnosis was catatonic schizophrenia, excited type. She was treated with fluphenazine, and 25 electroshock therapy sessions, without improvement. Rather, she became withdrawn, frozen and almost mute. Therefore, it was decided to add PFP [pet-facilitated therapy] *to her treatment programme. At first there was no improvement in Marsha's behavior on the unit. She remained very withdrawn and the*

only signs of communication were when she was with the dog. When the dog was taken away, she would get off her chair and go after it. She began to walk the dog a little and began to have less difficulty in stroking the dog. She was given a written schedule of the hours when the dog would come and visit her; she began to look forward to the visits and to talk about the dog with the other patients. Six days after the introduction of the dog Marsha suddenly showed marked improvement and shortly thereafter she was discharged.

Taken From: Corson, S.A., O'Leary Corson, E., & Gwynne, P.H. (1974). **In** R.S. Anderson (ed.), *Pet Animals & Society* (p. 32). British Small Animal Veterinary Association Symposium, Zoological Society of London.

Case Study:

Ms. P. is a 24-year old single female with a mild mental handicap. She has been a resident of a group home for the past 10 years and is now considering living in a supported independent living situation but is anxious about being alone. Staff are also concerned about her security.

A former candidate for assistance dog training is selected and introduced to Ms. P. Her ability to handle the dog is reinforced through on-going obedience classes and consultation with a dog trainer. Caring for the dog enhances Ms. P.'s self-care skills. She is less anxious about living alone and is less vulnerable due to the presence of the dog.

It is a simple medical fact that the calming influence of the company of a friendly pet animal reduces blood pressure and therefore the risk of heart attack. -- Desmond Morris

Taken From: Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program* (p.31).

Case Study:

Sometimes the dogs seem to demonstrate a special sense for what is needed, and they can push the patient to achieve it, whereas if a therapists pushes, the client may be more likely to resist. Diane had a stroke that left her paralyzed from the waist down. On this day, her therapist said that she was very depressed and refused to come out of her room for therapy. But Diane was glad to see Newton, the terrier mix; she fed him his treats and talked to him. Soon Newt started nosing into his visit bag. His partner told Diane he was probably looking for his ball since Diane usually threw it for him and that is what he loves best. But Diane told Newt she just didn't feel like ball that day. As if he understood, Newt stopped and waited for about two minutes, then started in on his bag again. And again! Finally Diane's resistance crumbled. "Okay, I give!" she laughed. "Take me out for some ball-throwing!" So Newton won the day, lifting Diane's spirits and sneaking in some important therapy at the same time.

Taken From: Klotz, K. & Franklin, B. (1999). In *Interactions, Delta Society, The Human-Animal Health Connection*, 20.

Case Study:

Peter, an eight year old, was diagnosed as developmentally delayed. The major goals for him were to increase attention span and to show appropriate behavior in interaction with peers. He was extremely hyperactive when initially brought to the barn. Everything distracted him and he darted from one animal pen to another, wanting to play with them all at once. The therapist felt that play with animal puppets in a quiet room would be a good introduction to later work with real animals. After 6 weeks of focused attention with cow and rabbit puppets, Peter was brought back to the barn where he chose a miniature rabbit to work with. He was able to hold the rabbit for about 10 minutes during the first session, combing and petting it. With each ensuing session he was able to stay focused on the rabbit for longer periods of time. In the first few sessions he handled the rabbit roughly and had to be reminded how to hold it. After several months, Peter was able to care for the rabbit on his own every day, feeding and watering it and occasionally brushing it. He appeared to be more focused, calmer in his movements, and better able to relate to his peers. It cannot be denied that the whole atmosphere of the residential farm-school contributed to his improvement, but having an animal of his own was a big factor.

Taken From: George, M. H. (1988). Child Therapy and Animals. **In** *Innovative Interventions in Child*

and Adolescent Therapy (pp. 413-414). New York, John Wiley and Sons.

Case Study:

Mr. W. is a 45-year old man with a history of schizophrenia and depression. His paranoia greatly affects his ability to connect with others, thus isolating him further. He is often absent from the weekly out-patient group meetings.

The therapist brings a rabbit to group therapy sessions and permits each participant to hold it in turn. Mr. W. is more relaxed and more engaged in interaction with the group while the rabbit is present. His attendance improves.

Taken From: Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program* (p.29).

Case Study:

Mr. D. is a 66-year old man exhibiting symptoms of clinical depression following the death of his wife 18 months earlier. Withdrawn and isolated, his own physical health status is deteriorating due to poor nutrition and lack of exercise. He has no close family members and a limited social circle due to his retirement from his job shortly before his wife's death.

The therapist and Mr. D. explore activities in the community. Mr. D. becomes involved in

the walk-and-groom program at the local animal shelter. Eventually, Mr. D. considers the adoption of a dog. His life becomes more structured and he feels a renewed sense of purpose in caring for the dog. He becomes active in a local dog club, increasing his exercise and socialization. His general health, mood and affect improve significantly.

Taken From: Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program* (p.30).

As a final point on possible goals and strategies of AAT, it should be remembered that, while goal setting is a crucial element, it is necessary to routinely evaluate strategies that are being used and to alter sessions to meet individual client needs. Therefore, the goals and strategies of AAT may be as diverse as the population it serves.

2.2 Valuable Roles Animals Can Play in Therapy

While animals are far more than "tools" in therapy, their innate natures are often ideally suited to promote therapeutic disclosures and to enhance therapeutic progress. The Person Centered Counselling approach mentions three conditions that must be present in order for therapeutic growth to occur: 1) genuineness; 2) unconditional positive regard; and 3) empathy. Animals provide these emotions freely and without judgment, in a manner that human counselors can only strive to achieve (McIntosh, 2002).

You will be lucky if you know how to make friends with strange cats. -- Colonial American Proverb

2.2.1 Assessment Tool:

Individuals in therapy may be unwilling to disclose information about their past because they feel the need to protect those who have hurt or wronged them. In other cases, they may feel guilty about past events or feel that they are to blame for the bad things that have happened to them. An animal in therapy can provide a valuable assessment tool. By observing the person's interactions and comments to or about the animal, the therapist may gather a lot of information about the client's thoughts and experiences. The client may also inadvertently show the therapist how they have been treated and what they have learned through their life experience. For example:

> ...[This] *is an experience during an initial session with "Jeremy", a nine year old boy. Jeremy was very interested and intrigued by Kala's presence* [Kala is a therapy dog]. *He was enthusiastic about seeing her perform her many tricks and wanted her to perform over and over again. I interjected and interpreted for Jeremy that Kala was becoming tired. I pointed out how Kala was "telling" us how she was feeling. Jeremy blurted "Why don't you hit her?" In addition to telling me something about life in Jeremy's family this provided me with one of those "teachable moments". I was able to explain that I never hit Kala. I explained that Kala tries very hard to do what is right and to please us but sometimes she gets tired or is confused. Hurting her would only make her feel more confused and frightened. In this particular*

instance my comments le[d] to a disclosure on Jeremy's part about how things were "sure different with his Dad."

This interaction with Jeremy illustrates the need for the animal-assisted therapist to always be present with the child and the animal. As well, the therapist must be prepared to intervene in such a way as to be supportive to both the child and the animal. I have on occasion prevented a child from hurting or pressuring Kala with the explanation that it is my job to protect Kala in the same way as I would protect them in a similar circumstance. This prompted one little boy to say "I wish I could be your dog."

Taken From: *Mayes, P. (1998, Spring). 'Therapetic' solutions for troubled children.* Newsletter of the Human Animal Bond Association of Canada *(p. 3). Peggy Mayes has shared her knowledge and expertise with the Chimo Project. We gratefully acknowledge her contributions.*

Wanda Polzin emphasizes that animals are of great benefit when working with or assessing clients who have undergone emotional or physical abuse. For example, the natural physical intrusiveness of a dog can bring up a lot of abuse issues during a session. (W. Polzin, personal communication, 2002)

2.2.2 Projective Tool:

Many people find it easier to express feelings, issues, and fears indirectly rather than directly. These people may find it helpful to express their thoughts through a companion animal. For

example, they could disclose information about particular situations as if the animal, and not themselves, had been involved. They could also imagine the animal in certain circumstances and express how the animal might feel, tell stories about the animal, draw pictures of the animal's experiences, etc. Using the animal in this way may pose less risk for the person, yet they would still benefit from the therapist's acceptance and validation (Mayes, 1998). For example, a sexually abused child could project their feelings onto the animal and the animal would serve as a transitional object, while putting the child at ease and facilitating disclosure and expression of emotion (Reichert, 1994).

2.2.3 Tool for Storytelling and Metaphor:

Individuals may also benefit from hearing stories of the animal's experiences that parallel their own issues. Some examples may include the therapist telling stories about how the animal was separated from its parents and siblings, travelled to a new home, was forced to live with a complete stranger, went to see the veterinarian, or went to obedience school ─ and also about how the owner helped the animal adjust to the new surroundings and made them feel safe and loved. There are numerous other instances that could be drawn upon, depending on the circumstances of the particular client (Mayes, 1998; Fine, 2000).

> *Experiences that clients encounter with* [a] *horse* [or another therapy animal] *can provide*

them with immediate insight into other aspects of their life ─ through interpreting the metaphor presented by this experience. For example, a child with behavioural problems may be asked to catch and groom a young horse. The young horse will be likely to fidget and fuss, not stand still, and generally make the task difficult. The client may feel frustrated and helpless. The counsellor can help the client explore how the feelings that the young horse invoked in the client may be very similar to the feelings that the client invokes in his parents. Similarly an adolescent girl with a history of sexual abuse can be guided through groundwork boundary exercises with a horse. At first the horse may not respect the client's boundaries and the client can explore the feelings this invokes in her. The client may not feel that she can ask the horse to respect her boundaries, may fear anger or rejection. This may be similar to how the client feels/has felt in other relationships. With the horse the client can learn new skills and experience having her boundaries accepted and respected. Once the client experiences this with a thousand pound horse, she can start to believe she might be able to insist that the people in her life also treat her with respect.

Taken From: *McIntosh, S. (2002). An Introduction to Equine Facilitated Counselling, Self-published.*

The usual dog about the Town is much inclined to play the clown. –T.S. Eliot

2.2.4 Role Modeling Tool:

Having an animal present in therapy may indirectly benefit the client as a result of observing the interaction between the therapist and the animal. Many people will unconsciously compare these interactions with their own personal relationships. The scenarios between the animal and handler that occur during a therapy session can be used to demonstrate to the client appropriate interactions and responses to behaviours. For example, there will be many times during therapy sessions in which boundaries will need to be placed on the animal. Therapists can use these times to model appropriate methods to discipline the animal and to problem-solve when the animal does not respond. Discussions about managing behaviour, setting boundaries on behaviour, or appropriate ways of interacting may then be initiated as a result (Mayes, 1998; Fine, 2000).

Animals also tend to know how to "get their needs met" (D. Scott, personal communication, 2002). Whether the need is to be petted, to be fed, or to be taken outside, an animal does not hesitate to demand your attention. A good example of how this trait can be used therapeutically follows:

> *Elizabeth, who has developed a strong attachment to Lucy* [a therapy dog]*, was holding and stroking the dog most of our session one day as she shared details of painful exclusion experiences. We discussed experiences from her memory as a child in her family group, as well as recent hurtful events involving her parents and her*

boyfriend. The recurring complaint was "Why don't they invite me? What do I have to do to get their attention?"

Elizabeth's question instantly made me think of Lucy and her easy way of being included wherever she goes. It occurred to me that when I observe Lucy's interactions with others she always counts herself in. She just assumes that she has been invited, whether it is total strangers encountered on a walk or another dog at the park. She takes her eager and open spirit and just 'counts herself in'. When I shared this insight about Lucy, there was a visceral change in my client. Elizabeth began to move to a deeper understanding of herself in the context of this issue remarking on the significance of her own responsibility for inclusion.

In a follow-up session, Elizabeth reported what a profound impact using Lucy as an example had been for her. She added, "I always think of Lucy now when I feel left out – she is an inspiration and a reminder to me to act on my own behalf."

Taken From: Shell, R. (2002). Moments of Magic: Animal-assisted interventions. *In Preparation.*

2.2.5 Teaching Tool:

Instruction can be therapeutic for people who are insecure or afraid due to insufficient knowledge about the things they fear. Therapists should take

He lies down when I sit, and walks when I walk, which is more than many good friends can pretend to do.
-- Alexander Pope

advantage of teachable moments and learning opportunities that arise during therapy. Discussing and observing animals and their interactions with the handler and with the client will provide the client with knowledge that can then be transferred to their own lives.

> *Many clients have a restricted awareness of themselves and are vague in relation to their problems; they may feel helpless and trapped, and unable to deal with their life. Equine facilitated counselling can provide the mirror which the counsellor holds up to the client to show them the restrictions they are allowing to live within themselves (or have contributed to) and to show them how they can take responsibility for changing this. This is particularly relevant to adolescents who are struggling with identity issues.*
>
> *The horse acts as a mirror to show the client how they impact others. If a client is aggressive, the horse will not trust or respect the client; if a client withdraws the horse will stop responding. The horse's immediate feedback can reflect the client's behaviour and approach. By understanding how his behaviour impacts the horse the client can start to understand how his behaviour impacts other people.*
>
> *Taken From*: McIntosh, S. (2002). An Introduction to Equine Facilitated Counselling. Self-published.

This same technique can be applied with other animals as well. The knowledge gained may make the client more sensitive to an animal's needs, thus

promoting empathy and respect for other living beings.

Animals can also help parents/therapists educate their children/clients about the cycle of life. Children with animals in the family (or in therapy) will likely experience the death of an animal. During these times, parents or therapists will influence how the children cope with illness and death during their life. This can be positive or negative, depending upon how the adult deals with the event (Robin & Bensel, 1985).

2.3 Alternative Ways to Utilize the Human-Animal Bond

2.3.1 Have an Animal Present:

In some cases, just having an animal present in a therapy session may be therapeutic. There are numerous anecdotal reports in the literature to indicate that the simple presence of an animal during a session can be revitalizing and therapeutic for clients.

> *I understand that there is some literature (mostly informal) on pets breaking through the social isolation of withdrawn individuals, aiding in the recovery of those with medical conditions, lowering blood pressure and creating healthy daily living patterns for folk who are not able to do so on their own. I don't know whether or not Bishop does this for any of my clients. I do observe, however, he tends to bring out the best in them. I had thought that he would make my work easier*

Yes, a queer mongrel, with a most amazing power of scent, I would rather have Toby's help than that of the whole detective force of London. –Sherlock Holmes

with children, and he does. Surprisingly though, he has been the most help with teenagers and adults.

He doesn't do anything startling from a therapeutic viewpoint. I don't think any client has ever told him a secret they haven't been able to tell me. However laughter, gentleness, an easing of tension and stories tend to emerge more easily when he is with me.

For some of us, we are most human (and humane) when we are around animals.

I have no romantic notion of this. I still have to work hard to be human (and humane) as part of the discipline of my profession. I have to be mindful of the fact that Bishop is not always appropriate for every client (in our suite of rooms we keep one that is a dog free zone for those with allergies or fears and another closed off room where Bishop will comfortably stay if I need to keep him out of the waiting room)…

He is an incredible asset…

Reprinted from *Psymposium* (2001, May) with permission (copyright 1998, Psychologists' Association of Alberta).

2.3.2 Use the Person's Relationship with Their Own Pet:

If a client has their own pet at home, then the therapist could use the client's relationship with their animal in the therapeutic process (Mayes,

1998). If appropriate, the client could bring their pet to therapy or the therapist could have the client do specific assignments with their pet between therapy sessions. This would allow the therapist to use the bond that the client has already established with their animal to help the client during difficult times.

Case Study:

I have one 10-year old female client that I have, in cooperation with the child's mother, engaged in an AAT program utilizing a guinea pig. The guinea pig belongs to me but is currently in the custody of this particular little girl. We established specific goals around this project, one of which involves the child maintaining a daily journal concerning the guinea pig. The child's weekly therapy sessions with me occur in her home and revolve around "B.B." the guinea pig.

Taken From*: Mayes, P. (1998, spring). 'Therapetic' solutions for troubled children.* Newsletter of the Human Animal Bond Association of Canada. *p.3.*

The therapist could also engage the client in specific pet-related activities, even if the client does not yet have their own pet. For example:

Several years ago, a 15-year-old boy, who was diagnosed as being depressed, was referred to my office. When he entered the waiting room he became very intrigued with the fish tanks. It seemed that over the years he had developed a strong interest in tropical

fish. This common interest appeared to enhance our therapeutic rapport quickly. During the next six months, our common interest went beyond talking about and observing the fish, to a higher level of involvement. After careful consideration and planning, we both believed that putting together a 60-gallon saltwater tank would be therapeutically beneficial for him. Indirectly and directly, his involvement and efforts in helping select the fish, plants, scenery, and rocks not only enhanced our bond but definitely appeared to diminish his sense of demoralization. Jeff had something to look forward to. His drive to fight off his lethargy and helpless thoughts seemed to be impacted by the sight of a new environment that he helped design and build. He would frequently stop at the office to check on the fish, taking pride in his accomplishments. Although Jeff continued to battle with his depression, he also continued to find refuge and support in the tank he established. The partnership we established in developing the tank was a definite asset to our working relationship.

*Taken From***:** Fine, A. (2000). Animals and therapists: incorporating animals in outpatient psychotherapy. **In** A. Fine (ed.) *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (p. 184). San Diego, California, Academic Press.

2.4 Summary

In addition to benefits of AAT already noted in this chapter, bringing animals to work can also result in

fringe benefits. For example, therapists who employ their animals as co-therapists indicate they have increased job satisfaction (Mason & Hagan, 1999). In addition, the animal serves to create an office with a homier atmosphere, making the therapist appear more approachable. This could ultimately result in lower cancellation rates and increased business. Therapist Betty Hodnefield relates that her canine co-therapist, Bernard, is quite a local attraction. He can often be seen sitting in the front window of the social services building that they work out of, much like "that doggy in the window" of a pet store. Betty believes that Bernard helps reduce the stigma of going to a "social services" building. In fact, clients have actually brought their spouses or their animal friends in to see Bernard and other people will come in just to see him and ask questions about him. (B. Hodnefield, personal communication, 2002)

Despite the numerous potential advantages of AAT, it is important to realize that the quality and effectiveness of AAT will vary according to the knowledge, skill, and experience of the therapist, and the different training, temperament, and aptitude of the companion animal. It is also important to note that, no matter how much we love and value our animals, not all clients are animal people and some may not respond to the inclusion of an animal in therapy. However, for those that do respond, the therapeutic partnership with an animal may be limited only by one's imagination. As psychologist Ruth Shell so eloquently writes: "*Working with an animal partner who is unfamiliar with theory adds a dimension that reduces the intellectual, and invites spontaneity. With my*

clients, I certainly witness a rather magical quality of communication that occurs because of [my dog] *Lucy, and that promotes growth and health in all of us."* (Shell, 2002)

2.5 References

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC.

Arambasic, L. & Kerestes, G. (1998). The role of pet ownership as a possible buffer variable in traumatic experience. **In** *8th International Conference on Human Animal Interactions, Animals, the Changing Role of Animals in Society*, **Sept. 10-12**, Prague.

Ascione, F.R. (1992). Enhancing children's attitudes about the humane treatment of animals: generalization to human-directed empathy. *Anthrozoos,* **VI (4)**, 226-247.

Barker, S.B. & Dawson, K.S. (1998). The effects of animal-assisted therapy on anxiety ratings of hospitalized psychiatric patients. *Psychiatric Services*, **49,** 797-801.

Beck, A.M., Seraydarian, L. & Hunter, G.F. (1986). Use of animals in the rehabilitation of psychiatric inpatients. Psychological Reports, **58**, 63-66.

Bergesen, F.J. (1989). The effects of pet facilitated therapy on the self-esteem and socialization of primary school children. *5th International Conference on the Relationship Between Humans and Animals, Monaco.*

Corson, S.A., O'Leary Corson, E.O. & Gwynne, P.H. (1974). Pet-facilitated psychotherapy. **In** R.S. Anderson (ed.), *Pet Animals and Society* (30-31). London: British Small Animal Veterinary Association.

Corson, S.A., O'Leary Corson, E., Gwynne, P.H., & Arnold, L.E. (1977). Pet dogs as nonverbal communication links in hospital psychiatry. *Comprehensive Psychiatry,* **18**, 61-72.

Cousins, N. (1989). *Head first: the biology of hope*. New York, E.P. Dutton.

Covert, A.M., Whiren, A.P., Keith, J. & Nelson, C. (1985). Pets, early adolescence and families. *Marriage and Family Review*, **8(3-4)**, 95-108.

The Delta Society (2001). Pet Partners Team Training Course manual.

The Delta Society (1996). The Human-Animal Health Connection: Standards of practice for animal-assisted activities & therapy.

The Delta Society (1997). Animal-Assisted Therapy, Therapeutic Interventions.

Fine, A. (2000). Animals and therapists: incorporating animals in outpatient psychotherapy. **In** A. Fine (ed.) *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (179-211). San Diego, California, Academic Press.

George, H. (1988). Child therapy and animals: a new way for an old relationship. **In** C.E. Schafer (ed.), *Innovative Interventions in Child and Adolescent Therapy* (400-418). New York: John Wiley and Sons.

Hoelscher, K. & Garfat, T. (1993). Talking to the animals. *Journal of Child and Youth Care,* **8**, 87-92.

Klotz, K. & Franklin, B. (1999). *Interactions*, Delta Society, The Human-Animal Health Connection.

Levine, M.M. & Bohn, S. (1986). Development of social skills as a function of being reared with pets. Living together: people, animals and the

environment. *Delta Society International Conference*, Boston, MA.

Levinson, B. (1965). Pet psychotherapy: use of household pets in the treatment of behaviour disorder in childhood. *Psychological Reports*, **17**, 695-698.

Levinson, B. (1961). The dog as "co-therapist." **In** *Annual Meeting of the American Psychological Association*, New York City.

Mallon, G.P. (1994). Cow as co-therapist: utilization of farm animals as therapeutic aides with children in residential treatment. *Child and Adolescent Social Work Journal*, **11**, 455-474.

Mallon, G.P. (1999). Animal-assisted therapy interventions with children. **In** G.P. Schafer (ed.), *Innovative Psychotherapy Techniques in Child and Adolescent Therapy, 2nd ed.* (415-434). New York, John Wiley and Sons.

Mason, M.S. & Hagan, C.B. (1999). Pet-assisted psychotherapy. *Psychological Reports*, **84**, 1235-1245.

Mayes, P. (1998, Spring). 'Therapetic' solutions for troubled children. Newsletter of the Human Animal Bond Association of Canada, *p.3.*

McCulloch, W.F. (1984). An overview of the human-animal bond: present and future. **In** A. Katcher & A. Beck (eds.), *New Perspectives on Our Lives with Companion Animals.* Philadelphia, University of Pennsylvania Press.

McIntosh, S. (2001, Dec). Four legged therapists reach children in need. *Synchronicity*.

McIntosh, S. (2002). *An Introduction to Equine Facilitated Counselling*. Self-published.

Melson, G.F. (1990). Pet ownership and attachment in young children: relation to behavior problems and social competence. *Annual Meeting of the Delta Society*, Houston, TX.

Nebbe, L. (1994). Animal-assisted activities/therapy as an animal and human welfare project. *Humane Innovations and Alternatives*, 8.

Peacock, C. (1986). The role of the therapeutic pet in initial psychotherapy sessions with adolescents. *Delta Society International Conference,* Boston, MA.

The Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program*.

Poresky, R.H. (1996). Companion animals and other factors affecting young children's development. *Anthrozoos,* **9(4)**, 159-181.

Reichert, E. (1994). Play and animal-assisted therapy: a group treatment model for sexually abused girls ages 9-13. *Family Therapy*, **21(1**), 55-62.

Robin, M. & Bensel, R. (1985). Pets and the socialization of children. *Marriage and Family Review*, **8(3/4)**, 63-78.

Salomon, A. (1995). Animals as a means of emotional support and companionship for children aged 9 to 13 years old. *Conference on Human Animal Interactions, Animal Health, and Quality of Life*, **Sept 6-9**, Geneva, Switzerland.

Shell, R. (2002, manuscript in preparation). Moments of magic: animal-assisted interventions in a psychotherapy setting.

Shertzer & Stone (2000). Fundamentals of counseling 2nd edition. **In** L Catford (ed.), *Psychology 307: Humanistic, Existential and Transpersonal*

Psychology. A Book of Readings (pp. 214-228), Rohnert Park, CA, Sonoma State University.

Smith, S. (1983). Interactions between pet dogs and family members: an ethological study. **In** A. Katcher & A. Beck (eds.), *New Perspectives on Our Lives with Companion Animals.* Philadelphia, University of Pennsylvania Press.

The Therapy Dog Training Institute (1999). *Utilizing therapy dogs in mental health settings.*

Triebenbacher, S.L. (1994). *Pets as Transitional Objects: Their Role in Children's Emotional Development.* Department of Child Development and Family Relations, School of Human Environmental Sciences, East Carolina University, Greenville, N.C.

Wells, E.S., Rosen, L.W. & Walshaw, S. (1997). Use of feral cats in psychotherapy. *Anthrozoös*, **10**, 125-130.

Wilson, C.C. (1991). The pet as an anxiolytic intervention. *The Journal of Mental and Nervous Disease*, **179**, 482-489.

Wilton, T. (2001, May). What We Do. *Psymposium*, **11(1**), 6-7.

Chapter 3

Guidance for Implementing Animal-Assisted Therapy Programs

Humankind is drawn to dogs
because they are so like ourselves –
bumbling, affectionate, confused,
easily disappointed, eager to be
amused, grateful for kindness and
the least attention.

Pam Brown

Chapter 3.0

3.1 Standards for Animal Selection

The Delta Society recommends that before becoming involved in AAT, an animal should pass a three-part screening of health, skills, and aptitude. The skills and aptitude screen test not only the animal, but the animal/handler team as well (i.e., how well they communicate with each other and work together).

Animals are evaluated to determine if they are:

- Sociable and people-oriented
- Comfortable being touched
- Suitable for AAT
- Able to enjoy AAT
- Reliable and predictable
- Controllable at all times
- Able to cope with stressful situations and high emotions.

In 1996, the Delta Society published a handbook called *Standards of Practice for Animal-Assisted Activities and Therapy*. According to *Standards of Practice*, the most important selection criteria for animals involved in AAT are reliability, predictability, controllability, suitability, and ability to inspire confidence (Fredrickson & Howie, 2000). Some aspects which will impact these selection criteria are as follows:

If your dog doesn't like someone, you probably shouldn't either. -- Anonymous

3.1.1 Problem or Unacceptable Behaviours:

There are some behaviours that are problematic and/or not acceptable for a therapy animal to display. Some problem behaviours may serve as a valuable teaching tool during AAT and be easy to correct over time. However, if an animal demonstrates unacceptable behaviour that is difficult to extinguish, then the animal is likely not suitable to participate in AAT.

Some examples of problem behaviours in dogs are:

- Jumping Up – this behaviour is especially problematic with large dogs, but can pose a problem with smaller breeds as well. If a dog jumps on a client, the client may lose his/her balance. Even if the dog is jumping because he is excited to see the client, the client may become frightened from the physical aggressiveness of the dog. In addition, there is more chance of the dog scratching a client if it jumps up.

- Nipping, Biting, and Mouthing – it is never appropriate for any dog to use its teeth on a person, even if it is in play.

- Inappropriate Urinating – dogs who instinctively "mark" their territory must not display this behaviour in AAT programs. Additionally, if a dog urinates when they are excited, stressed, or being submissive to a human or animal, then they are not appropriate for AAT unless the problem can be corrected.

- Excessive Sniffing – this behaviour needs to be discouraged or, at least controlled, in AAT to avoid client discomfort with the animal.

- Excessive Vocalization – whining, barking or howling need to be controlled in AAT because these vocalizations will likely not be welcomed by colleagues or clients.

- Inappropriate Eating – it would be helpful in therapy work if the dog is trained to eat only what is offered with the approval of the handler. Otherwise, the dog may "go into business for himself" and bother clients by begging or cajoling them for food.

Taken From: The Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program.*

3.1.2 Age and Health Status:

It is recommended that dogs less than one year of age do not participate in AAT. It is thought that puppies have less predictable behaviour and that their exuberance may increase the risk of accident or injury.

Older dogs can also carry additional risk. For example, dogs with orthopedic problems such as arthritis may be less patient and more easily stressed. It is essential that handlers know their dogs well and are able to recognize and respond to their dog's individual circumstance.

Dogs with health problems may exhibit behaviours

that are not acceptable in an AAT program. The Pet Therapy Society of Northern Alberta recommends the following health screens for animals participating in AAA/AAT:

Recommended annual immunizations include:

- ✓ Rabies
- ✓ Distemper
- ✓ Hepatitis
- ✓ Leptospirosis
- ✓ Parainfluenza
- ✓ Parvovirus

Parasite prevention methods include:

- ✓ Fecal Exam

Optional vaccinations or health screens may include:

- ✓ Heartworm
- ✓ Bordatella
- ✓ Giardia

Ongoing monitoring should include:

- ✓ Fleas
- ✓ Lice
- ✓ Ear Mites
- ✓ Mange
- ✓ Hot Spots

Taken From: The Pet Therapy Society of Northern Alberta (1999). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program*.

Health screening requirements will vary depending on personal or organizational beliefs and policies.

For example, some individuals will have limited vaccinations given to their animal, but will demonstrate the animal's immunity based on antibody levels in the blood. On the other hand, some organizations may require additional routine vaccinations or more frequent veterinary examinations due to a more vulnerable client population (e.g., the chronically ill or elderly).

In all circumstances, animals who show signs of ill health should be excused from AAT sessions until a licensed veterinarian deems them healthy and physically ready to resume their role.

3.1.3 Socialization:

An animal's socialization is one of the most important areas in assessing an animal's suitability for therapy work. To work well with clients, an animal must be comfortable being touched and handled by strangers. The animal must also be comfortable with frequently meeting new people. A dog that is shy or reluctant to approach strangers is not going to make your clients feel accepted and loved. On the other hand, a dog that is too friendly can also pose a problem. For example, an overly friendly dog that cannot be controlled by the handler may be overwhelming for a client.

Problem or unacceptable behaviours may be identified in the three-part screening that is recommended for animals before they participate in AAT. Chimo Project criteria require that the animal's health screen is performed by a licensed veterinarian to ensure that the animal is free from parasites, disease, and infections. Skills are tested

In order to keep a true perspective of one's importance, everyone should have a dog that will worship him and a cat that will ignore him. -- Dereke Bruce

with the Canadian Canine Good Citizen Test (CCGC; see Appendix A). This test demonstrates whether or not the animal has basic obedience skills and can be effectively controlled by the handler. The aptitude test used for the Chimo Project (see Appendix B) was developed by the Pet Therapy Society of Northern Alberta, and incorporates some of the things that The Pet Therapy Society looks for when they are screening animals for their programs. The aptitude test is used to help determine if the animal has the capacity, desire, ability, and potential to work in a specific therapeutic environment (for the Chimo Project, the primary environment is a therapist's office).

The ultimate reason for the screening is to determine, as accurately as possible, that the animal is safe and reliable. The screening process is thought to give a comprehensive picture of the animal. One difficulty with screening is that it is often conducted in an environment that the animal is not familiar with (e.g., a training facility or large group area). Unless the animal is also tested in the actual environment where they will be working, the evaluator may not get a complete picture of the animal or its capabilities/limitations.

If you are considering working with an animal, it is your responsibility to be honest about the animal. Even if the animal passes the screening, do not use the animal in AAT if he exhibits unpredictable behaviour. Rationalizing the unpredictable behaviour by noting unusual circumstances that caused it does not make the behaviour any less of a concern.

In addition to findings from the screening process, therapists must also consider what type of animal would be a good adjunct for their practice. For example, some animals may be more appropriate for children than adults. It is important for therapists to determine what animal characteristics or qualities will best serve their needs.

For more thorough and detailed information on animal selection and criteria for AAT programs, the following publications are recommended:

- *Standards of Practice for Animal-Assisted Activities and Therapy.* The Delta Society 1996.
- *PAWS in Your Facility.* The Pet Therapy Society of Northern Alberta 2000.
- *Handbook on Animal-Assisted Therapy.* A. Fine, ed. 2000.

3.2 Guidelines for Training and Orientation

3.2.1 Training in AAT Techniques:

Therapists considering incorporating animals into their practice must seriously consider the factors of liability, training, and the safety and welfare of both the animal and the client. Hines and Fredrickson (1998) and the Delta Society's Pet Partners program strongly advocate that health care professionals have training in techniques of AAT. Therapists who live in Alberta, Canada can have their animals screened by the Pet Therapy Society of Northern Alberta (www.paws.shopalberta.com). The Pet Therapy Society also offers a pet education workshop where animals and handlers are educated and evaluated for AAA and AAT participation. For

those clinicians living elsewhere in North America, the Delta Society offers a one-day workshop or a home study course for AAA/AAT. Furthermore, there are a few programs that offer specific training in the field of AAT. (See Section 3.5 below for a listing of known programs). It has been suggested that, without adequate training on how to apply AAT, therapists may not incorporate animals into their practice in the best way possible and, thus, may get inferior results (Hines & Fredrickson, 1998).

3.2.2 Administrative Support and Policy Development:

The first step in establishing an AAT program is to obtain administrative approval from the appropriate authority. This will usually require a well-developed proposal, including risk management policies. Do not expect to obtain universal enthusiasm for your request, and do anticipate concerns, fears, and objections that others will bring forward. Be well prepared to respond to administrative and staff issues, such as:

- What about the risk of disease, infection, or allergic reactions?
- How do you ensure that the animals will be clean?
- Will this increase our workload?
- What if someone is scratched or bitten?

(Pet Therapy Society of Northern Alberta 2000. *PAWS in Your Facility*).

It is important to use a multidisciplinary approach to planning, policy development, and implementation

of the AAT program. The success of the AAT program depends on the acceptance of the program by staff members from all disciplines. With input from all staff members, policies will need to be drafted to address risk management concerns, responsibilities, and animal welfare issues. Examples include:

- Animal health screening policy – define what is required, how often the information must be updated, where paperwork will be located.
- Animal welfare policy – address issues such as animal elimination area, rest area, exercise area, conditions that contraindicate AAT.
- Infection control policy – hand-washing policy, off-limit areas for animals.

(Pet Therapy Society of Northern Alberta, 1999. *PAWS in Your Facility*).

Staff members will contribute tremendously to an AAT program by bringing forward real issues and concerns from their respective areas. If staff are satisfied that their issues have been properly addressed, the AAT program has a much better chance of running successfully.

3.2.3 Program Planning and Design:

Before planning an AAT program, it is important to define what you envision as the ideal AAT program for the organization. The following questions will help guide this process:

- What clients will be eligible for AAT?
- What clients are not eligible for AAT? What if some of the excluded clients would like to be involved in AAT?
- Who is responsible for orientation and supervision of the program, including volunteers?
- How will staff or volunteers who participate in the program be supported by the organization?
- What steps need to be taken to manage risks associated with the AAT program?
- How will ongoing risk-management issues be monitored?
- Who will screen and evaluate animals?
- Who will evaluate the AAT program?

AAT programs will differ depending on the specific needs and vision of a particular organization but, with careful planning, an AAT program can be effectively incorporated into the organization.

3.3 Liability Issues

Organizations and/or individuals involved in AAT need to consider the potential for liability issues to arise during therapy due to inherent risks that come with having animals on-site in a mental health organization. Thus, the organization must ensure

that their insurance policy includes AAT and that liability coverage is for staff, volunteers, and clients (Fine, 2000).

3.3.1 Non-Profit Organizations:

Volunteers and non-professional animal-handlers who have successfully completed a training program in AAT, are often covered by the non-profit training organization's liability coverage. For example, the Pet Therapy Society provides insurance for animal-handler teams they have personally screened, during the course of volunteer visits to approved facilities. Likewise, the Delta Society offers protection for non-professionals who have completed their training program. Unfortunately, this coverage is not extended to professionals who practice AAT.

3.3.2 Homeowner's and Renter's Insurance:

Professionals may have a more difficult time securing liability coverage, even if they have completed a training course on AAT. Often, homeowner's insurance will cover bodily injuries to others, but if your dog bites a client and the client sues for damages, you will have to prove that you had rigorous controls in place to prevent the incident. Some homeowner insurers may refer you to private insurance companies for liability coverage.

3.3.3 Professional Liability Insurance:

In some instances, professionals and their practice may have coverage for AAT through their

professional liability insurance. The insurance policies will vary, depending on the carrier, but many neither include nor exclude coverage for bodily injury as a direct or indirect result of using AAT. It is important to read your contract and then contact the carrier if explicit clauses for AAT need to be incorporated into the policy. Some insurance carriers will charge a fee to add a specific clause to the policy, whereas others will include the clause in your policy at no charge.

3.4 The Chimo Project and the Future

As previously mentioned in this manual, there is a need for therapists to utilize various techniques and strategies that will help to engage a client in the therapeutic process. The Chimo Project is investigating the impact an animal has when added to a therapist's armamentarium of treatment techniques. It is anticipated that, in the long-term, more varied and effective therapeutic tools and techniques may:

1) lead to a reduction in the number of dollars spent on mental health care, due to reduced treatment time;
2) result in more people contributing to a greater degree to the tax base of the province; and
3) lead to a reduction in the use of mental health facilities.

The Chimo Project aspires to be an active catalyst by encouraging or providing practical services with animals. Together with other organizations, the

Chimo Project is interested in playing a key role in the following initiatives:

1. *"Breaking Down the Barriers"* – Using information collected in the Chimo Project, this initiative will focus on researching methods that will allow more people with mental health issues to own an animal or to have regular access to the healing benefit of animals. The objectives of this initiative are to:
    a) Research legislation that may inhibit the interaction with animals by those with mental health concerns.
    b) Investigate current barriers to animal ownership (e.g., housing that does not allow animals, limited financial resources to provide appropriate care, lack of free education and training about animal care, and limited support programs for animal loss).
    c) Develop recommendations to help professionals provide clients with appropriate information about obtaining an animal, assist hospitals and outpatient facilities in providing ongoing human-animal relationships, allow people to have regular access to an animal without full ownership, and encourage changes to legislation that pose a barrier to the individuals with mental health concerns working with an animal.

2. *Post Secondary Educational Development* – The goal of this initiative is to provide mental health professionals with educational opportunities to learn about using AAT as a therapeutic adjunct. This initiative will focus on developing course curricula for AAT programs in conjunction with schools of therapy in Alberta, and then across Canada. The objectives of this initiative are to:
    a) Research all AAT programs that are offered in post-secondary institutions, worldwide, to determine what information may be practical for Alberta- or Canada-based AAT courses.
    b) Collaborate with various school faculties to determine the most effective methods to train potential mental health professionals to use AAT as an adjunct for treating mental health issues.
    c) Use the manual produced in the first phase of the Chimo Project, in conjunction with the data gathered from the project, as tools for curriculum development.
    d) Collaborate with various school faculties to recruit appropriate academic staff to teach AAT courses.
    e) Develop AAT course curricula in conjunction with academic staff.
    f) Recommend methods to encourage or continue AAT course development and implementation through higher learning channels.

3. *Community Partnership Development* – This initiative will focus on establishing collaborative research projects with community agencies. These projects will include expansion of the current project's criteria, such as:
    a) Inclusion of more and different psychiatric diagnoses – including acute onset symptoms, such as grief and bereavement.
    b) Inclusion of group therapy, family therapy, and/or individual therapy – including short-term or brief therapy that encompasses a limited number of sessions; and more intensive involvement of the animal in the therapeutic process.
4. *Primary Educational Initiative* – The purpose of this initiative is to adapt the AAT manual produced by the Chimo project and to make it available to Edmonton-area public and private schools. Seminars and orientation sessions will also be available to counselors in the school system so they can learn more about how to use AAT.

It is hoped that through these types of initiatives, individuals in Canada suffering from mental illness will have practical access to AAT and/or more accessible information on the benefits of the human-animal bond.

3.5 Selected AAT Training Courses and Degree Programs

Life plus a cat adds up to an incalculable sum. -- Ranier Maria Rilke

According to Turner (2000), a number of universities in North America have curricula in human-animal relations. Unfortunately, few of these curricula are designed for mental health therapists. Below is a list of some known places where AAT curricula exist:

- Camden County College, Blackwood, NJ
- Certificate program in AAA & AAT, Centenary College, Hackettstown, NJ
- BS in Equine Studies, includes elective in Therapeutic Riding Instruction, Harcum College, Bryn Mawr, PA
- Joint venture program with the Devereaux Foundation and the University of Pennsylvania.
- Two-semester certificate program in AAT through the Veterinary Department, Mercy College, Dobbs Ferry, NY
- BS in Veterinary Technology with special program in PAT, North American Riding for the Handicapped Association (NARHA), Denver, CO
- Therapeutic riding instructor training courses, held at NARHA-member centers in California, Connecticut, South Carolina, and Texas
- BA in Therapeutic Riding, Tufts Center for Animals and Public Policy, North Grafton, MA
- MS in Animals and Public Policy, University of California, Davis, CA and University of Findlay, Findlay, OH

- BS in Equestrian Studies, University of New Hampshire – Thompson School of Applied Science, Durham, NH
- Associate Degree Program in Applied Animal Science, Small Animal Care. Electives in AAA/T and the Human-Animal Bond, University of Minnesota, Minneapolis, MN
- CENSHARE-Center to Study Human-Animal Relationships & Environments, People, Animals, Nature, Inc. (PAN, Inc.) certificate program in AAT
- Two–year program for continuing education in AAT for professional therapists in Zurich, Switzerland.
- Continuing education in human-animal relations at University of Southampton and University of Cambridge, UK.

[Information from: McIntosh (2002) and Turner (2000)].

3.6 References

The Delta Society (1996). *The Human-Animal Health Connection, Standards of Practice for Animal-Assisted Activities and Therapy.*

Fine, A. (2000). Animals and therapists: incorporating animals in outpatient psychotherapy. **In** A. Fine (ed.), *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp. 179-211). San Diego, California, Academic Press.

Fredrickson, M. & Howie, A.R. (2000). Guidelines and standards for animal selection in animal-assisted activity and therapy programs. **In** A. Fine (ed.), *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp. 99-

114). San Diego, California, Academic Press.

Hines, L. & Fredrickson, M. (1998). Perspectives on animal-assisted activities and therapy. **In** C.C. Wilson & D.C. Turner (eds.), *Companion Animals in Human Health* (pp. 23-39). Thousand Oaks, CA, Sage Publications.

McIntosh, S. (2002). *An Introduction to Equine Facilitated Counselling*. Self-published.

The Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program.* Edmonton, Alberta.

Turner, D.C. (2000). The future of education and research. **In** A. Fine (ed.), *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp. 449-459). San Diego, California, Academic Press.

Chapter 4

Monitoring and Evaluating Animal-Assisted Therapy Programs

My wife claims I love my toy poodle Missy more than I love her. Just once, she wants me to be as excited to see her as I am Missy. But Doc, it ain't gonna happen. Ya see, when I get home from a long day in the cab, dead tired, I open the door and there are the two of them looking at me, Ma and Missy. Ma has a scowl on her face and is ready to tear into me. Missy, on the other hand is shaking all over; she's that happy to see me--her face is grinning so wide she could eat a banana sideways. Now who do you think I'm gonna run to?

Chicago Cab Driver

Chapter 4.0

In this manual, you have read many accounts of positive therapeutic results being achieved by working with an animal. But how do you measure these effects? This chapter will briefly describe some techniques you can use to help evaluate your AAT program.

4.1 Performance Indicators

Performance indicators are measurement tools used to help determine if programs meet our expectations, by acting as guides to monitoring and evaluating aspects of a program that affect client outcomes. The development of performance indicators can help therapists focus on those things that are really important to them and to their clients. It may be helpful for therapists to plan, up front, how they will decide if their AAT program is a success. This will also help determine what they need to measure in order to know how well the program is doing. Some key questions may include:

- Which activities are appropriate and effective?
- Which activities are efficient and how efficient are they?
- Which processes need to be improved?
- What evidence is there that client outcomes have improved?

Examples of performance indicators that may begin to address these questions include:

- Number and percent of clients who agree to include an animal in the therapy session;
- Number and percent of clients who come to their scheduled appointment (if possible, compare AAT clients with non-AAT clients);
- Number and percent of clients who are on concurrent medication for their mental health illness (if possible, compare AAT clients with non-AAT clients);
- Length of time clients are seen, prior to discharge (if possible, compare AAT clients with non-AAT clients);
- Number and percent of clients who achieve therapeutic gains and are discharged;
- Number and percent of clients who have increased knowledge about animal care; and
- Number and percent of clients who report satisfaction with the AAT program.

Of course, the information that is obtained will ultimately depend on what data is routinely collected and available.

4.2 Outcome Measures

After the performance indicators are established, the measures to be used to monitor the success of the program will be easier to select. Much of the data may come from routine program statistics (e.g., admissions, discharges, length of stay, wait time). However, client-related outcome data may be obtained for individual clients using any of the following:

1) Standardized psychological instruments that are administered on a regular basis;

2) Direct observation and documentation of specific behaviours;
3) Surveys or questionnaires that capture specific, but subjective information; or
4) Therapist progress notes.

These measures can provide information about the client's therapeutic progress. However, in most cases, the data will not help determine why or how the change occurred. In other words, the data will not necessarily provide evidence that the client's progress (or lack of progress) is the direct result of AAT. Thus, regardless of what outcome measures are chosen to evaluate an AAT program, it must be recognized that unless the presence of the animal in the therapy session is controlled for, it is not possible to make unequivocal claims about an animal's impact in therapy. The outcome measures used for the Chimo Project are described below to provide an example of an AAT program evaluation strategy.

Several outcome measures are being monitored for clients involved in the Chimo Project. Therapists involved in the project are asked to create specific goals for each client on a session-by-session basis. At the end of each session, the therapist and the client fill out a questionnaire. The therapist's questionnaire (see Appendix C) addresses specific information from that particular session and, if an animal was present, the therapist's feelings about the helpfulness of the animal. In addition, the therapist is asked to indicate what the goals of the session were and whether, in their opinion, the goals were attained. The client's questionnaire (see Appendix D) asks specific questions about the

therapy they received in the session and, if an animal was present, the client's feelings about the presence of the animal. The questionnaires take five to ten minutes to complete following each session. Because there is a paucity of empirical investigation into the efficacy of AAT, itself, instruments assessing its efficacy are unavailable. As a result, the questionnaires mentioned above were developed by the Chimo Project. Although the questionnaires do not have established psychometric properties, they are designed to quantify anecdotal information. In addition to these subjective data sources, therapists are also asked to provide case studies, where possible.

The Chimo Project is interested, not only in the subjective information obtained from the questionnaires described above, but also in measuring the clients' response to therapy (i.e., their therapeutic progress). The primary sources of data collection used here are standardized psychological rating scales. Because the Chimo Project is focusing primarily on individuals with depression or anxiety, the Beck Depression Inventory and the Beck Anxiety Inventory are used to measure levels of depression and anxiety, respectively. These standardized scales are administered at the very beginning of therapy, then every two months until the end of the project (or until the client is discharged). In this way, therapeutic progress can be monitored and treatment gains can be measured.

In essence, you can choose or develop outcome measures that best fit your practice and that provide you with the information you wish to obtain. The most important point is that you do what you can

(based on how much time and how many resources you are able to allow for data collection and analysis) to actively evaluate your therapy program. The measures you use will likely change and become more refined as your program evolves. The data you collect should provide you with information that can be used to improve processes and, ultimately, client outcomes.

4.1 4.3 Efficacy

It is important to assess the reliability of the data collected to monitor a program. This will help avoid premature and inappropriate conclusions. Indicator and outcome results that are based on unreliable data are always invalid. Some factors that may influence results include missing or incomplete records, incorrectly recorded information, inconsistent administration of measurement tools (e.g., surveys), and misinterpretation of questions.

It is also important to determine whether the data provides useful information or is valid for determining program efficacy. Dr. Dean Ornish from the University of San Francisco Medical Center warns that we need to be careful not to become so obsessed with the scientific method that we forget what is important. He says, "We think if we can't measure it, it does not exist. But who can measure love?" This is very true for AAT programs. Thus, it is important to recognize what information you will and will not obtain with the measures you have chosen, and then revise them as necessary. Good measurements for program monitoring are dynamic and are often changed as needs and requirements change.

No man can be condemned for owning a dog. As long as he has a dog, he has a friend; and the poorer he gets, the better friend he has. -- Will Rogers

4.4 Testimonials as Outcome Measures

It is difficult to measure the internal emotional benefits a client may experience when an animal is involved in a therapy session (Shell, 2002). Diamond Davis states that "*Therapy dogs often help people without anyone knowing exactly how*...[they] *provide people with emotional benefits through the use of [their] social instincts and social skills*" (Davis, 1992, p.1). Thus, anecdotal accounts (or testimonials) from therapists, but especially from clients themselves, can provide powerful information that can be included in a program evaluation. Even though these testimonials are highly subjective, they can provide detailed information that captures emotional experiences and thoughts about AAT. This information can be useful when interpreting data collected from a program, and may help to highlight discrepancies between measurement instruments.

Ruth Shell shares a letter she received from a client of a colleague about Ruth's dog, Lucy. This client had weekly contact with Lucy in the waiting room until Ruth moved her practice to a different location.

> *Although I am not Ruth Shell's patient, I benefited so much from the brief moments I spent with Lucy in the waiting room. Her exuberance and delight in seeing me always buoyed my spirits, as I waited to see my own therapist. After greeting me on one occasion, she followed Ruth into her office, but then returned and buried her head in my skirt. Somehow, she knew how sad I felt that day,*

and I was so grateful for her comforting act.

I am most anxious at the beginning of a therapy session, but I found I could relax by talking about Lucy. It is very difficult for me to talk about deep emotional feelings, but through Lucy, I began to feel comfortable doing this. Lucy's most endearing charm is her ability to make you feel special, and that was a great source of comfort and encouragement as I tried to face the painful aspects of my past. Initially, I couldn't understand why Lucy would want to see me, but over time, I realized that she gives her love unconditionally and unselfishly. What a beautiful way to learn to trust and to acknowledge my own self worth!

Taken From: Shell, R. (2002). Moments of Magic: Animal-assisted interventions. *In preparation.*

The following are some examples of testimonials that therapists and their clients shared with the Chimo Project regarding AAT programs:

…when I first moved to Bosco Homes I was very depressed and I shut everyone out. I didn't want to talk about my problems so I would get angry at my therapist and I would sometimes cry and won't say anything at all but as the months gone by I have started to trust staff and when I gone to therapy [the therapist] asked me if I wanted to do pet therapy so I said yes because I love animals. After awhile I liked going to therapy because

Nobody can fully understand the meaning of love unless he's owned by a dog. -- Gene Hill

of my therapy dog. Whenever I was feeling uncomfortable he would sit on my lap and I felt better…

Letter presented at the 2002 Annual General Meeting for Bosco Homes, Edmonton, Alberta.

Why I Love My Dog

I have a dog named Drew,
He's always there for me when I am blue,
He listens caringly to what I have to say,
No matter place, time, or day.

Drew is a positive role model,
Even though sometimes he tends to doddle!
I love him dearly with all my heart,
And was sad when we had to part.

He plays with me and makes me great,
He's the best friend anyone could ever make.

My dog is like my best friend. I would do anything for him. I love him to death. He is the sweetest thing to me on Earth. He always knows when I am feeling uncomfortable or sad. He is not like a person…he would never turn on me. He would never stop listening when he heard something that he didn't want to hear. He will always be in my heart.

From: Crystal, age 16, 2002.

I work with a dog named Nelson in Pet Therapy. Nelson makes me feel good to be

with. I love Nelson because he's cuddly and he likes to be with me. I am teaching him lots of things like sitting, going through hoops and staying. He is special to me. I can always count on him to visit me. When I am having a bad day, he makes me happy. I love Nelson.

From: Brandy, age 16, 2002.

What is a cat?

They are perfect
They are meek and grateful
Their love runs bottomless
Their love is unquenchable
They heed not of your masquerade
Of your age or hair hue
They reflect not of if you are the most
contemptible soul in the human race
They merely care of your woes and conquests
They care of your day
They care if you are not feeling sound
They come to soothe you if you are gloomy
They never criticize
They love your home just the way it is
They love you just the way you are
But if you alter
They will still love you
For that is of all they identify
That is of all they care
Love
They love you

From: Devon, age 17, 2002.

My pet's name is Cutie. She is a cat. I love her because she is friendly, kind, and nice to be around with. She is fun to play with. She is cuddly and she likes cuddling with me. I like to take her for walks. She is very cute! Most of all, I like to take care of her. She listens to me and always knows when I am sad or sick. I love her and always will.

From: Connie, age 14, 2002.

On December of 1996, I got my first dog Holly. She's a Collie. She came in a brown box with a red ribbon tied around her neck. At first sight, I fell in love with her instantly. For the past 5 years, she has been my best friend through lots of ups and downs. I love her so dearly. She is one of the best things that have ever happened to me. She's there when you need her; she's the sweetest thing on earth. She is a very accepting dog…she never judged me. She is an angel sent down from heaven.

From: Jami, age 13, 2002.

"I don't think a day passes without someone saying they were looking forward to coming to see Bishop [a canine co-therapist]."

From: T. Wilton, psychologist, 2002.

4.5 Safety

There are many components to a safe AAT program. Characteristics of the animal, client, and environment must be taken into consideration, in addition to health concerns. The following sections highlight some safety components of AAT programs that should be monitored on an ongoing basis.

4.5.1 Stress:

It is important to recognize signs of stress in your dog, especially while he is participating in AAT. His "work" may be tiring and stressful and it is your responsibility to be able to recognize when he needs a break. Dogs may be reaching their stress threshold if they start to pant or drool, shiver, or if their paws become sweaty. Once a dog reaches his threshold, learning stops and safety may be compromised. Some signs of stress in dogs may include:

- shaking
- excessive dandruff
- dilated pupils
- excessive blinking
- piloerection
- loss of appetite (refusing a treat)
- sudden onset of excessive shedding
- diarrhea
- yawning
- sniffing
- licking lips
- scratching
- restlessness, distraction, agitation
- sweating through the pads of the feet

- inappropriate urination/defecation
- "shutting down" by turning away or avoiding eye contact
- shyness, reluctance to approach people
- increased activity or pacing
- panting and salivating
- whining, excessive vocalizing
- hiding behind the handler
- need for repeated commands

Every animal reacts differently to its environment. Dogs have the ability to calm themselves in the face of a fearful or stressful situation and to calm each other as well. Calming signals (known to psychologists as "displacement behaviours") are ways that dogs release nervous energy. Calming signals use a dog's natural "language" to maintain a healthy social hierarchy and resolve conflict within a pack. By observing your dog's calming signals, you can recognize when your dog is stressed. Interestingly, some calming signals can be imitated by humans to help them communicate with dogs.

Turid Rugaas of Norway has studied dogs for most of her adult life and has identified a variety of calming signals used by dogs, including:

- Turning the head, turning away
- Moving slowly/freezing
- Moving in an arc
- Sniffing the ground
- Lip licking
- Sitting, lying
- Blinking, averting eyes, turning away
- Yawning

- Play position
- Wagging tail

Not surprisingly, calming signals often overlap with signs of stress, because they are essentially one and the same. For example, if a dog is feeling stressed he may yawn or sniff to calm himself.

Just as a client is more at risk of danger when an animal is stressed, an animal is also at risk of being harmed when a client is agitated or stressed. Thus, it is important for the therapist to recognize stress levels and take appropriate actions (e.g., place animal in kennel or remove them from the session) to maintain a safe working environment for their animal and the client, alike.

4.5.2 Health and Infection Control:

Monitoring animal health is a crucial component of AAT that is necessary to control the transmission of diseases. Zoonoses are infectious diseases that are transmitted under natural conditions from vertebrate animals to human beings. While transmission of zoonoses is relatively infrequent, it is important to be aware of the potential for transmission and to take steps to lessen the risk. Zoonoses can be transmitted from animals to people by 1) contact with an infected animal, its feces, or living environment; 2) a bite or scratch from the animal; and 3) inhalation. Thus, it is important to recognize the degree of risk of zoonoses, as well as steps that can be taken to minimize the risk of zoonoses.

Some of the most common zoonoses that are identified with companion animals are:

- **Rabies –** transmitted to humans through the bite of an infected animal (wild, domestic, or pet). Bats and skunks are the chief carriers of rabies. The best protection is to immunize all pets and avoid handling wild animals.
- **Salmonellosis –** a strain of bacteria that causes intestinal infections with severe diarrhea and vomitting. Although pets that carry salmonella often don't get sick from it, people do. It is spread by direct contact with anything (e.g., pets, cages, living areas) contaminated by salmonella. Reptiles pose a particular risk of salmonella to infants and young children.
- **Campylobacteriosis –** a strain of bacteria that can be contracted from a puppy with diarrhea. The resulting diarrhea in humans is usually self-limiting, but severe cases may require antibiotics.
- **Streptococcal Infection –** sometimes found in pets, although humans are the original source of infection. If there is a persistent recurring infection in people, then both the people and the resident animals should have bacteria cultures taken and be treated, if necessary.
- **Giardiasis –** also known as "beaver fever" can be spread by infected animals through food and water. If there is evidence of giardiasis in the house, pets should be checked. Symptoms include diarrhea, bloating, nausea and abdominal cramps.

Contraction of parasites is another risk associated with animal contact. Although they are relatively uncommon, some animal parasites include:

- **Toxocariasis.** Most infected puppies are infected before birth, whereas older dogs excrete the organism if infected with it. The excreted eggs can survive in soil for months and can cause infection if an animal ingests contaminated soil. The resulting roundworms can migrate in the body and cause damage to the retina of the eye, or may enter the lungs, heart, or brain and cause serious illness.
- **Larva Migrans** ("creeping eruption") is a parasite caused by hookworms. Human infection follows direct contact with larvae in areas contaminated by infected feces.
- **Toxoplasmosis.** Most pet species carry this disease, but only cats shed the single-celled parasite that causes it. It can be transmitted to humans from cat feces, raw or undercooked meats, and from an infected pregnant woman to her fetus. Cats become infected by eating raw meat, rodents, cockroaches, or flies, or by contacting infected cats, infected cat feces, or contaminated soil. For people with a compromised immune system, toxoplasmosis can lead to potentially life-threatening central nervous system disorders. Limiting the cat's environment and ensuring proper

cat hygiene are the best preventative measures.

- **Echinococcosis (Hydatid Disease).** Dogs are good hosts for the tapeworm. Transmission of eggs to humans occurs through contact with infected feces. In people, the cyst form of the tapeworm may be found in the liver or lung. It grows like a slow tumour and its surgical removal is the only effective treatment. The disease can be prevented by avoiding feeding dogs raw meat that may be contaminated due to unsanitary slaughter conditions.

In addition to zoonoses and parasites, animal-related skin problems can also occur in humans. For example:

- **Canine Scabies** – caused by mites that can be transmitted to humans. The rate of transmission from infected dogs is relatively high.
- **Fleas –** cannot survive on human hosts, but can bite them. Although not usually a major medical concern, some people are hypersensitive to a flea bite and will have a reaction.
- **Ticks –** Tick-borne diseases are not generally spread by dogs, but dogs can bring us in contact with the tick. Diseases caused by ticks include Lyme disease, Rocky Mountain Spotted Fever, and tick paralysis.
- **Dermatophytosis –** although caused by ringworm, it is actually not a worm, but a fungus. It can be transmitted to

humans by direct contact (touch) with an infected animal.

It is important that all animals who participate in AAT are healthy and free from parasites, disease, infections, and illnesses. To reduce the risk of transmission of zoonoses and other health-related problems:

- Maintain a regular vaccination and parasite prevention schedule.
- Try to avoid contact with wild animals.
- Clean up your animal's feces in public areas and your own yard.
- Check for fleas and skin problems by running your hands through your animal's coat on a regular basis.
- Feed your animal fresh nutritious food from clean dishes and have fresh water in a clean bowl available.
- Do not allow your animal to drink from the toilet.
- Practice good personal hygiene including handwashing. *NOTE: In the absence of effective handwashing facilities, a waterless antibacterial gel is available and can act as a substitute for handwashing.*
- Do not involve your companion animal in therapy if you suspect the animal is not well. Your animal should not participate in therapy if the following symptoms occur: skin rash, lameness, extreme hair shedding, runny nose, change in eating or elimination habits, odd-smelling ears or breath, vomitting, eye infections, or diarrhea or bloody

stools (Delta Society, 2001). Furthermore, if your animal has sutures, is on medication for an infection or illness, or is chronically ill, he should be removed from his role in therapy.

- Limit area to which your companion animal has access.
- Ensure that companion animal respects "off-limit" areas (i.e., kitchen)

Although there are a variety of animal-related diseases that could potentially be transferred to humans, one of the most common animal-related health concerns for people are allergies. Allergies can be triggered by direct contact with an animal (petting or contact with saliva), or by inhaling animal dander in the air. For some individuals, irritation-type allergic reactions can occur after petting an animal. Others may have more serious reactions (ranging from compromised breathing to anaphylactic shock).

The allergic reaction that results in an irritation to the skin is likely to be less problematic than a reaction that affects the respiratory system. However, it is still important to recognize that there may be residents or clients who are not able to handle an animal, or who should take precautions to avoid unnecessary discomfort.

Some examples of ways to deal with known allergies include:

- Limit the area in which AAT is conducted, and ensure the area is well-ventilated. Some facilities have reported

using a filter on the cold air return to reduce the spread of animal dander.

- If possible, reduce the animal's presence in hallways and common areas.
- Conduct AAT in an area that is not carpeted so that it can be easily swept and damp-mopped following the session, to reduce allergens.
- Follow handwashing protocols with clients after AAT sessions. This should be the general rule for all people who handle animals, in order to prevent the possible spread of disease.
- Limit or avoid exposing clients to animals if they have known allergies to animals.

4.5.3 Preventing Accidents and Injuries:

Most potential accidents and injuries can be prevented with a little preparation and forethought. Some general guidelines for safe human-animal interaction include:

- Work only with health-screened and behaviour-assessed companion animals in AAT programs.
- Never encourage or permit an animal to be left unattended with a client.
- Never tie an animal to furniture.
- Make sure the animal's collar, leash, etc., are appropriate and aid the handler in working with the animal.
- Never place an animal in a potentially dangerous situation, or ask clients to

engage in an activity that is deemed unsafe.

Note: We gratefully acknowledge the Pet Therapy Society of Northern Alberta for providing the above overview of safety considerations.

4.6 Ethical Issues

4.6.1 Animal Welfare:

Employing animals in AAT just because they are available (e.g., a personal pet of a staff member) may be an unethical exposure of the animals to stress, and clients to health risks. Therapists have the ethical responsibility to address the implications of involving animals in their practice. This means addressing both client and animal concerns. Historically, AAT appears to have a good safety record, but as programs involve more people the risks increase. Responsible and concerned therapists need to ensure that any problems that occur during AAT, or any other therapy, are reported and evaluated.

Although client safety is of highest priority, therapists must also consider the safety and welfare of the animals used in their practice. All therapists involved in AAT need to make a conscious effort to preserve and safeguard their animal's quality of life. Hubrecht and Turner (1998) argue that if an animal is not properly cared for, or is stressed while working, the quality of the therapy session will suffer. This can impact the therapeutic benefit of the session for the client. Therapists should recognize some of the risks that therapy animals may be

exposed to and consider how to best protect their safety and welfare (Pet Therapy Society of Northern Alberta, 2000). For example:

- Identify clients with unpredictable or aggressive behaviour and monitor them in order to protect the animal from rough handling or injury.
- Perform a careful visual check of the floor, clients' pockets, table tops, etc., to ensure that no medication is accessible to a therapy animal.
- Ensure that all hazardous materials (cleaners, chemicals, poisons, etc.) are properly stored and not accessible.
- Ensure there is safe drinking water available, and a safe place for your companion animal to eliminate.
- Do not encourage or permit over-feeding of treats.
- Be willing to modify or even cancel your AAT session if the temperature is too hot. Heat can affect an animal's personality and may make it irritable and more easily stressed.

Therapy animals need to be safe from abuse or danger from any client at all times. Throughout the day, the animal will need to have a break from actual patient contact and be able to express normal animal behaviour. Clients, especially children, should be taught to respect this decision and allow the animal a rest period. To that end, the animal must be able to find a safe refuge within the office that he or she can go to if exhausted or stressed. When the animal is ready to return to the

therapeutic area, she or he should be allowed to do so (Serpell, Coppinger, & Fine, 2000).

It is important for therapy animals to be free from pain, injury, or disease (Hubrecht & Turner, 1998). Therapy animals should be up to date on all innoculations and visually appear to be in good health. If the animal seems ill, stressed, or exhausted, medical attention must be given. The animal should be under the supervision of a veterinarian who is aware of the therapeutic dimension of the animal's life and who sees the animal on a regular basis to ensure that it is in good health. The veterinarian may also advise the therapist on any medical concerns that may pertain to the animal's welfare (Serpell et al., 2000).

As a therapy animal ages, its schedule for therapeutic involvement will require adjustment. This is also true if the animal is ill for an extended period of time. The transition to reduced therapy hours may be difficult, not only for the therapist, but also for the client and the animal (Serpell et al., 2000). An animal that is used to an active schedule may appear saddened by reduced involvement in therapy sessions. Therapists should consider this issue and think about what they can do to help their clients and their animal during transition stages.

4.6.2 Animal Abuse:

This section has been included to briefly reflect on the ethical implications of reporting client disclosures of animal abuse. For a detailed analysis of this topic, please see Ascione & Arkow (1999). As mentioned previously, it is estimated that

approximately 25% of conduct disorder cases include a history of abuse to animals. The significance of these findings led the American Psychiatric Association (APA) to cite animal cruelty as a diagnostic criterion for conduct disorder in the DSM-IV (APA, 1994). The inclusion of animal cruelty in the DSM-IV has renewed attention to animal abuse as being a potential precursor to human mental health problems. The reasons why children abuse animals are varied and complex. It is known, however, that children who are being physically and/ or sexually abused are more likely to be cruel to animals (Ascione, 2001, cited in McIntosh, 2002). Despite the cause of animal abuse, "*injury to animals is one way that a child signals that something is wrong*." (Adams, 1994, p.69, as cited in McIntosh, 2002). Unfortunately, animal abuse still goes unreported, or does not always receive enough attention to identify potentially dangerous or vulnerable individuals (Ascione, 2001).

The links between animal abuse and other forms of family violence are many, varied, and complex. Many abusers use the family pet to intimidate, threaten, coerce, violate, or control children or spouses, and this often includes the use of threats or actions towards the animals to obtain the victim's silence (Arkow, 1997; Adams, 1994). Adams notes that "*testimony of survivors of child sexual abuse reveals that threats and abuse of their pets were often used to establish control over them, while also ensuring their silence, by forcing them to decide between their victimization or the pet's death*" (Adams, 1994, p.67 as cited in McIntosh, 2002).

Canadian (Ontario) statistics collected by the Ontario SPCA in 2000 indicate that of the 111 women leaving abusive situations who were surveyed, 42% had pets threatened by their abuser, 44% had pets abused or killed by their partner, and 43% reported that they delayed leaving the abusive situation due to fear for the safety of their pet (Daniell, 2001, as cited in McIntosh, 2002).

In a study conducted by McIntosh (2002) in Calgary, Alberta, it was determined that 25% of women who entered a shelter had delayed their decision to enter the shelter due to concern for the safety of their pet(s). Furthermore, 56% stated their abuser either threatened and/or actually hurt or killed a pet, 27% (of respondents with both children and pets) indicated that their children had been overly rough and/or had actually hurt or killed an animal, and 21% (of all respondents) indicated that they were aware that their partner had abused animals as a child or teenager. These results are consistent with prior research in the U.S. and Ontario, and further confirm that animal abuse and other forms of family violence frequently co-exist. These results have a number of implications with regards to the dynamics of animal abuse within family violence situations, the seriousness of children abusing animals, and the manner in which human service and animal welfare organizations can work together to detect and prevent violence and abuse. Indeed, the FBI currently educates their investigators about links between animal abuse and domestic violence, and recognizes the need for mental health professionals, who are bound by professional ethics, to disclose all cases of client or animal abuse so they can be further investigated.

The FBI advises that "*people shouldn't discount animal abuse as a childish prank*" (Lockwood & Church, 1996, p. 30, as cited in McIntosh, 2002).

4.7 References

Adams, C.J. (1994). Bringing peace home: a feminist philosophical perspective on the abuse of women, children, and pet animals. *Hypatia*, 9(2), 63-84.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC.

Arkow, P. (1997). The relationship between animal abuse and other forms of family violence. *The Latham Letter,* **XVIII(1)**, 1.

Ascione, F.R. & Arkow, P. (1999). *Child Abuse, Domestic Violence, and Animal Abuse*. West Lafayette, Indiana, Purdue University Press.

Davis, D.K. (1992). *Therapy Dogs: Training Your Dog to Reach Others*. Toronto, Maxwell Macmillan Canada.

Hubrecht, R. & Turner, D.C. (1998). Companion animal welfare in private and institutional settings**. In** C.C. Wilson & D.C. Turner (eds.), *Companion Animals in Human Hea*lth (pp. 267-289). Thousand Oaks, CA, Sage Publications.

Lockwood, R. & Church A. (1996, Fall). Deadly serious: an FBI perspective on animal cruelty. *HSUS New,* 27-30.

McIntosh, S. (2002). *An Introduction to Equine Facilitated Counselling*. Self-published.

The Pet Therapy Society of Northern Alberta (2000). *PAWS in Your Facility: A Guide to Planning Your Pet Therapy Program.* Edmonton, Alberta.

Serpell, J., Coppinger, R., & Fine, A. (2000). The welfare of assistance and therapy animals: an ethical comment. **In** A. Fine (ed.), *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp. 415-431). San Diego, California, Academic Press.

Shell, R. (2002, manuscript in preparation). Moments of magic: animal-assisted interventions in a psychotherapy setting.

Chapter 5

Experimental Research Studies on Animal-Assisted Therapy

The disposition of noble dogs is to be gentle with people they know and the opposite with those they don't know... How, then, can the dog be anything other than a lover of learning since it defines what's its own and what's alien?

Plato

Chapter 5.0

5.1 Experimental Studies of Animal-Assisted Therapy

As mentioned in Chapter 1 of this manual, the Delta Society defines AAT as a goal-directed intervention in which an animal that meets specific criteria is an integral part of the treatment process. The Delta Society differentiates between AAT and Animal-Assisted Activity (AAA). Although both forms seek to bring about improvement in physical, social, or emotional function, AAT is always administered by a trained health professional and is goal-directed, with measurable objectives. In contrast, Animal-Assisted Activities are less formal opportunities for interaction with animals.

Before reviewing the experimental studies in the literature, it should be noted that the practical application of AAT takes a variety of forms and that many forms do not follow the strict definition set out by the Delta Society. In addition, confusion often arises when trying to compare studies in the literature, which use different therapeutic techniques and varied methodologies. For example, AAT can be practiced in individual or group therapeutic settings by professionals with different educational backgrounds or treatment philosophies, and using a variety of animal species and breeds. The animals can be incorporated in diverse programs that vary from infrequent visitation to full-time companionship, as part of the treatment strategy for patients with an assortment of medical

or psychiatric conditions with a range of severity. As mentioned, it is difficult to make comparisons between such varied methodological approaches.

The following is a review of the impact of AAT on mental health by examining those studies where experimental design and inclusion of control groups have been attempted. Studies are categorized by the type of human-animal interaction involved, including ownership, visitation within the home, and visitation in institutional settings.

5.1.1 Ownership:

One of the earliest studies, and one of the most meticulous experimental designs to date, was conducted by Mugford and M'Comisky in 1974. Using a pre-post methodology, investigators compared the performance of four experimental groups and one control group on a standardized questionnaire assessing attitudes towards self and others. Elderly subjects living in their own homes were assigned to one of the following groups in which they were allowed the following things in their home: 1) Budgie and TV, 2) Begonia and TV, 3) Budgie and no TV, 4) Begonia and no TV, and 5) Control group with neither a budgie or a begonia, but half were allowed a TV and half had no TV. After five months, the researchers were able to report a generally positive effect for the groups who had budgies, but were unable to provide proper statistical analysis due to an inadequate sample size (n = 17 divided into 5 groups) caused by high rates of subject mortality or relocation prior to the end of the study. Although lacking in conclusive results, the study demonstrates that quantitative research in

the area of human-animal interaction is possible if investigators use a large enough sample size to guard against subject loss.

Using a similar longitudinal research design, Serpell (1990), administered a series of questionnaires to seventy-one adults who had recently acquired pets (dogs and cats) and to an unmatched control group of twenty-six non-owners. Data was collected at baseline, and after one, six, and ten months. Upon analysis, significant changes in a number of areas emerged. Pet owners reported fewer minor health problems in the first month ($p<0.001$). Dog owners exhibited a significant ($p<0.01$), but transient improvement in general health, while the control group did not show this change. Serpell reports that the positive effects are stronger and longer lasting for dog owners than for cat owners. For example, dog owners experienced a significant and prolonged increase in physical exercise due to walking of their dogs. Although, the study incorporates a large sample, repeated measures and an awareness of potential confounds, the researchers disclose that there are significant differences between the experimental and control groups, even at baseline. These differences are likely due to a lack of exclusionary or inclusionary criteria.

A recent project (Cole & Gawlinski, 2000) examined the effects of animal ownership by providing each patient in an intensive care unit with their own fish tank. In a single group design, ten patients awaiting orthotopic heart transplants were given fish tanks and then scored on the Multiple Affect Adjective Checklist-Revised (MAACL-R) at baseline and post-treatment. The test, designed to

assess levels of anxiety, depression, hostility, sensation-seeking, and positive affect, did not detect any significant change on any measure. The authors cite the small sample size as a possible explanation for the lack of significant results.

5.1.2 Visitation within the Home:

AAT, through regular visitation, has been applied in a number of different settings. From private homes to psychiatric hospitals, the technique has been employed with varied success. Francis, Turner, and Johnson (1985), using a relatively simple and inexpensive methodology, introduced six SPCA puppies to twenty-one older, chronic mentally ill residents of a community adult home in three-hour weekly group sessions for eight weeks. Utilizing a pre-post design and a control group of a matched population at a separate adult home, investigators measured nine variables using seven standardized tests. Analysis showed statistically significant improvement in the animal visitation group on measures of social interaction, psychosocial function, life satisfaction, mental function, depression, social competence, and psychological well-being ($p < 0.03$). Although an improvement in life satisfaction was observed in the control group, no other variable demonstrated significant change.

A similar program was developed where volunteers and their animals visited homebound elderly (Harris, Rinehart, & Gerstman, 1993). Sixteen elderly homebound clients participated in the research study. Four non-experimental visits conducted by the nurse coordinator preceded four experimental visits where a volunteer and a dog

accompanied the coordinator. Researchers made measurements of systolic and diastolic blood pressure, pulse and breathing rates, and asked half the participants to complete the General Well-Being Scale at the beginning and end of each visit. Investigators found significant decreases in blood pressure and pulse rate with a visit from the pet and volunteer ($p<.05$), and similar significant differences in pulse and respiration following a control visit. The General Well-Being Scale revealed no significant differences. There are some grounds for criticism in this study. As is the case with many investigations in the field of AAT, the sample size is insufficient to be representative of a normal population. Furthermore, there was little control over the nature of the control visits versus the experimental visits. A nurse conducted control visits and no mention is made of diversionary activities being incorporated. Instead, the control visits contained discussions of the patients' current circumstances and loss of previous pets; discussions of an emotional nature may have affected physiological indicators of emotional state, thereby potentially skewing comparative results.

5.1.3 Visitation in Institutional Settings:

Perhaps the most common paradigm for AAT or AAA is visitation within an institutional setting, such as a nursing home or psychiatric ward. Walsh, Mertin, Verlander, and Pollard (1995) examined the effects of introducing animals to an institutional setting. In this study, a dog was introduced to a group of seven dementia patients on a psychiatric ward. The dog visited the ward twice each week for three-hour sessions during which he and his handler

would visit each patient independently. A group of patients with less severe dementia in an adjacent ward served as the control group. The study found no significant difference on the London Psycho-Geriatric Scale, the Brighton Clinic Adaptive Behaviour Scale, or diastolic or systolic blood pressure between the experimental and control groups. Investigators did note that a substantial, but not enduring, reduction in ward noise levels occurred during and after the dog's visit (not significant) and that patients in the experimental group experienced a significant reduction in heart rate ($p=0.021$). A larger sample size in a replicate study would add credibility to the results.

Recognizing the need for adequate sample sizes, Zisselman, Rovner, Shmuely, and Ferri (1995) introduced pets to fifty-eight geriatric psychiatry inpatients as an adjunct to traditional phamaco- and psychotherapy. Group sessions consisted of a one-hour visit with dogs for five consecutive days. A control group participated in an exercise session while the experimental group visited with the dogs. Analysis showed no significant differences between or within groups on the Multidimensional Observation Scale for Elderly Subjects (MOSES) or its subscales. This investigation included one of the largest subject groups and, with the exception of other concomitant treatments, made provisions for controlled conditions.

Barker and Dawson (1998) examined the effect of animal interaction on anxiety ratings of psychiatric in-patients. The animal-assisted activity used in this study was of a recreational nature and was directed by volunteers and not by a trained healthcare

professional. The researchers involved 230 patients in a pre-post crossover design that allowed patients to participate in a single session with animals and/or a single session of recreational therapy. Fifty subjects completed a pre- and post-treatment measure for both activity types. The State-Trait Anxiety Inventory was administered before and after each session to determine the patients' levels of anxiety. While only patients with mood disorders experienced a significant decline in anxiety scores after attending recreational activities ($p<.001$), among patients who participated in AAA, those with psychotic, mood, and "other" disorders all experienced significant declines in levels of anxiety ($p<.026$). Despite these within-group improvements, the study found no significant differences between groups in anxiety level changes.

A similar approach focused on the introduction of a dog into two wards in a psychiatric hospital (Haughie, Milne & Elliot, 1992). A total of thirty-six patients participated in a repeated measures design across three conditions: 1) baseline, 2) dog and visitor, and 3) visitor with photographs of dog. The activity described in the study was intended to relieve anxiety and boredom. The authors employed a Patient Interaction Observation scale that monitored various social behaviours, and a nurses' rating scale that catalogued similar measures, but from a more clinical perspective. One-minute observations were made according to a strict rotation procedure during the visit, while nurses were asked to complete the rating instrument two hours after each visit. A total of eight visits were completed for each condition. Haughie

reports greater significant increases in mean interaction during the dog condition than in either the baseline ($p<-.05$) or photograph condition ($p<.05$). The author also suggests that the improvements were generalizable across psychiatric conditions, across settings (i.e., in both wards), and across behaviour types. The study gives considerable attention to controlling for confounding variables and the implementation of methodological guidelines; it would be instructive to use a similar design to measure a greater range of dependent variables.

Many articles assessing the effects of AAT involve older participants, diagnosed with various psychiatric conditions and housed in institutional settings. In a crossover design, Jendro, Watson and Quigley (1983) introduced twenty-two geriatric patients with severe mental illness to four weekly sessions of interaction with three or four puppies. Participants were divided into two groups; each group was exposed to both AAA and a control condition of no AAA, but in opposite sequence. Investigators found no significant differences on the Nurse's Observational Scale for Inpatient Evaluation (NOSIE), the Stockton Geriatric Scale (SGRS), or the Ward Behavior Characteristics Instrument (WBCI). Statistically significant increases in purposeful behaviours before AAA ($p<.001$) and during the sessions with the puppies ($p<.001$) were reported. The authors interpret these results with caution, as an observer who was obviously not blind to experimental conditions collected the data. No enduring treatment effects were found.

Kongable, Buckwalter, and Stolley (1989) reported an increase in the number of social behaviours in 12 Alzheimer's clients in a Veterans' Home. In a within-subject repeated measures design, various social behaviours including smiles, looks, and touches, were tallied in the absence, temporary placement, and permanent placement of a dog in the home. The subjects were observed for five-minute intervals in individual and group sessions. Investigators report a significant increase in social behaviours in the presence of the animal ($p<.001$); however, they did not find a significant difference between temporary or permanent placement. Like many other studies in its field, this investigation is hampered by an inadequate and heterogeneous sample; only twelve patients were included and the severity of dementia and other impairments was not controlled. The observations fail to discriminate between positive and negative social behaviours and are limited in number and duration. In group sessions, individuals were not observed simultaneously but instead were monitored on a rotating basis, leaving substantial potential for error due to novelty effects, or change in activity type or level during the session.

Another study, examining the impact of animal interaction on patients with Alzheimer's disease, found a significant ($p=0.05$) decrease in agitation and an increase in socialization during sundown hours, a time reputed to be of high distress for many patients (Churchill, Safaoui, McCabe, & Baun, 1999). The dog and a researcher visited with twenty-eight patients in a group setting while another researcher made periodic video tapings of behaviours for later analysis. Unfortunately, this

methodology suffers from the same limitations as the study mentioned previously, in that periodic observations made on a rotating basis may not achieve representative results. Furthermore, as only two sessions occurred (one with the dog and one without), there is no control for novelty.

Most of the studies mentioned previously concentrate on the effect of AAT on observable social behaviours, as opposed to assessing direct clinical outcome. In contrast to the typical investigative paradigm, one study, conducted as part of a thesis program (Hagmann, 1997), measured the effect of animal interaction on measured levels of anxiety and/or depression using the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory (BDI) – two instruments with established psychometric properties. In the initial phase of the study, a total of eighty participants, split into two groups, completed both the BAI and the BDI. The first group had participated in visits with animals for an average of 8.4 years, with visits occurring no less than four times per month. The second group had never received any form of AAT. The study found no significant difference in the levels of measured anxiety reported by members of the experimental group and the control group. In contrast, the level of depression was significantly higher in the control group ($p<.05$). In a second phase of the study, Hagmann studied a much smaller sample of volunteers from the original experimental ($n = 9$) and control ($n = 13$) groups, in order to determine if two weeks of AAA would have an effect on BDI and BAI scores. Interestingly, the results show a significant increase in depression in the experimental group while levels

of anxiety and depression drop among members of the control group (significance not reported). The small sample size in the second phase of the study and non-randomized method of selection (volunteer) for all participants suggest that the sample is not representative of a normal population. Furthermore, as participants were selected from twelve separate institutions in different cities, environmental conditions could not be adequately controlled. In addition, the visits occurred over different periods of time, were conducted by different volunteers and animals, and occurred at frequencies varying from four visits per month to fifteen visits per month. This degree of variation threatens the validity of the results. Although the study requires greater variable control, it demonstrates the feasibility of utilizing standardized psychometric instruments in the study of clinical outcome in AAT.

There are many animal-interaction programs operating under the label of AAT; however, it is clear that some patients are participating in a social activity rather than structured, directed therapy. While AAA may be beneficial, it is important to differentiate between the two forms of interaction. Below, are summaries of studies where animal visitation is incorporated into regular, supervised therapy sessions.

Thompson, Kennedy, and Igou (1983), endeavoured to quantify improvement among a group of twenty chronic psychiatric patients. Animals were introduced as part of a normal therapy program administered by a professional, and provisions were made for objectives and outcome measures. The

patients were screened for inclusion in the study, randomly selected, and divided between a locked or open ward. The investigators used the Physical and Mental Impairment of Function (PAMIE) and the Mini-mental State Questionnaire administered by staff blind to subject assignment. Subjects in the pet-facilitated psychotherapy group participated in three-hour group therapy/pet education sessions for six weeks. Control group participants took part in similar sessions and activities, but without exposure to pets. The pre-post design found a statistically significant ($p<.05$) improvement on the total PAMIE score in patients who were members of the experimental group and had an "intermediate" level of impairment. This difference was not observed until three subjects who scored very high or very low on the PAMIE were removed from the sample. These outlier subjects, removed during analysis, further reduced the sample size to seventeen and allowed differences between groups to become apparent. There was no significant difference on any measure for any individual subject.

As part of a program designed for psychiatric inpatients at risk for substance abuse, animals were introduced into therapy sessions (Marr, French, Thompson, Drum, Greening, Mormon, Henderson & Hughes, 2000). Researchers compared a daily traditional therapy group to a daily AAT group and observed social behaviours according to an observational guide of pro-social behaviours, over a period of four weeks. Both groups were identical, except for the use of AAT in the experimental group. The investigators report that patients in the AAT group engaged in greater social interaction with other group members than did patients in the

control group ($p=0.022$). This increased socialization effect continued over the four-week period. The study does provide support to the hypothesis that the effects of AAT can be studied using rigorous experimental design.

Clark Brickel (1984) studied the impact of animal-assisted psychotherapy in the nursing home. Fifteen male members of a nursing home unit were divided into three groups: 1) regularly scheduled traditional therapy, 2) dog present during regularly scheduled therapy sessions, 3) casual meetings with therapist, but no active therapy. Following two 45-90 minute sessions every week for a duration of four weeks, a significant improvement in depression was observed in both treatment groups (using pre-post Zung Self-Rating Depression Scales $p<.05$). Brickel also describes an increase in social interaction in the AAT sessions, over those where the animal was not present. In addition, a greater pre-post difference was reported for the AAT group, but this difference was not reported to be significantly greater than that for traditional therapy. Although this experimental design is commendable, a substantial increase in sample size would be essential in order to demonstrate true effect.

Beck, Seraydarian, and Hunter (1986) conducted a pre-post test design comparing two matched groups of psychiatric inpatients. Seventeen patients were to voluntarily attend daily therapy sessions for a period of eleven weeks. The patients were assigned to two groups: the first group would attend sessions held in one room, while the second group met in an identical room with four caged finches.

Considerable care was taken to ensure random assignment and controls for the two groups. Measures of attendance, participation, standardized scales [Nurse's Observation Scale for Inpatient Evaluation (NOSIE) and the Brief Psychiatric Rating Scale], and discharge status were compared between groups. The results indicated that attendance was significantly greater for the bird group ($p<.008$); members of the bird group contributed to discussion more frequently ($p<.05$); and that, at the conclusion of the study, the members of the bird group were less hostile than those in the control group ($p<.05$). No significant variation was found on the NOSIE total score or any of the subscales. Interestingly, 50% of the patients in the bird group were discharged by the end of the study, while all of the non-bird group remained in treatment. It is unfortunate that such a carefully controlled study was undermined by a small sample size.

Acknowledging the need to quantify the effects of AAT using appropriate measures, one team focused on the development of a standardized rating instrument for use in evaluation of AAT. Draper, Gerber, and Layng (1990), a Canadian research team, monitored the behaviour of ten patients participating in three twenty-minute one-on-one therapy sessions in a psychiatric hospital. The team categorized activity according to displays of appropriate or inappropriate affect or communication, approach or avoidance movement, and whether the patient's attention was directed at the animal or the therapist. The researchers were able to achieve high inter-rater correlations, but found no significant changes for affect,

communication, or movement across sessions. A non-significant trend towards increasing attention to therapist and decreasing attention to animal was observed, indicating that perhaps the animal was serving to strengthen the therapeutic bond and communication with the therapist. Although the sample size was small, and the animal used in therapy sessions was not consistent, the study does serve as a starting point for the development and subsequent validation of appropriate measurement instruments.

While many studies have been conducted on the effects of AAT in institutionalized psychiatric or geriatric populations, few have examined the consequences of AAT on young people residing in the community. One study introduced college students who had scores indicative of depression on the Beck Depression Inventory to either AAT alone (n = 12), traditional group psychotherapy with adjunctive AAT (n = 9), and a control condition that received neither treatment (n = 27) (Folse, Minder, Aycock, & Santana, 1994). The study failed to find a difference between the psychotherapy group and the control, while, surprisingly, a significant decrease in depression was found in the AAT-only-group compared to the control group (p value not reported). The authors admit that these results should be interpreted with caution for a number of reasons. First, subjects were not randomly assigned and post-hoc examination of depression levels showed distinct differences between groups. Second, there were substantial variations between treatment groups. For instance, group sessions were directed by two separate moderators with different qualifications (therapist vs. grad student), and

different animals were used in the two types of sessions. Furthermore, the treatment groups were quite small, while the control group was twice the size of either treatment group. Because AAT research using younger participants is uncommon, further research with greater attention to controls, would be of interest.

5.2 Summary of Experimental Studies

Although variable in design and research paradigm, the studies cited above all address the effects of human-animal interaction in either therapeutic or social settings. Upon conducting a systematic analysis of the investigations available, it is felt that more research, of a rigorous experimental nature, is still required. It is especially evident, upon review, that most of the studies conducted to date have lacked appropriate sample sizes, thus providing insufficient power for statistics and limited ability to compare to normal populations.

In addition to the need for thorough experimental research, the field of animal interaction in therapeutic settings may benefit from incorporating more structure into existing programs and practices. For example, agreement as to what constitutes therapy as opposed to recreation, and clear delineation of the roles of the patient, therapist, and animal in AAT would allow for further development of the field and also assist in the training of AAT professionals. In order to gain acceptance as a legitimate technique, the domains of therapy and recreation need to be made distinct. Furthermore, it is believed by many that validated standards for selecting and training therapy animals,

as well as universal guidelines for the implementation of AAT programs, would greatly enhance the efficacy and safety of this treatment modality.

Clinicians and researchers, alike, express the intuitive conclusion that AAT is effective in reducing anxiety, alleviating depression, and improving the self-esteem and socialization of their patients. However, while some of the studies published to date have been able to show some increases in social interaction, improvements in clinical condition have not been clearly quantified. It is hoped that further research, incorporating sound experimental design, adequate samples, and standardized measures will provide the scientific foundation to support continued utilization of this innovative technique.

5.3 References

Angulo, F.J., Siegel, J.M., & Detels, R. (1996). Pet ownership and the reliability of the companion animal bonding scale among participants of the multicentre aids cohort study. *Anthrozoös*, **9**, 5-9.

Barba, B.E. (1995). The positive influence of animals: animal-assisted therapy in acute care. *Clinical Nurse Specialist,* **9**, 199-202.

Barker, S.B. & Dawson, K.S. (1998). The effects of animal-assisted therapy on anxiety ratings of hospitalized psychiatric patients. *Psychiatric Services*, **49**, 797-801.

Beck, A.M., Seraydarian, L. & Hunter, G.F. (1986). Use of animals in the rehabilitation of psychiatric inpatients. *Psychological Reports*, **50**, 63-66.

Brickel, C.M. (1982). Pet-facilitated psychotherapy: A theoretical explanation via attention shifts. *Psychological Reports*, **50**, 71-74.

Brickel, C.M. (1984). Depression in the nursing home: a pilot study using pet-facilitated psychotherapy. **In** R.K. Anderson, B. Hart, & L. Hart (eds.), *The Pet Connection: Its Influence on Our Health and Quality of Life* (pp. 407-415). Minneapolis, Minnesota: Center for Study of Human-Animal Relationships and Environments.

Brickel, C.M. (1986). Pet-Facilitated Therapies: A Review of the Literature and Clinical Implementation Considerations. *Clinical Gerontologist*, **5 (3/4)**, 309-332.

Brickel, C.M. (1984). The Clinical Use of Pets with the Aged (comment). *Clinical Gerontologist*, **2 (4),** 72- 74.

Brickel, C.M. (1980). A review of the roles of pet animals in psychotherapy and with the elderly. *International Journal of Aging and Human Development*, **12**, 119-128.

Brodie, S.J. & Biley, F.C. (1999). An exploration of the potential benefits of pet-facilitated therapy. *Journal of Clinical Nursing*, **8**, 329-337.

Carmack, B.J. (1984). Animal assisted therapy. *Nurse Educator,* 40-41.

Churchill, M., Safaoui, J., McCabe, B., & Baun, M. (1999). Using a therapy dog to alleviate the agitation and desocialization of people with Alzheimer's Disease. *Journal of Psychosocial Nursing,* **37**, 16-22.

Cole, K.M. & Gawlinski, A. (2000). Animal-assisted therapy: the human-animal bond. *AACN Clinical Issues: Advanced Practice in Acute and Critical Care,* **11,** 139-149.

Corson, S.A., O'Leary Corson, E., Gwynne, P.H., & Arnold, L.E. (1975). Pet-facilitated psychotherapy in a hospital setting (pp. 277-286). **Adapted from:** Pet Facilitated Therapy (1975), R.S. Anderson (ed.) *Pet Animals and Society*. London: Balliere Tindall.

Counsell, C.M., Abram, J., & Gilbert, M. (1997). Animal assisted therapy and the individual with spinal cord injury. *Science and Nursing*, **14**, 52-55.

Culliton, B.J. (1987). Take two pets and call me in the morning. *Science*, **237,** 1560 – 1561.

Davis, J.H. (1988). Animal-facilitated therapy in stress mediation. *Holistic Nurse Practitioner,* **2,** 75-83.

Draper, R.J., Gerber, G.J., & Layng, E.M. (1990). Defining the role of pet animals in psychotherapy. *Psychiatry Journal of the University of Ottawa*, **15**, 169-172.

Folse, E., Minder, C.C., Aycock, M.J., & Santana, J.R. (1994). Animal-assisted therapy and depression in adult college students. *Anthrozoös*, **7**, 188-194.

Francis, G., Turner, J.T., & Johnson, S.B. (1985). Domestic animal visitation as therapy with adult home residents. *International Journal of Nursing Studies*, **22**, 201-206.

Francis, G. (1984). Plush animals as therapy in a nursing home (comment). *Clinical Gerontologist,*. **2**, 75-76.

George, H. (1988). Child therapy and animals: a new way for an old relationship. **In** C.E. Schafer (ed.), *Innovative Interventions in Child and Adolescent Therapy* (pp. 400-418)*,* New York, John Wiley and Sons.

Granger, B.P. & Carter, D. (1990). The use and non-use of companion animals by volunteers in nursing homes: a comparative study. *Anthrozoös*, **4**, 237 – 246.

Hagmann, C.S. (1997). *The effect of animal-assisted therapy on levels of measured anxiety and depression in*

residents of assisted living and health care communities. Knoxville: University of Tennessee, thesis.

Haughie, E. (1992). An evaluation of companion pets with elderly psychiatric patients. *Behavioural Psychotherapy,* **20**, 367-372.

Iannuzzi, D. & Rowan, A.N. (1991). Ethical issues in animal-assisted therapy programs. *Anthrozoös*, **4**, 154-163.

Jendro, C. & Watson, C. (1984). The effects of pets on the chronically-ill elderly. **In** R.K. Anderson, B.L. Hart, & L.A. Hart (eds.), *The Pet Connection: Its Influence on Our Health and Quality of Life* (pp. 416-422). Minneapolis, Minnesota: Center to Study Human-animal Relationships and Environments, University of Minnesota.

Jorgenson, J. (1997). Therapeutic use of animals in health care. *Journal of Nursing Scholarship*, **29**, 249-254.

Katcher, A. & Wilkins, G.G. (1998). Animal-assisted therapy in the treatment of disruptive behavior disorders in children. **In** A. Lundberd (ed.), *The Environment and Mental Health: A Guide for Clinicians* (pp. 193-204). Mahwah, NJ: Lawrence Erlbaum Associates.

Kongable, L.G., Buckwalter, K.C., & Stolley, J.M. (1989). The effects of pet therapy on the social behavior of institutionalized Alzheimer's clients. *Archives of Psychiatric Nursing*, **3**, 191-198.

Mallon, G.P. (1994). Cow as co-therapist: utilization of farm animals as therapeutic aides with children in residential treatment. *Child and Adolescent Social Work Journal*, **11**, 455-474.

Mallon, G.P. (1999). Animal-assisted therapy interventions with children. **In** G.P. Schafer (ed.) *Innovative Psychotherapy Techniques in Child and Adolescent Therapy, 2nd ed.* (pp. 415-434). New York: John Wiley and Sons.

Marr, C.A., French, L., Thompson, D., Drum, L., Greening, G., Mormon, J., Henderson, I., & Hughes, C.W. (2000). Animal-assisted therapy in psychiatric rehabilitation. *Anthrozoös*, **13**, 43-47.

Martin, S. (1993). Ask the experts: what criteria should be used for pet therapy in critical care? Are you aware of any hospitals doing that? *Critical Care Nurse*, 74.

McCulloch, M.J. (1981). The pet as prosthesis – defining criteria for the adjunctive use of companion animals in the treatment of medically ill, depressed outpatients. **In** B. Fogle (ed.), *Interrelations Between People and Pets* (pp. 101-123). Springfield, IL: Charles C. Thomas.

McCulloch, M. (1984). Pets in therapeutic programs for the aged. **In** R.K. Anderson, B.L. Hart, & L.A. Hart (eds.), *The Pet Connection: Its Influence on Our Health and Quality of Life* (pp. 386-398). Minneapolis, Minnesota: Center to Study Human-animal Relationships and Environments, University of Minnesota.

McNicholas, J. & Collis, G.M. (2000). Dogs as catalysts for social interactions: Robustness of the effect. *British Journal of Psychology*, **91**, 61-70.

Miller, J. & Connor, K. (2000). Going to the dogs…for help. *Nursing 2000*, **30**, 63-67.

Miller, J. & Ingram, L. (2000). Perioperative nursing and animal-assisted therapy. *AORN Journal,* **72**, 477-483.

Mugford, M.A. & M'Comisky, J.G. (1974). Some recent work on the psychotherapeutic value of cage birds with old people. **In** R.S. Anderson (ed.), *Pet Animals and Society*. London: British Small Animals Veterinary Association by Ballière Tindall.

Olsen, G., Mandel, J., & Bender, A. (1984). Evaluating pet facilitated therapy in long term care. **In** R.K.

Anderson, B.L. Hart, & L.A. Hart (eds.), *The Pet Connection: Its Influence on Our Health and Quality of Life* (pp. 339-406). Minneapolis, Minnesota: Center to Study Human-animal Relationships and Environments, University of Minnesota.

Proulx, D. (1998). Management: animal-assisted therapy. *Critical Care Nurse,* **18**, 80-84.

Rowan, A.N. (1991). Ethical issues (editorial). *Anthrozoös*, **4**, 143-144.

Saylor, K. (1998, June). Pet visitation program. *Journal of Gerontological Nursing,* 36-38.

Schantz, P.M. (1991). Preventing potential health hazards incidental to the use of pets in therapy. *Anthrozoös*, **4**, 14-23.

Serpell, J. (1991). Beneficial effects of pet ownership on some aspects of human health and behavior. *Journal of the Royal Society of Medicine*, **84**, 717-720.

Serpell, J.A. (1990, April). Evidence for long term effects of pet ownership on human health. *Waltham Symposium, 20*.

Thompson, M., Kennedy, R.W., & Igou, S. (1983). Pets as socializing agents with chronic psychiatric patients: an initial study. **In** A. Katcher and A. Beck (eds.), *New Perspectives on our Lives with Companion Animals* (pp. 427-430). Philadelphia: University of Pennsylvania Press.

Walsh, P.G., Mertin, P.G., Verlander, D.F., & Pollard, C.F. (1995). The effects of a 'pets as therapy' dog on persons with dementia in a psychiatric ward. *Australian Occupational Therapy Journal,* **42**, 161-166.

Willis, D.A. (1997). Animal therapy. *Rehabilitation Nursing*, **22**, 78-81.

It wasn't until Socks arrived with his toy mouse and Buddy walked in with his rawhide bone that this house became a home. Pets have a way of doing that. -- Hillary Rodham Clinton

Zisselman, M.H., Rovner, B.W., Shmuely, Y., & Ferrie, P. (1996). A pet therapy intervention with geriatric inpatients. *The American Journal of Occupational Therapy*, **50**, 47-50.

Appendix A

Canadian Canine Good Citizen Test

The dog's kennel is not the place to keep a sausage.

Danish Proverb

The Canadian Canine Good Citizen (CCGC) Test

The purpose of Canine Good Citizen training is to ensure that our favourite companion, the dog, can be a respected member of the community because it is trained and conditioned to act in a mannerly way in the home, in public places, and in the presence of other dogs.

Ten Steps to Demonstrate Confidence and Control:

1. Accepting a Friendly Stranger

This exercise demonstrates that the dog will allow a friendly stranger to approach it and speak to the handler in a natural, everyday situation. The instructor and handler shake hands and exchange pleasantries. The dog must show no sign of resentment or shyness and must not attempt to jump on or bite the instructor. Ideally, the dog will sit or lie at the handler's side.

2. Sitting Politely for Petting

This exercise demonstrates that the dog will allow a friendly stranger to touch it while it is out with its handler. While the dog is sitting at the handler's side, the instructor pets the dog on head and body only, then leaves the dog and handler, completing the test. The dog must not show shyness or resentment or jump on the instructor. The dog may lie down during this exercise.

3. Appearance and Grooming

This practical test demonstrates that the dog will welcome being groomed and examined and will permit a stranger, such as a veterinarian, groomer or friend of the owner, to do so. It also demonstrates the owner's care, concern, and responsibility. The instructor inspects the dog, then combs or brushes the dog and lightly examines the ears and each front foot. The dog must not show shyness or resentment or jump on the instructor. The dog may lie down during this exercise.

4. Out for a Walk (Walking on a loose leash)

This exercise demonstrates that the handler is in control of the dog. The dog may be on either side of the handler, whichever the handler prefers. There must be a left turn, a right turn and an about turn, with at least one stop in between and another at the end. The dog need not be perfectly aligned with the handler and need not sit when the handler stops.

5. Walking Through a Crowd

This exercise demonstrates that the dog can move about politely in pedestrian traffic and is under control in public places. The dog and handler walk around and pass close to several people (at least three). The dog may show some interest in the strangers, without appearing over-exuberant, shy or resentful. The handler may talk to the dog and encourage or praise the dog throughout the test. The dog should not be straining at the leash.

6. Sit and Flat on Command/Staying in Place

This exercise demonstrates that the dog has training, will respond to the handler's command to sit and flat and will remain in place as commanded by the handler. The handler may take a reasonable amount of time and use more than one command to make the dog sit and then flat. The handler may choose which position the dog will stay in.When instructed to, the handler tells the dog to stay and walks forward for twenty feet, turns, and faces the dog for twenty seconds. Then, on the instructor's command, the handler returns to the dog. After returning to the dog, the handler must command the dog to sit. The dog must remain in place, but may slightly change positions. The handler will leave the leash on the dog for this exercise.

7. Come When Called

This exercise demonstrates that the dog will come when called by the handler. The handler will command the dog to sit and stay, hand the dog's leash to an assistant and then walk thirty feet from the dog, turn to face the dog, and, on the instructor's command, will call the dog. The handler may use body language and encouragement to get the dog to come. The handler must take the dog's collar after it comes. Ideally the dog will remain sitting until called.

8. Reaction to Another Dog

This exercise demonstrates that the dog can behave politely around other dogs. Two handlers and their dogs approach each other from a distance of about ten yards, stop, shake

hands and exchange pleasantries, and continue on for about five yards. The dogs should show no more than a casual interest in each other. The dogs must sit or lie down while the handlers are stopped.

9. Reactions to Distractions

This exercise demonstrates that the dog is confident at all times when faced with common distracting situations, such as the dropping of a large book or a jogger running in front of the dog. The dog may express a natural interest and curiosity and may appear slightly startled, but should not panic, try to run away, or show aggressiveness. This exercise will be done at the same time as "Walking on a Loose Leash."

10. Supervised Separation

This exercise demonstrates that a dog can be left alone, if necessary, and will maintain its training and good manners. The instructors will say something like, "Would you like me to watch your dog?" and a person will hold the leash of the dog. The dog will be held for approximately ninety seconds and does not have to stay in position, but should not continually bark, whine, howl, pace unnecessarily, or show anything other than mild agitation or nervousness. Ideally the dog will remain in the sitting or flat position.

Appendix B

Canine Aptitude Test

The great pleasure of a dog is that
you may make a fool of yourself
with him and not only
will he not scold you,
but he will make a fool
of himself too.

Samuel Butler

PET THERAPY SOCIETY OF NORTHERN ALBERTA

APTITUDE TEST FOR DOGS IN MENTAL HEALTH SETTINGS©

Handler name:

_____

Dog Name:

_____

Breed: _____ Age: _____
male ___ female ___ altered ___ intact ___

Date of Test: _____

Evaluator(s): _____

Important Notes

Dogs must be at least one year old.

Dogs must have earned a Canine Good Citizen Certificate prior to being evaluated.

All tests are performed on leash or off leash at the discretion of the evaluator with the owner/handler in the testing area.

Dogs are evaluated on the basis of acceptable and unacceptable responses to each of the tests. A dog whose response is acceptable but exhibits stress or discomfort will be considered borderline. Should a dog exhibit borderline responses in more than three (3) tests, the dog will be considered unsuitable for animal-assisted therapy in a mental health setting.

Any dog that growls, barks, snaps, bites, or lunges at a person will be considered unsuitable for animal-assisted therapy in a mental health setting.

Any dog that touches anyone with his teeth or feet will be considered unsuitable for animal-assisted therapy in a mental health setting.

Any dog that eliminates during the testing will be considered unsuitable for animal-assisted therapy in a mental health setting.

A = Acceptable, U = Unacceptable, B = Borderline

	Description	A	U	B	Comments
1.	Handled by Stranger The animal is handled and manipulated by a stranger. The evaluator will look in ears, hold tail, put fingers in mouth, and handle feet.				
2.	Exuberant/Clumsy Petting The evaluator will repeat the petting manipulation using stronger, more aggressive pressure. Evaluator becomes exuberant, speaking in a high-pitched voice, squealing, jiggling the animal and handling feet. Evaluator will pet the animal using an inanimate object.				
3.	Test for Hand-Shy The evaluator will, unexpectedly, move their hand directly at the animal's head in a quick motion.				
4.	Restraining Hug The evaluator will, unexpectedly, give the animal a full body hug that restricts the animal's movement.				
5.	Pain Response The evaluator will pet the dog and then, unexpectedly, pinch the dog between the toes or on the flank.				
6.	Direct Stare The evaluator will stare directly at the animal until the animal breaks the stare and averts his eyes.				

	Description	A	U	B	Comments
7.	Bumped From Behind While the animal is distracted, the evaluator will bump into the animal's body from behind. If the dog is very small, a hard stomp or loud slap will be made behind the animal.				
8.	Loud, Angry Vocalization (indirect) The evaluator will begin to shout and wave arms approximately two metres from the animal without making eye contact with the animal.				
9.	Loud, Angry Vocalization (direct) The evaluator will shout and wave arms approximately two metres from the animal making direct eye contact with the animal.				
10.	Sitting with Stranger (touching) The evaluator will sit in a chair and the dog will be asked by its handler to "go see". The evaluator will pet and talk to the animal (duration of three minutes)				
11.	Sitting with Stranger (not touching) The evaluator will sit in a chair and the dog will be asked by its handler to "go see". The evaluator will not pet or talk to the animal (duration of three minutes).				

	Description	A	U	B	Comments
12.	Reaction to Movement The evaluator will sit in a chair and swing an extremity in the proximity of the animal.				
13.	Taking a Treat The evaluator will offer the dog a treat by finger pinch and by open hand.				

Cautionary

A = Acceptable, U = Unacceptable, B = Borderline

	Description	A	U	B	Comments
14.	Blow In Face The evaluator will, unexpectedly, blow into the animal's face.				
15.	Feet Stomping The evaluator and at least one other person will walk around the animal in a wide circle (at least two metres from the animal) stomping their feet loudly.				
16.	Reaction to Running/Being Chased The evaluator will run past the animal; if the animal begins to run, the evaluator will chase the animal.				
17.	Play/Settle The evaluator will excite the dog with enthusiastic play for up to one minute and then terminate the interaction.				

	Description	A	U	B	Comments
18.	Crowded Petting The evaluator and two other persons will gather closely around the animal and begin to touch it. All people will talk at once and will try to gain the animal's attention.				
19.	Come When Called (other than handler) The evaluator and two other persons will stand at least three metres from the animal and call the animal to come one at a time.				

Summary:

Appendix C

Therapist Questionnaires

There is no psychiatrist in the world
like a puppy licking your face.

Ben Williams

The Chimo Project

Therapist Questionnaire For AAT Sessions

Note: This section (A: General Information) is to be completed at the beginning of the study only. The information from this section will be detached from the initial questionnaire and will be kept on file. You will be asked to complete the other sections of the Therapist Questionnaire (Sections B to G) at each of the therapy sessions over the course of the study. An ID number, which will be assigned at the beginning of the study, will identify these sections of the therapist questionnaire. This is done to protect your privacy and the confidentiality of your answers over the course of the study.

A. General Information

1. Today's Date:
_____/_____/_____
(Day) (Month) (Year)

2. Name: _____

3. Address:

_____

4. Postal Code: _____

5. What is your age? _____ Sex? _____

6. What is your professional affiliation?
- ☐ Clinical Psychologist
- ☐ Social Worker
- ☐ Counseling Psychologist
- ☐ Other _____ (please specify)

7. How many years have you been in practice? ____

B. Specific Information (to be completed for both intervention and control clients)

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint as shown below.

Not at all | _____ | _____ | To a great extent

↑

(This mark indicates your level of agreement.)

1. The client is comfortable talking with me.

Not **at all** | _____ | To a great **extent**

2. The client is able to focus on important problems when talking with me.

Not **at all** | _____ | To a great **extent**

3. The client looks forward to coming to therapy.

Not **at all** | _____ | To a great **extent**

4. The client would like therapy sessions to last longer.

Not **at all** | _____ | To a great **extent**

5. The client is willing to discuss what is happening to important people in his/her life.

Not **at all** | _____ | To a great **extent**

6. The client is willing to talk about his/her feelings during therapy sessions.

Not **at all** | _____ | To a great **extent**

7. As a result of this therapy session, the client is more hopeful about his/her life.

Not **at all** | _____ | To a great **extent**

8. The client's mood has improved because of this therapy session.

Not **at all** | _____ | To a great **extent**

9. The client is less anxious because of this therapy session.

Not **at all** | _____ | To a great **extent**

C. Individual Goals

At the beginning of this therapy session, you made a list of goals for this therapy session (possibly in conjunction with the client). Please write down each of those goals. Then, indicate the degree to which you feel each of the goals were met by checking the appropriate box to the right of the goal.

	Degree to which goal met				
	-2 Much less than expected	**-1 Somewhat less than expected**	**0 Expected level**	**+1 Somewhat better than expected**	**+ 2 Much better than expected**
Goal #1: _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #2: _____ _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #3: _____ _____ _____ _____	☐	☐	☐	☐	☐

D. Overall Assessment

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint on the line. Please answer all questions that apply to your client.

1. I feel that therapy helps the client to perform better at school.

Not at all | _____ | To a great extent

2. I feel that therapy helps the client to perform better at their own home.

Not at all | _____ | To a great extent

3. I feel that therapy has helped the client to perform better at work.

Not at all | _____ | To a great extent

E. Specific Information (to be completed for intervention clients only)

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint on the line.

1. The animal assisted in establishing rapport with the client more quickly than in sessions where the animal was absent.	Not at all	_____	To a great extent
2. Having the animal present seemed to make the client more willing to come to therapy.	Not at all	_____	To a great extent
3. The animal served as a source of comfort for the client.	Not at all	_____	To a great extent
4. The animal provided impetus to discuss love and bonding with the client.	Not at all	_____	To a great extent

5. Having the animal present helped the client stay longer in the session.	Not at all	_____	To a great extent
6. The client was more open as a result of the animal's presence.	Not at all	_____	To a great extent
7. Having the animal present helped the client to discuss positive feelings.	Not at all	_____	To a great extent
8. The client paid more attention to the animal than to the therapist.	Not at all	_____	To a great extent
9. The client was distracted by the animal.	Not at all	_____	To a great extent
10. In the presence of the animal, the client was more communicative.	Not at all	_____	To a great extent
11. The client exhibited aggressive behaviours directed at the animal.	Not at all	_____	To a great extent

11. The client touched the animal. Not at all | _____ | To a great extent

12. The client talked directly to the animal. Not at all | _____ | To a great extent

13. The client was more willing to share as a result of the animal's presence. Not at all | _____ | To a great extent

14. The client was unable to focus on clinically relevant issues. Not at all | _____ | To a great extent

F. The following section is to be completed only if an animal handler (e.g., child care worker and his/her dog) was present in the therapy session.

1. I felt comfortable having the handler in the room. Not at all | _____ | To a great extent

2. Having the handler in the room did not change the way I felt talking to the client. Not at all | _____ | To a great extent

G. Comments

_____

_____

_____

_____

_____

_____

_____

_____

Therapist Questionnaire For Control (e.g., No AAT) Sessions

Note: This section (A: General Information) is to be completed at the beginning of the study only. The information from this section will be detached from the initial questionnaire and will be kept on file. You will be asked to complete the other sections of the Therapist Questionnaire (Sections B to E) at each of the therapy sessions over the course of the study. An ID number, which will be assigned at the beginning of the study, will identify these sections of the therapist questionnaire. This is done to protect your privacy and the confidentiality of your answers over the course of the study.

A. General Information

1. Today's Date:
_____/_____/_____
(Day) (Month) (Year)

2. Name: _____

3. Address:

_____

_____

4. Postal Code: _____

5. What is your age? _____ Sex? _____

6. What is your professional affiliation?
- ☐ Clinical Psychologist
- ☐ Social Worker
- ☐ Counseling Psychologist
- ☐ Other _____ (please specify)

7. How many years have you been in practice? ____

B. Specific Information (to be completed for both intervention and control clients)

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint as shown below.

Not at all | _____ | _____ | To a great extent

↑

(This mark indicates your level of agreement.)

1. The client is comfortable talking with me. Not **at all** | _____ | To a great **extent**

2. The client is able to focus on important problems when talking with me. Not **at all** | _____ | To a great **extent**

3. The client looks forward to coming to therapy. Not **at all** | _____ | To a great **extent**

4. The client would like therapy sessions to last longer. Not **at all** | _____ | To a great **extent**

5. The client is willing to discuss what is happening to important people in his/her life.

Not **at all** | _____ | To a great **extent**

6. The client is willing to talk about his/her feelings during therapy sessions.

Not **at all** | _____ | To a great **extent**

7. As a result of this therapy session, the client is more hopeful about his/her life.

Not **at all** | _____ | To a great **extent**

8. The client's mood has improved because of this therapy session.

Not **at all** | _____ | To a great **extent**

9. The client is less anxious because of this therapy session.

Not **at all** | _____ | To a great **extent**

C. Individual Goals

At the beginning of this therapy session, you made a list of goals for this therapy session (possibly in conjunction with the client). Please write down each of those goals. Then, indicate the degree to which you feel each of the goals were met by checking the appropriate box to the right of the goal.

	Degree to which goal met				
	-2 Much less than expected	**-1 Somewhat less than expected**	**0 Expected level**	**+1 Somewhat better than expected**	**+ 2 Much better than expected**
Goal #1: _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #2: _____ _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #3: _____ _____ _____ _____	☐	☐	☐	☐	☐

D. Overall Assessment:

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint on the line. Please answer all questions that apply to your client.

3. I feel that therapy helps the client to perform better at school.

Not at all | _____ | To a great extent

4. I feel that therapy helps the client to perform better at their own home.

Not at all | _____ | To a great extent

3. I feel that therapy has helped the client to perform better at work.

Not at all | _____ | To a great extent

E. Comments

_____

_____

_____

Appendix D

Client Questionnaires

Until one has loved an animal, a part of one's soul remains unawakened.

Anatole France

The Chimo Project

Client Questionnaire for AAT Sessions

Note: This section (A: General Information) is to be completed at the beginning of the study only. The information from this section will be detached from the initial questionnaire and will be kept on file. You will be asked to complete the other sections of the Client Questionnaire (Sections B to G) at each of your therapy sessions over the course of the study. An ID number, which will be assigned at the beginning of the study, will identify these sections of the client questionnaire. This is done to protect your privacy and the confidentiality of your answers over the course of the study.

A. General Information

1. Today's Date:
_____/_____/_____
(Day) (Month) (Year)

2. Name: _____

3. Address:
_____

4. Postal Code: _____

5. What is your age? _____ Sex? _____

6. Marital Status: Married_____ Single_____
Other (please specify) _____

7. Do you own a pet? ☐ Yes ☐ No
   a. If yes, what type of pet do you own?
   ☐ dog ☐ cat ☐ other (please specify)

b. How long have you owned this pet?
_____ (for example, 2 years)

8. How would you rate your physical health?
☐ Excellent ☐ Very good ☐ Good ☐ Poor
☐ Very poor

9. How many people are there that you can count on to listen when you need to talk to someone? (Check only one box)
☐ No one ☐ 1 person ☐ 2 people
☐ 3 people ☐ 4 people ☐ more than 4 people

10. How many people are there that help you feel better when you are generally feeling down in the dumps? (Check only one box)
☐ No one ☐ 1 person ☐ 2 people
☐ 3 people ☐ 4 people ☐ more than 4 people

B. Specific Information

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint as shown below.

Not at all |_____|_____| To a great extent

↑

(This mark indicates your level of agreement.)

1. I feel comfortable talking with the therapist. Not at all |_____| To a great extent

2. I find it easy to focus on important problems when I talk with the therapist. Not at all |_____| To a great extent

3. I look forward to coming to therapy. Not at all |_____| To a great extent

4. I would like therapy sessions to last longer. Not at all |_____| To a great extent

5. I am willing to discuss what is happening to important people in my life.

Not at all | _____ | To a great extent

6. I am willing to talk about my feelings during therapy sessions.

Not at all | _____ | To a great extent

7. As a result of this therapy session, I am more hopeful about my life.

Not at all | _____ | To a great extent

8. I feel like my mood has improved because of this therapy session.

Not at all | _____ | To a great extent

9. I feel less anxious because of this therapy session.

Not at all | _____ | To a great extent

C. Individual Goals

At the beginning of this therapy session, you and your therapist made a list of goals for this therapy session. Please write down each of those goals. Then, indicate the degree to which you feel each of the goals were met by checking the appropriate box to the right of the goal.

	Degree to which goal met				
	-2 Much less than expected	**-1 Somewhat less than expected**	**0 Expected level**	**+1 Somewhat better than expected**	**+ 2 Much better than expected**
Goal #1: _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #2: _____ _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #3: _____ _____ _____ _____	☐	☐	☐	☐	☐

D: Overall Assessment:

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint on the line. Answer only the questions that apply to you.

1. I feel that therapy helps me to perform better at school.

Not at all | _____ | To a great extent

2. I feel that therapy helps me to perform better at my own home.

Not at all | _____ | To a great extent

3. I feel that therapy has helped me to perform better at work.

Not at all | _____ | To a great extent

E. Specific Information (To be completed only by clients receiving Animal Assisted Therapy)

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint on the line.

1. The animal helps me feel more comfortable with the therapist.

Not at all | _____ | To a great extent

2. The animal helps me focus on important problems.

Not at all | _____ | To a great extent

3. The animal was of comfort to me during the therapy session.

Not at all | _____ | To a great extent

4. The animal makes me look forward to coming to therapy next time.

Not at all | _____ | To a great extent

5. Having the animal in the room makes me want to stay in the therapy session longer.	Not at all	_____	To a great extent
6. I am more willing to discuss what is happening to important people in my life with the animal present.	Not at all	_____	To a great extent
7. I am more willing to talk about my feelings with the animal present.	Not at all	_____	To a great extent
8. The animal accepts me for who I am.	Not at all	_____	To a great extent
9. I feel like taking better care of myself because of the animal.	Not at all	_____	To a great extent
10. I have trouble concentrating with the animal in the room.	Not at all	_____	To a great extent

F. Animal Handler Information

The following section is to be completed only if an animal handler (e.g., child care worker and his/her dog) was present in the therapy session.

1. I feel comfortable having the animal handler in the room.

Not at all | _____ | To a great extent

2. Having the animal handler in the room changes the way I talk with my therapist (that is, I feel less open in talking with the therapist).

Not at all | _____ | To a great extent

G: Comments

_____
_____
_____
_____

Client Questionnaire For Control (e.g., No AAT) Sessions

Note: This section (A: General Information) is to be completed at the beginning of the study only. The information from this section will be detached from the initial questionnaire and will be kept on file. You will be asked to complete the other sections of the Client Questionnaire (Sections B to E) at each of your therapy sessions over the course of the study. An ID number, which will be assigned at the beginning of the study, will identify these sections of the client questionnaire. This is done to protect your privacy and the confidentiality of your answers over the course of the study.

A. General Information

1. Today's Date:
_____/_____/_____
(Day) (Month) (Year)

2. Name: _____

3. Address:
_____

4. Postal Code: _____

5. What is your age? _____ Sex? _____

6. Marital Status: Married_____ Single_____
Other (please specify) _____

7. Do you own a pet? ☐ Yes ☐ No
   a. If yes, what type of pet do you own?
   ☐ dog ☐ cat ☐ other (please specify)
   b. How long have you owned this pet?
   _____ (for example, 2 years)

8. How would you rate your physical health?
☐ Excellent ☐ Very good ☐ Good ☐ Poor
☐ Very poor

9. How many people are there that you can count on to listen when you need to talk to someone? (Check only one box)
☐ No one ☐ 1 person ☐ 2 people
☐ 3 people ☐ 4 people ☐ more than 4 people

10. How many people are there that help you feel better when you are generally feeling down in the dumps? (Check only one box)
☐ No one ☐ 1 person ☐ 2 people
☐ 3 people ☐ 4 people ☐ more than 4 people

B. Specific Information

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint as shown below.

Not at all |_____|_____| To a great extent

↑

(This mark indicates your level of agreement.)

1. I feel comfortable talking with the therapist. Not at all |_____| To a great extent

2. I find it easy to focus on important problems when I talk with the therapist. Not at all |_____| To a great extent

3. I look forward to coming to therapy. Not at all |_____| To a great extent

4. I would like therapy sessions to last longer. Not at all |_____| To a great extent

5. I am willing to discuss what is happening to important people in my life.

Not at all | _____ | To a great extent

6. I am willing to talk about my feelings during therapy sessions.

Not at all | _____ | To a great extent

7. As a result of this therapy session, I am more hopeful about my life.

Not at all | _____ | To a great extent

8. I feel like my mood has improved because of this therapy session.

Not at all | _____ | To a great extent

9. I feel less anxious because of this therapy session.

Not at all | _____ | To a great extent

C. Individual Goals

At the beginning of this therapy session, you and your therapist made a list of goals for this therapy session. Please write down each of those goals. Then, indicate the degree to which you feel each of the goals were met by checking the appropriate box to the right of the goal.

	Degree to which goal met				
	-2 Much less than expected	**-1 Somewhat less than expected**	**0 Expected level**	**+1 Somewhat better than expected**	**+ 2 Much better than expected**
Goal #1: _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #2: _____ _____ _____ _____ _____	☐	☐	☐	☐	☐
Goal #3: _____ _____ _____ _____	☐	☐	☐	☐	☐

D: Overall Assessment:

For each of the questions below, place a mark on the line at a point that best represents your level of agreement with the statement. For example, if your level of agreement to a statement is midrange, then you will mark the line at the midpoint on the line. Answer only the questions that apply to you.

1. I feel that therapy helps me to perform better at school.

Not at all | _____ | To a great extent

2. I feel that therapy helps me to perform better at my own home.

Not at all | _____ | To a great extent

3. I feel that therapy has helped me to perform better at work.

Not at all | _____ | To a great extent

E. Comments

_____

_____

_____

_____

_____

Appendix E

Summary of Goals and Strategies for AAT in Mental Health Settings

Until he extends the circle of compassion to all living things,
man will not himself find peace.

Dr. Albert Schweitzer

Table 1: Example goals and strategies to develop rapport and foster relationships.

TREATMENT GOALS	AAT STRATEGY
Deepen trust with therapist (transference).	• Permit the client to hold or pet the companion animal while interacting with the therapist or the therapy group.
Develop rapport with therapist.	• The animal may be a common interest between the therapist and client and, thus, can create a bond and foster discussion.
Increase social interaction skills.	• Encourage the client to talk to the animal rather than the therapist. The client's focus on the animal may result in easier articulation of thoughts and words because animals are sympathetic listeners and cannot tell secrets. • Transfer the improved social interaction skills to family and peers.
Increase socialization and participation (individual or group).	• Prepare a scrapbook of photos, information, or articles about a specific dog breed and share the information with others. • Document attendance in therapy groups to determine if it increases when an animal is present.

TREATMENT GOALS	AAT STRATEGY
Improve relationships with peers.	• Use the relationships between the handler and the animal and between the therapist and the animal as a metaphor for human relationships. • Work at transferring this experience to peers.
Increase amount of eye contact with people.	• Work with the human-animal team to develop appropriate eye contact. • Work at transferring that skill to other relationships.
Improve appropriateness of voice tone with people.	• Work with the human-animal team to develop appropriate voice tone when training the animal. • Work at transferring this skill to other relationships.
Improve socialization, communication.	• Practice teaching an animal something new.

Table 2: Example goals and strategies to facilitate bonding.

TREATMENT GOAL	AAT STRATEGY
Encourage bonding to a living being.	• Give the client a photograph of themselves and the companion animal to help strengthen the bond between sessions. • Establish predictable routines for greeting and saying goodbye to the animal at each session.

TREATMENT GOAL	AAT STRATEGY
Acknowledgement of positive interactions.	• Observe the animal's recognition of the client at each session. • Observe and interpret the animal's happiness to see the client for each session.
Encouraging nurturing behavior.	• Allow client to nurture the animal with appropriate rewards and affection.
Improve ability to trust.	• Interact with and learn about the animal and its behaviours. • Talk to the animal. • Receive affection from the animal.
Learn about appropriate touch.	• Observe and discuss the animal's response to human touch. • Learn gentle ways to handle the animal. • Receive apparent acceptance from the animal. • Give appropriate affection to the animal. • Compare appropriate animal touch to appropriate human touch. • Forecast "what would happen if...?"
Distract from discomfort and pain (emotional or physical).	• Focus the discussion on the animal, rather than the client.

Table 3: Example goals and strategies to address emotions.

TREATMENT GOAL	AAT STRATEGY
Openly discuss feelings.	• Talk about traumatic events in the animal's life (e.g., being taken from its parents and siblings, going to live in a stranger's home, losing an owner due to illness, staying at a boarding kennel, getting in a fight with another animal, etc.) and ask the client to describe how the animal may have felt during these events. • Ask the client how they would feel if they were faced with similar situations. • Encourage the client to talk about their feelings through the animal. • Ask the client to interpret the animal's emotions as they occur. • Learn about animal emotions. • Observe and discuss the animal's response to human emotions. • Use pictures of feeling faces (animals and people) to make a game out of identifying emotions that are depicted in the pictures. Talk about what events might have resulted in those feelings. Give bonus points if the clients can identify their own negative self-beliefs and then state rational contradictions to these beliefs.

TREATMENT GOAL	AAT STRATEGY
Improve verbal expression.	• Ask the client to answer questions about the animal (express opinions).
Differentiate between comfortable and uncomfortable feelings.	• Talk about events in the animal's life and ask the client to determine if the animal likely felt comfortable or uncomfortable during these situations. • Ask the client how they would feel if they were faced with similar situations. • Transfer this information to relevant situations in the client's life.
Identify different emotions.	• Observe and interact with the animal. • Ask the client to describe what the animal may be feeling in a variety of situations (e.g., excited to see them, eager to do a trick, bored by repetitive activity, ecstatic to see a toy, frustrated if they cannot have something they want, uncertain about a new activity, frightened by a loud noise, tired after a run, disappointed about not being allowed to play).
Learn about verbal and non-verbal expressions of feelings.	• Observe and discuss the animal's verbal and non-verbal expressions and what they mean. • Compare what is learned to human expressions.

TREATMENT GOAL	AAT STRATEGY
Acquire socially acceptable ways of expressing feelings.	• Observe and interact with the animal. • Discuss the ways the animal expresses its feelings and what behaviours the client finds acceptable (e.g., prancing, wagging tail) or unacceptable (e.g., licking face, barking). • Discuss self-control and how to regulate behaviours in human relationships and experiences.
Recognize how others are feeling.	• Observe and interact with the animal. • Ask the client to describe what the animal may be feeling. • Transfer this to the human situation.

Table 4: Example goals and strategies for promoting empathy.

TREATMENT GOAL	AAT STRATEGY
Demonstrate appropriate nurturing behaviour.	• Observe and discuss appropriate nurturing behaviour with the animal. Observe humane animal-handling techniques. • Observe the loving bond between the animal and the handler. • Transfer these observations to human situations.

TREATMENT GOAL	AAT STRATEGY
Demonstrate appropriate correction techniques.	• Observe the animal making mistakes and the correction techniques used to handle the mistakes. • Discuss these observations. • Observe and discuss the empathy that the handler has for the animal.
Demonstrate patience and understanding.	• Teach the animal something new or try to get the animal to respond to obedience commands given by the client. • Encourage patience and teach the client how to get successful results.

Table 5: Example goals and strategies to build self-esteem.

TREATMENT GOALS	AAT STRATEGY
Increase sense of purpose.	• Provide care for the animal (e.g., walk, brush). • Research options for getting a companion animal after discharge.
Increase self-esteem through learning a new skill or re-learning/adapting a skill to previous status.	• Learn how to teach the animal something by first learning how to treat the animal with respect, developing a relationship with the animal, developing observation and listening skills, learning proper praising techniques, learning to be tolerant of mistakes (their own and the animal's), and

TREATMENT GOALS	AAT STRATEGY
	recognizing their progress. • Practice what is learned over a series of sessions. • Share the new skill with others. • Re-acquire an old skill (e.g., braid a rope that can be used as a leash for the animal, throw a ball).
Improve self-confidence.	• Have the client earn the respect and trust of the animal over time so that the animal will respond to the client's instructions. • Provide care (food, water, brushing) for the companion animal. • Receive recognition and attention from the animal.
Improve self-image.	• Receive apparent affection from the animal. • Have positive interactions with the animal.

Table 6: Example goals and strategies to promote 'giving' behavior.

TREATMENT GOAL	AAT STRATEGY
Learn about appropriate touch.	• Observe and discuss the animal's response to human touch. • Learn gentle ways to handle the animal. • Receive apparent acceptance from the animal. • Give affection to the animal. • Generalize the animal's behaviour to human circumstances.
Decrease self-talk and recognize the needs of others.	• Work with the human-animal team to determine the needs of the animal. • Discuss the importance of meeting the animal's needs. • Determine what might happen if the animal's needs were not met. • Transfer this information to other situations.

Table 7: Example goals and strategies for enhancing personal growth and development.

TREATMENT GOAL	AAT STRATEGY
Increase leisure awareness and lifestyle choices.	• Learn about proper animal care. • Compare animal and human care. • Discuss possible changes that would improve the client's lifestyle.

Increase vocabulary.	• Learn new words relating to different dog breeds, obedience commands, animal characteristics, etc. • Read or talk to the animal.
Stimulate interest, desire for knowledge.	• Give the client a project relating to an animal they are interested in. • Allow the client to share their information with peers.

Table 8: Example goals and strategies to provide a sense of control.

TREATMENT GOAL	AAT STRATEGY
Teach the animal a new trick or obedience command.	• Learn how to teach the animal something by first learning how to treat the animal with respect, developing a relationship with the animal, developing observation and listening skills, learning proper praising techniques, learning to be tolerant of mistakes (their own and the animal's), and recognizing their progress.
Increase assertiveness as shown/measured by _____.	• Practice role-playing assertive responses, with the animal as either an antagonist or a victim needing protection. Practice non-verbal assertion (tone of voice, eye contact, body posture).

Table 9: Example goals and strategies for reducing abusive thoughts and behaviors.

TREATMENT GOAL	AAT STRATEGY
Promote empathy for living beings.	• Learn about and interact with the animal. • Discuss the animal's feelings in a variety of situations. • Compare the animal's feelings to human emotions.
Decrease negative comments and increase positive comments.	• Work with the human-animal team to learn appropriate praising techniques. • Directly confront this issue, using the animal as an example, and transfer it to other situations.
Decrease abusive tendencies.	• Observe and discuss compassion and understanding within the human-animal team. • Observe and discuss appropriate ways to address frustration or anger. • Learn about and then assist in the care/grooming/feeding of an animal. • Learn about animal emotions. • Discuss how animals might feel if they are neglected or abused (relate to client's circumstances). • Transfer these observations to relevant situations in the client's life.

TREATMENT GOAL	AAT STRATEGY
Decrease anger outbursts and increase appropriate reactions to frustration.	• When situations of frustration or nonsuccess arise while working with the human-animal team, use the opportunity to confront inappropriate or appropriate reactions. • Reinforce appropriate responses to frustration and nonsuccess. • Transfer the observations to relevant situations in the client's life.
Decrease manipulative behaviours.	• Observe the animal's behaviour(s). • Learn about the meaning of animal behaviour(s). • Observe and discuss the animal's response to human behaviour (immediate consequences). • Generalize animal behaviour to human circumstances. • Practice teaching an animal something new. • Develop a cooperative plan to accomplish something with an animal. • Forecast "what would happen if...?" • Engage in play with an animal.
Improve cooperation.	• Learn about and then assist in the care/grooming/feeding of an animal. • Develop a cooperative plan to accomplish something with the animal.

Table 10: Example goals and strategies to address mental health concerns.

TREATMENT GOALS	AAT STRATEGY
Anxiety	
Decrease symptoms of anxiety or agitation.	• Hold or stroke the companion animal while interacting with the therapist or the therapy group. • Talk to the animal. • Receive affection from the animal.
Improve ability to relax using diaphragmatic breathing and relaxation techniques.	• Observe how a relaxed animal rests and breathes. • Practice imitating the animal while imagining stressful situations in anxiety hierarchy (desensitization).
Identify and reduce irrational thoughts which trigger or exacerbate anxiety.	• Discuss possible origin and symptoms of the animal's irrational fears (e.g., thunder) and relate to client's fears when possible. • Have client consider the origins of their own anxiety or phobia and identify the thoughts and sensations that trigger anxiety. • Have client explain why the animal need

TREATMENT GOALS	AAT STRATEGY
	not be afraid. Help client develop coping self-statements for client's situation. • If client is a child, then ask child to help animal confront fears with rational and more positive beliefs. A card game that matches irrational thoughts with the best counter ideas could be developed.
Reduce avoidance of anxiety-provoking situations, place, groups, etc.	• While client pets the animal, use guided imagery to desensitize fears (e.g., confrontations, using elevators, giving a speech, taking a test successfully, sleeping alone in the dark, etc.). • The animal may be able to accompany the client while they face some fears

TREATMENT GOALS	AAT STRATEGY
Increase assertiveness as shown/measured by:_____.	• Discuss fight or flight reactions in animals (cowering vs. aggression) and apply to people. • Practice role-playing with the animal taking various roles. • Practice process of gradually getting the animal to approach something it initially fears.
Identify and modify lifestyle variables that increase stress.	• Discuss stressors on animals and people (e.g., excessive noise, not eating or sleeping well, arguments, losses, etc.) and how these situations could be improved.
Reduce frequency of worrying, apprehension, and avoidance tactics.	• Write/tell stories (related to client's own anxiety and worries) about a dog or other animal that overcomes its fears by facing them and discovering they are not real. • If client is a child, then have them illustrate the story.

TREATMENT GOALS	AAT STRATEGY
Reduce secondary symptoms of anxiety (e.g., restlessness, fatigue, irritability, stomach aches, sleep disturbances.)	• Include client's symptoms in above stories with ways to reduce them. • If client is a child, then exercise/play hard with animal, then practice relaxing while petting animal and imagining relaxing scenes together.
Depression	
Brighten affect and mood.	• Hold or stroke the companion animal while interacting with the therapist or the therapy group. • Teach the animal to do a trick or engage in play with the animal.
Decrease learned helplessness behaviours. Increase sense of control over self and environment.	• Work with the human-animal team to effectively command the animal and to problem-solve when it does not respond correctly. • Directly confront this issue, using the animal as an example, and transfer it to other situations.

TREATMENT GOALS	AAT STRATEGY
Reduce isolation, boredom, loneliness.	• Engage in play with the animal. • Learn about and then assist in the care/grooming/ feeding of the animal. • Reminisce about the past. • Remember and repeat information about the animal. • Learn about the animal, then introduce the animal to peers. • Take the animal for a walk. • Receive apparent acceptance from the animal. • Give appropriate affection to the animal.
Decrease feelings of worthlessness.	• Provide pleasure for, or affection to the animal. • Spend time caring for/grooming the animal. • Take the animal for a walk, play its favourite game (e.g., fetch).

TREATMENT GOALS	AAT STRATEGY
Address grieving/loss issues.	• Talk about animals the person has known. • Reminisce about past animal loss(es). • Discuss how animals might feel when their animal companion dies, when baby animals leave their mothers, etc. • Transfer this to the human situation.
Reduce suicidal ideation/behaviour	• Ask: "If the animal were to die suddenly, what impact would his death have on those who love him? What impact would YOUR suicide have on your family and friends?" • Reflect on the animal's total self-acceptance without shame, without judging or comparing himself to others. • If the client is a child, then talk about how the animal has suffered a loss similar to the child's. Discuss how the animal might feel sad/hopeless or guilty and what could be done to help the

TREATMENT GOALS	AAT STRATEGY
	animal feel better. • Then discuss how the animal could let you know that he was feeling better. Apply to the child.
Increase positive mood, attitudes for a period of ____ consecutive weeks.	• Consider the simple things that make animals/people happy. • Engage in some of those activities. • Have client keep a "Pleasure Journal" of small, enjoyable events. • Ask clients about their future and what will make them happy? If client is a child, then ask him to draw picture of himself in the future.
Improve reality testing and orientation (reduce dissociation, self-mutilation, etc.).	• Have client touch or stroke animal to help ground them in the present. • Have client describe the animal objectively in terms of their appearance, needs, activities, where the animal is now, what month it is, etc.

TREATMENT GOALS	AAT STRATEGY
Increase energy, initiative, and activity level.	• Play actively with the animal, take animal on regular walks (either client's own animal or therapists). • Have client plan and teach the animal a new trick.
Increase assertion.	• Have client obedience train their own animal or therapists. • Compare the ways animals and people react to an assertive tone of voice, to "no," to positive reinforcement, etc.
Improve decision-making and concentration.	• Ask client what to do about a problematic behaviour of the animal's (parallel to client's behaviour when possible). • Plan short-term goals and steps toward reaching goals. • Apply process to client's situation. • If client is a child, then allow the child to decide what food treat to give the animal, or which game to play, or to decide when the animal needs to go out.

TREATMENT GOALS	AAT STRATEGY
	• If client is a child, then play "Simon Says" and "Mother May I?" using the animal's name (e.g., Rufus Says...) or the child's name (e.g., Jill says..."Sit!").
Reduce irrational thoughts that increase or maintain depression.	• Discuss the client's (or animal's) negative self-beliefs (e.g., I can't do anything right, nobody likes me, etc.) • Practice contradicting with rational statements. • As evidence to refute client's irrational thoughts, point out the animal's affection and loyalty to client, despite past mistakes, imperfections, etc.
Increase social interaction.	• Have client interpret the animal's feelings based on the animal's behaviour. • Ask the client to talk about their own feelings and behaviours in similar circumstances. • In groups, take turns throwing a ball for the animal or demonstrating tricks

TREATMENT GOALS	AAT STRATEGY
	the animal has learned to do. • Discuss amazing animal tales or feats.
Get an adequate amount of restorative sleep most nights for a period of _____	• Client observes how relaxed the animal is and how it breathes deeply. Practice similar breathing techniques while visualizing relaxing dream images for the client (or animal). • Try the same technique at night.
Increase interest and participation in daily activities.	• Monitor attendance and interaction at AAT sessions. • Talk about the client's daily activities and determine what may make them more fun. • Note how frequently the client smiles at or pets the animal.
Improve appetite most days for a period of ____ consecutive weeks.	• Point out character flaws or flaws in physical appearance of the animal and how they do not affect the animal's self-image. Work on translating this to clients who have problems with their own self-image. • If client is a child,

TREATMENT GOALS	AAT STRATEGY
	then have a tea party where the child feeds the animal and him/herself. • Play "red light-green light" when eating meals.
Attention-Deficit Hyperactivity	
Improve attention/concentration.	• Teach the animal a trick or an obedience command. • Transfer success in activities with the companion animal to treatment activities and daily living activities.
Decrease distractibility.	• Work with the human-animal team to help maintain concentration on the work with the animal when giving commands or teaching a trick. • Directly confront this issue, using the animal as an example, and transfer it to other situations.

TREATMENT GOALS	AAT STRATEGY
Improve memory (short-term or long-term) or recall.	• Recall information about the animal (name, age, colour, etc.). • Reminisce about animals the person knew or had in the past. • Remember details about the animal and the animal's care. • Describe the animal when it is not present. • Follow a sequence of instructions with the animal.
Improve reality orientation.	• Take the animal around and introduce it to others. • Interact with (pet, play, talk to, groom, etc.) the animal. • Give affection to and receive affection from the animal. • Reminisce about the past. • Remember and repeat information about the animal. • Describe the animal.

TREATMENT GOALS	AAT STRATEGY
Decrease self-talk relating to the fantasy world.	• Work with the human-animal team to emphasize the importance of staying focused on the "here and now" with the animal when giving commands. • Directly confront this issue, using the animal as an example, and transfer it to other situations.

The Chimo Project is named after
“Chimo”,
the Blue Heeler/Labrador cross pictured
below.

The name Chimo comes from the
Inuit toast to “good cheer”,
which is what this manual hopes to bring
to those who benefit from its message.